Training in Intercultural and Bilingual Competencies in Health and Social Care (TRICC)

UK Handbook

Nov 2010

ppre CIC

64 Antill Road

London

E3 5BP

ppre@onetel.com

Edited by John Eversley

With contributions from

Akgul Baylav

Jasmin Begum

L. Sukran Day

Gita Malhotra

Frances Rifkin

Bilan Said

This project has been carried out with support from the European Commission. This publication reflects the views only of the authors and the Commission cannot be held responsible for any use which may be made of the information contained therein.

Contents Page

1. Introduction	6
2. The Social Context	8
Country of Birth	8
Language	11
London's languages	14
Culture	17
3. Capability, Competences and Critical Health Literacy	21
Background	21
Capability	21
Competences	21
Critical Health Literacy	22
The Framework	23
Language	24
Communication	25
Knowledge	26
Power	29
Conclusions	30
4. Legal and Policy Context	35
Equality legislation	35

Human Rights	36
Citizenship	36
Regional and Minority Languages	37
Policy	37
5. The Organisational Context	40
Working definitions of mediator roles	40
Models of mediation	42
Guidelines and standards	43
Training and development for mediators and clinicians	44
Costs	48
6. Ethical Issues	48
Completeness and accuracy	48
Neutrality	49
Children as interpreters	50
Confidentiality	51
Informed Consent	52
Clinician and Patient responsibility	52
Choice	53
Professional and government guidance	54
The reality	55

7. The use of informal interpreters in three London communities	60
The Turkish-speaking communities	60
The Bangladeshi community	62
The Somali community	64
Methodology, Settings and Ethics	66
Results	67
Research participants' comments	73
8. The Training	79
Aim	79
The participants	79
Non-Governmental Organisations: Informal Interpreters	82
Further Education students	83
University student nurses	83
Health and healthcare managers and practitioners	83
Imams	84
Needs	84
Aims of specific training events	87
Organisation of training	88
Learning methods	89
Programme	90
Intended learning outcomes	93

Evaluation of training	94
Accreditation	98
9. Forum Theatre	100
Theory	100
The practice	102
Forum Theatre in the UK TRICC programme	102
Evaluation	104
Appendices	108
1. Expectations of training- Non-Governmental Organisations	108
2. Statements for university students	109
3. Case studies	110
4. Three part evaluation	112
5. Forum Theatre exercises	125
6. Spider's web	127
8. ppre associates backgrounds	128

1. Introduction

TRICC – Training in Intercultural and Bilingual Competencies in Health and Social Care

Background

John Eversley and Akgul Baylav (of ppre CIC) were the UK partners in a European Union (Grundtvig II) project called BICOM - Promoting Bilingual and Intercultural Competencies in Public Health - which ran from 2005 to 2007. The output of the BICOM project is described at http://www.bicom-eu.net/. This project identified the widespread practice of friends, neighbours, relatives, and colleagues being used as informal and *ad hoc* mediators in health and social care. The project recognised that the mediation was not simply linguistic but also related to inter-cultural interactions.

The present project - Training in Intercultural and Bilingual Competencies in Health and Social Care (TRICC) - is a follow-up from this earlier project. It ran from November 2008 to December 2010 and set out to elaborate on the findings of the BICOM project.

TRICC's Aims

- To acknowledge, support and enhance migrants' informal bilingual and intercultural competencies
- To develop informal adult education courses
- To test the training methodologies based on varied forms of learning techniques
- To make these courses ready for implementation for any European minority groups dealing with multilingualism.

The TRICC Partners

- Faculty of Social and Behavioural Sciences, Utrecht University (Utrecht, Netherlands)
- dock europe Training -Consultation - Mediation (Hamburg, Germany)
- COOSS Marche Social Cooperative (Ancona, Italy)
- Boğaziçi University (Istanbul, Turkey)
- ppre CIC (London, UK)

The project

During the programme, clinicians, social scientists, public health and social care experts and organisations working with ad-hoc interpreters:

- Carried out audits of the extent of the use of informal and *ad hoc* interpreters

- Undertook training needs assessments of *ad hoc* and informal mediators and health care providers and students
- Developed training opportunities (e.g. courses, seminars, conferences) for different target groups in order to enhance their intercultural and bilingual awareness and competencies in health and social care services.

Partner countries undertook different activities under these broad headings. The Turkish partner engaged in a parallel programme - 'cultural mirroring' - which looked at the need for and development of public service interpreting in Turkey. The Turkish partner was invited to join the programme because the preceding BICOM project had focussed its practical work on the Turkish and Kurdish immigrants and refugees living in the various partner countries.

It was intended that the partners would produce a portfolio of best practice for training courses in intercultural and bilingual competencies for health and social care providers as well as for service users from ethnic minority groups based on the research, training and evaluation of the TRICC activities. This Handbook is the UK's portfolio. The other partners are also producing their respective national handbooks and an International Handbook will bring the work of the project together, in its totality.

More information is at http://www.tricc-eu.net/index.html

2. The Social Context

Trying to capture the size and nature of the population who might experience barriers to access to health and well-being, healthcare and social care because of their differing migration histories, language abilities or cultural backgrounds is not at all straightforward. This chapter reviews some of the data which is available.

Country of birth

Whole population

January 2009 to December 2009

Estimated population resident in the United Kingdom, by country of birth

Country of Birth	Estimate 000's	%	Confidence Interval: can be +/- figure below
All	60,932		
United Kingdom	54,022	88.66	312
Non-United Kingdom	6,910	11.30	111
European Union 26[1]	2,183	3.60	63
Republic of Ireland	389	0.64	26
EU 13[2]	871	1.43	40
EU A8[3]	738	1.20	36
Rest of the World	4,727	7.76	92

Source: Office for National Statistics (2010a)

[1] European Union 26 consists of the countries in the EU13, the Republic of Ireland, EU A8, Malta and Cyprus, Bulgaria and Romania. The United Kingdom is not included in this group, but is shown separately in this table.

[2] Estimates are shown for the European Union 13 that is: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Italy, Luxembourg, Netherlands, Portugal, Spain and Sweden. The United Kingdom and the Republic of Ireland are not included in this grouping, but are shown separately in this table.

[3] European Union A8 consists of the Eastern European countries that joined the EU in 2004: Czech Republic, Estonia, Poland, Hungary, Latvia, Lithuania, Slovakia and Slovenia.

Mothers

Live births: age of mother and country of birth of mother [1], 2009		
		%
Total	**706,248**	
United Kingdom[2]	**532,046**	75.0
New Commonwealth	**69,633**	9.8
Other European Union (excluding UK and the Irish Republic)	**44,128**	6.2
Rest of Europe	**7,861**	1.1

Source: Office for National Statistics (2010b) New workers

NINo[4] registrations to adult overseas nationals entering the UK,

by year of registration and world area of origin

Thousands

	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
All	**435.35**	**663.06**	**705.84**	**733.09**	**686.11**	**572.74**
Europe - EU excluding Accession Countries	80.71	97.84	102.75	107.47	120.14	91.36
Europe - EU Accession Countries	116.84	276.68	317.50	332.44	257.04	182.77
Europe - non-EU	14.04	15.50	16.14	17.21	16.10	12.90
Africa	64.08	74.03	60.72	59.63	63.31	48.14
Asia and Middle East	109.39	134.40	143.79	149.87	163.04	190.57
The Americas	26.52	31.53	31.50	32.64	36.45	28.15
Australasia and Oceania	23.16	32.51	32.98	33.35	29.53	18.34
Others and Unknown	0.61	0.56	0.46	0.49	0.50	0.52

Source: Department for Work and Pensions (2010)

[4] National Insurance Registrations

Language

The data on the number of children whose mother tongue is other than English is much more comprehensive that of adults who speak another language than or as well as English.

State schools in England are required to collect data on:

"a first language other than English… where a child was exposed to this language during early development and continues to be exposed to this language in the home or in the community. If a child was exposed to more than one language (which may include English) during early development, a language other than English should be recorded, irrespective of the child's proficiency in English." (DCSF DfES, 2006)

It should be born in mind therefore that the data does not provide information on the number of languages spoken by a child, their language preference or their fluency in English. However it gives an insight into 'home' languages. Across England as a whole it shows that minority languages are known by (spoken or understood) 900,000 school pupils or a bit less than 14% of the school population.

Pupils with languages other than English

Table: Number and percentage of pupils by first language January 2010

	Pupils of compulsory school age and above					
	Maintained Primary Schools		State-Funded Secondary		Special Schools	
	Number of pupils	Percentage of pupils	Number of pupils	Percentage of pupils	Number of pupils	Percentage of pupils
First language is known or believed to be other than English	518,020	16.0	378,220	11.6	9,380	10.9
First language is known or believed to be English	2,707,240	83.8	2,856,590	87.9	76,320	88.9
Unclassified (6)	4,830	0.1	14,150	0.4	190	0.2
Total (7)	**3,230,090**	**100.0**	**3,248,960**	**100.0**	**85,890**	**100.0**

Source: School Census

Maintained, Primary, State-funded Secondary and Special Schools, England

Source: Department for Education, 2010

In the Millennium Cohort study, in a little over 15% of households either only a language other than English is spoken at home or English and another language:

Language spoken at home	Percentage
English only	83.6433
English and other language(s)	12.0974
Other language(s) only	3.3483

Source: Millennium Cohort Study: Second Survey, 2003-2005

When we look for information about the number of adults who have a home language other than English or have very limited English, the figures are less comprehensive and up-to-date. Gill and Quirke (2007) calculated that there were over half a million people from four minority ethnic groups who had slight or limited English based on the 2001 size of the communities and information from a sample survey:

Ethnic Group	Gender	Population within England and Wales	Slight or no ability to speak English (%)	Number with slight or no ability to speak English	Total number by ethnic group
Indian	Men	1,036,807	26.3	66,155	191,508
	Women		35.1	125,353	
Pakistani	Men	714,826	37.2	67,734	192,265
	Women		48.3	124,531	
Bangladeshi	Men	280,830	42	30,615	89,476
	Women		59.1	58,861	
Chinese	Men	226,948	55.7	41,808	85,950
	Women		48.1	44,142	
Total					559,199

Source: Gill and Quirke, 2007

British Sign Language (BSL) has been a recognised British language since 2003; it is the fourth commonest language in the UK, and is the primary language used by around 250,000

Deaf British citizens, many of whom cannot understand spoken or written English (Stapleton, 2007).

In an earlier study of adults using the health services, whilst 45·6% of South Asian patients had a good command of English, 29·4% did not understood English at all. The situation was more pronounced among elderly patients, with only 3·2% of those aged 65 years or above being fluent in English in contrast to 67·2% of those under 65 years. Nevertheless, 14·8% of adult patients were unable to communicate in English when accessing health care. South Asian women were less likely than South Asian men to be able to communicate in English with 66·7% of women having little or no understanding of English in contrast to 45·2% of men. In 60% of the 75 visits by District Nurses made to South Asian patients who understood little or no English, a family member interpreted; however, in 37·3% of cases no interpreter was available (Gerrish, 2001)

Although one might expect that the longer people live in the UK the more likely they are to be exposed to English, Jones (date) points out one potential countervailing tendency. Another study (Carr-Hill et al, 1996) noted that nearly 90% of 1200 people from nine different minority linguistic communities watched television in English.

"Ten years later technology has moved on, and the homes of my patients have satellite TV invariably tuned to non-English channels" (Jones, 2007).

London's languages

More detailed information is available for pupils in London. It shows that a little fewer than 40% of pupils in London have a home language other than, or as well as, English.

Language data categories	'000	%
English or Believed to be English	644	59.4
Minority languages (specified)	358	32.9
Minority languages (unspecified)	8	0.8
'Other than English' and 'Believed to be Other than English'	63	5.9
Information not obtained, refused or unknown	11	1.0
Total	1,084	100

Source: Eversley et al, 2010

233 different languages are recorded but a third of those have less than ten speakers in London's schools and twelve languages account for about 60% of the pupils with minority languages.

Numbers of pupils speaking a language other than English

Size of minority language group (number of pupils)	No. of languages in 2008
10,000+	12
1,000 to 9,999	30
100 to 999	44
10 to 99	68
1 to 9	76
Languages where data not available or reliable	3
Total no. of languages recorded	233

Source: Eversley et al, 2010

Specific languages in London

	Language	No. of pupils in 2008
1	Bengali (with Sylheti)	46,681
2	Urdu	29,354
3	Somali	27,126
4	Panjabi	20,998
5	Gujarati	19,572
6	Arabic	19,378
7	Turkish	16,778
8	Tamil	16,386
9	Yoruba	13,961
10	French	13,020
11	Portuguese	11,915
12	Polish	10,991

Source: Eversley et al, 2010

Culture

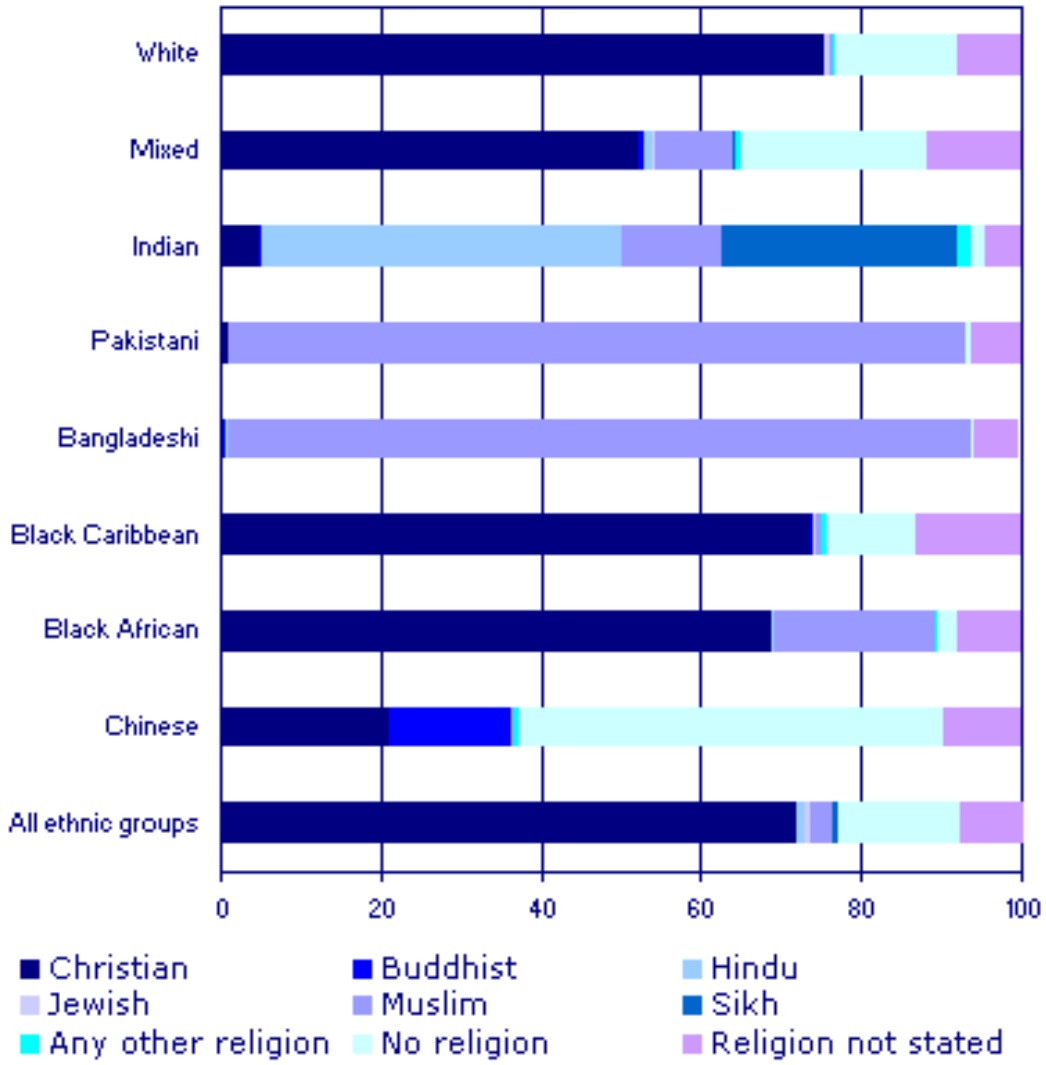
It is possible to give numbers of people by broad ethnic group and by religion but, as the Chapter on Capability, Competences and Critical Health Literacy highlights, there are issues about what exactly is being measured. Also, the most comprehensive information is from the Census taken in 2001 and is therefore seriously out-of-date.

Population of the United Kingdom: by ethnic group, April 2001

United Kingdom

	Total population		Non-White population
	(Numbers)	(Percentages)	(Percentages)
White	**54,153,898**	**92.1**	.
Mixed	**677,117**	**1.2**	**14.6**
Indian	1,053,411	1.8	22.7
Pakistani	747,285	1.3	16.1
Bangladeshi	283,063	0.5	6.1
Other Asian	247,664	0.4	5.3
All Asian or Asian British	**2,331,423**	**4.0**	**50.3**
Black Caribbean	565,876	1.0	12.2
Black African	485,277	0.8	10.5
Black Other	97,585	0.2	2.1
All Black or Black British	**1,148,738**	**2.0**	**24.8**
Chinese	**247,403**	**0.4**	**5.3**
Other ethnic groups	**230,615**	**0.4**	**5.0**
All minority ethnic population	**4,635,296**	**7.9**	**100.0**
All population	**58,789,194**	**100**	.

Source: Office for National Statistics (2010c)



Source: Office for National Statistics (2010d)

References

Carr-Hill R.; Passingham, S.; Wolf, A.; Kent, N. (*1996) Lost opportunities: the language skills of linguistic minorities in England and Wales*. London: Basic Skills Agency,

DCSF DfES (2006) *Pupil Language Data: Guidance for Local Authorities on schools' collection and recording of data on pupils' languages* http://www.standards.dcsf.gov.uk/ethnicminorities/collecting/Pupil_First_Lang/ (Accessed 20 March 2010)

Department for Education, 2010 *Schools, Pupils and their Characteristics: January 2010* http://www.dcsf.gov.uk/rsgateway/DB/SFR/s000925/SFR09-2010NT.xls (Accessed 26 October 2010)

Department for Work and Pensions (2010) National Insurance Number Allocations to Adult Overseas Nationals Entering the UK for 2009/10 http://statistics.dwp.gov.uk/asd/asd1/tabtools/nino_allocations_aug10.pdf (accessed 26 October 2010)

Eversley, J.; Mehmedbegovic, D.; Sanderson, A.; Tinsley, T.: von Ahn, M.: and Wiggins, R.D. (2010) *Language Capital - Mapping the languages of London's schoolchildren* London: CILT

Gerrish, K (2001) The nature and effect of communication difficulties arising from interactions between district nurses and South Asian patients and their carers *Journal of Advanced Nursing* Volume 33, Issue 5, pages 566–574, March 2001

Gill, P and Quirke, T (2007) Urgent need for local data to meet the translation need *BMJ online* 1 March 2007 http://www.bmj.com/content/334/7590/398.full/reply#bmj_el_162432 (Accessed 27 Oct. 10)

Centre for Longitudinal Studies (Online) *Millennium Cohort Study: Second Survey, 2003-2005* http://www.esds.ac.uk/findingData/variableInfo.asp?sn=5350&recid=7&class=0&varid=32&qu=language (Accessed 1st Nov 2010)

Gill, P. and Quirke, T. (2007) Urgent need for local data to meet the translation need *BMJ Online* 1 March 2007

http://www.bmj.com/content/334/7590/398.short/reply#bmj_el_160766 (Accessed 1st Nov 2010)

Gill, P.; Shankar, A; Quirke, T. Freemantle, N. (2009) Access to interpreting services in England: secondary analysis of national data *BMC Public Health* 9: 12.Published online

January 12. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2654558/ (Accessed 1st Nov 2010)

Office for National Statistics (2010a) *Population by Country of Birth and Nationality Jan-Dec 2009* http://www.statistics.gov.uk/downloads/theme_population/Population-by-country-of-birth-and-nationality-Jan09-Dec09.zip(Accessed 27 Oct. 10)

Office for National Statistics (2010b) *Birth summary tables, England and Wales 2009: 21/07/* http://www.statistics.gov.uk/downloads/theme_population/country-of-birth-tables.xls (accessed 26 October 2010)

Office for National Statistics (2010c) *Focus on Ethnicity – Ethnic Group* http://www.statistics.gov.uk/cci/nugget.asp?id=455 (Accessed 3 November 2010)

Office for National Statistics (2010c) *Focus on Ethnicity – Religion* http://www.statistics.gov.uk/cci/nugget.asp?id=460 (Accessed 3 November 2010)

3. Capability, Competences and Critical Health Literacy

1. Background

There are many factors that affect access to healthcare and healthy living for Black and Minority Ethnic, Migrant and Refugee communities. The literature on barriers focuses on institutions, processes and people as obstacles to equal access to health and healthcare (Szczepura 2004). Here we focus on people and their relationships to structures and processes.

There are differences in:

- Explanations of what the issues or barriers are
- Responses to the issues

Therefore there is a need for a framework to consider the different perspectives. This chapter outlines such a framework.

2. Capability

Capability is the will and the power to do something. If we are trying to understand whether people have human rights to health, healthcare or to be understood, it is important to look at all the barriers that may prevent realisation of the potential to be and to do. These include institutional arrangements as well as personal actions. Amartya Sen's Capability approach expresses this (Vizard, 2005).

The concept of capability can be applied to economic, political, social or psychological barriers to accessing health and health care. The concepts of capability and competence are often conflated. To adopt Agatha Christie's formula for solving mysteries capability involves having the Means, Motive and Opportunity to do 'the right thing'. Capability is having the structures and processes in place to enable meaningful interactions to improve health mainly involving planners and managers of public health and healthcare.

3. Competences

Competence is about 'doing the thing right'. Competence is having and using the knowledge and skills to perform the tasks necessary to achieve capability. Competence is the action. Competences in health are the individual inter- and intra-personal skills healthcare providers, health promoters and mediators need to deliver effective healthcare.

They are attributes of individual practitioners and are increasingly required by regulatory bodies such as the Nursing and Midwifery Council (NMC) competences for midwives which requires midwives to provide seamless care and interventions which are appropriate to the woman's assessed needs, context and culture (NMCa. Online). They are often linked to

standards of practice. For nurses and midwives there is, for example, a requirement to 'make arrangements to meet people's language and communication needs' (NMCb, Online).

4. Critical Health Literacy

Much of the writing about language and culture and healthcare either focuses on deficits in skills of practitioners or of users. Practitioners are characterised as lacking cultural sensitivity (Machlachlan and McGee, 2007) and users as lacking (English) language skills and knowledge on how the system works (Tribe and Raval, 2003).

Critical Health Literacy has a different perspective in that it looks at the knowledge and skills that people often have but are locked up or underutilised. The idea of critical consciousnesses comes from the work of Paulo Freire (Freire, 1972). It is worth observing that part of the specific context in which Freire developed his ideas was that in Brazil, Peru and Chile people were fluent in 'indigenous' languages but could not communicate in the official languages of Portuguese and Spanish. The concept has been specifically applied to health by Nutbeam (Nutbeam and Kickbush, 2000) among others. Greenhalgh has applied critical consciousness to language and cultural competence:

'*Education has a critical role in creating engagement and liberating society's most vulnerable members from oppression...NHS Interpreters should be developed as community educators (Greenhalgh, 2007).*

The idea that critical health literacy is 'the other side of the coin' to cultural capability comes from Chiu (Chiu, 2010).

Critical Health Literacy relates to a number of other important ideas about the removal of barriers to effective access to health and healthcare:

> Co-production (Bovaird, 2007): critical health literacy includes the resources (including confidence, knowledge and skills) that users need to be co-producers of health and healthcare. The need for health providers to develop skills in order to unlock the knowledge of patients is contained in ideas like Narrative-based healthcare (Greenhalgh and Hurwitz, 1998):
> Concordance: focuses on the skills, knowledge and attitudes of health providers, particularly in relation to shared ethnic faith or linguistic backgrounds (Cooper and Powe, 2004). This in turn may be part of a wider approach to community or social cohesion or social capital.[5]
> Autonomy and self-determination: The idea that health and health care are a means to the ultimate aim of the capability of freedom is contained in the theoretical work

[5] The relationship between community and social cohesion is explored in a forthcoming chapter by Peter Ratcliffe (in Ratcliffe and Newman, in press)

of Amartya Sen (Vizard, 2005), and applied specifically to interpreting in healthcare by Cushing (Cushing in Tribe and Raval, 2003)).

5. The framework

We have developed a framework to contextualise the approaches to overcoming linguistic and cultural barriers to accessing effective healthcare and maintaining health and well-being. This is explored in the sections following but is summarised in this diagram:

Issue	**Intervention**			
	Patient responsibility	**Capable or competent health professionals**	**Paid, trained mediators**	***Ad hoc* or informal mediators**
Language	Patients should learn English'	Bilingual practitioners	Interpreters	Friends, neighbours, relatives, colleagues as interpreters
Communication	'Just ask the patient'; patients have to say if they don't understand	Practitioners need to enhance communication skills	Advisers on 'plain' or lay language	Friends, neighbours, relatives, colleagues as escorts
Cultural Knowledge	Assimilation; Expert patients'; patients should articulate their needs	Concordance or trained in cultural and faith competences	Linkworkers; writers of fact packs	'Community' and religious advisers
Power	Empowerment: critical health literacy	Anti-racism training; consciousness of power of professions	Advocates	Friends, neighbours, relatives, colleagues as representatives

6. Language

This model starts from the recognition that even if there is a dominant or official language, there are users of minority languages. In the UK the dominant language is English.

6.1.'Why don't they speak English?'

Some people would argue that it is neither necessary nor desirable to provide access to healthcare in anything other than the dominant or official language (Oak, 2007). They might favour 'prescribing' English language classes (Adams, 2007).

Users of minority languages are often described as 'Bilingual speakers'. As Baker points out there are actually five basic language competences [sic] – speaking, listening, reading, writing and thinking. Many people use different language competences in different contexts (Cruz-Ferreira, 2010). They are more accurately described as 'plurilingual' if they use more than one language (Council of Europe, 2001). This is of practical importance: people will rate their fluency and choose which language to use according to the context (Alexander et al, 2004). `In the Council of Europe classification people are plurilingual and places are multilingual if more than one language is used. It is also widely recognised that not all languages have equal status. People over-report their fluency in 'high-status' languages and under-report their fluency in lower-status languages (DSCSF/DfES, 2006). This has implications for assessing needs and the effectiveness of interventions.

The need to have capability in order to acquire competences is relevant to language. The ability to acquire the competences in English is impaired by economic, social and psychological barriers, both to learning English and being able to use it (Working Group on ESOL, 2000). Even when people want to learn or use it they may not get the opportunity. In 2007 and 2008 the government cut back the provision for English for Speakers of Other Languages (BBC, 2007, Sunderland, 2008, Gidley and Jayaweera, 2010).

6.2. Bilingual healthcare professionals

This intervention requires the recruitment of people to work in clinical and gate keeping jobs who speak minority as well as the majority language. Some employers have specifically recruited and/or trained people with such language skills.

Bilingual health workers… workers remove the need for a third party to be involved and are the ideal option for most patients. Bilingual health workers are, however, few and will never be universally available

(Phelan and Parkman, 1995).

Despite the fact that many people see this as the gold standard, there is surprisingly little research on how effective it is and how it feels to the practitioners and the service users. There is evidence of patients choosing GPs because they speak their language but the positive aspects are often part of a wider package of 'concordance' in relation to culture and

faith. There are also negatives which relate to the over-representation of Black and Minority Ethnic GPs in smaller, less well-resourced practices.

6.3. Paid Interpreters

Specialist language interpreters who are recruited and trained to work alongside healthcare providers and patients are discussed extensively in the Organisation Context chapter. As well as face-to-face interpreters there are remote interpreters using phones or web cams.

6.4. Informal and *ad hoc* interpreters

Friends, neighbours, relatives and colleagues are often called upon as interpreters. Research for the TRICC project has shown that this may happen even when paid and trained mediators are available – see Chapter 7.

7. Communication

The communication perspective starts from the premise that in every interaction between people there is a need for knowledge and skills for effective communication. Apart from the 'inevitabilist' perspective that miscommunication is inevitable and it is up to the patient to make an effort to understand and be understood, there are three main approaches to enhancing communication:

7.1. 'Just ask the patient'

As Greenhalgh and Hurwitz say 'even the most pompous of professors have been known to chide their students with the warning, "Listen to the patients; s/he is telling you the diagnosis" '(Greenhalgh and Hurwitz, 1998b in Greenhalgh and Hurwitz 1998a). However, the development of pathological anatomy and new techniques of physical examination from the eighteenth century onwards made doctors less reliant on patients' narratives (Hogarth and Marks, 1998). In any case understanding what patients tell practitioners is much more complicated than just listening (Greenhalgh and Hurwitz, 1998a).

7.2. Communication skills for health professionals

Regulatory bodies may require or encourage the learning of communication skills for health workers. Regulatory and professional bodies require good communication skills and practice (E.g. GMC, Online). For more than ten years communication has been one of the benchmark areas for the Government's 'Essence of Care' (Department of Health, Online). It is part of the curriculum for doctors, nurses and other health practitioners.

7.3. Paid advisers

Healthcare and health promotion bodies may employ specialist advisers on 'Communications' or 'social marketing' who are tasked with advising both healthcare providers and users on how to be understood. Specifically, where there are cultural or linguistic differences between health providers and users, they may be called Linkworkers (See Organisational context chapter).

7.4. Unpaid advisers

Patients may be allowed or encouraged to have someone with them when they go for a consultation who is a 'second pair of ears' or a 'second head'.

8. Knowledge

The third approach to interventions to overcome barriers to access starts from the premise that what is needed is to share culture, or at least to understand different cultures.

To explore this, it is first necessary to clarify what might be meant by culture.

8.1. Culture

Kirmayer identifies three phases in the evolution of the word 'culture'. The first emerged when people moved from agrarian and nomadic societies to more urban and static living. Culture was associated with rules of conduct, refinement and civilisation (Kirmayer, 2007). This is essentially a sociological meaning of culture at a meta- level – going beyond specific societies. The second meaning is a collective identity – setting apart of one group of people on the basis of historical lineage, language, religion, gender or ethnicity (Kirmayer, 2007). This is more on the macro – level of identifying characteristics within specific societies and times and uses the academic disciplines of anthropology, social psychology and sociology. The third notion is of culture as a way of life: values, customs, beliefs and practices that form a complex system (Kirmayer, 2007). This might be outward behaviour or internal attitudes and beliefs about personal identity - a micro and nano – level drawing on psychology, sociology and political science.

All three meanings raise questions about what individuals and groups have in common and what differentiates them; how dynamic, contextual or static characteristics are; how gender, age, faith and socio-economic status intersect with culture identified by ethnicity.

The complexity of this is illustrated by the results of the government's Citizenship Survey which asked people about being British and which values they thought were most important for living in Britain. Among the results:

- Indian (89%) and Pakistani people (89%) were more likely to feel they strongly belong to Britain than White people (84%).
- Bangladeshi and Pakistani people were more likely (both 64%) to place 'Respect for the Law' as the most important value than White people
- Respect for the law was seen as more or less equally important by Christians and Muslims (60% and 61%, respectively)
- Differences by age were bigger: 49% of 16-24 year olds and 61% of 50 -64 year olds saying respect for the law was one of the five most important values for living in Britain.

8.2. Cultural Capability and competence

There is now an extensive literature on the concept of cultural capability and its relevance to healthcare, including literature reviews (Brach and Fraserirector, 2000; Fortier and Bishop, 2004; Goode et al, 2006).

Bhui and Bhugra say in relation to cultural capability and competence:

'Cultural competency' [is] often reduced to knowledge about specific cultural groups and tends to be applied concretely as if competence were a static entity. Cultural capability... includes elements of ability in more general term, referring to possession of skills, knowledge, and powers, or something being possible.

(Bhui and Bhugra in Bhugra and Bhui, 2007)

Cultural competence has been defined as

'A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, [etc] … to work effectively in cross-cultural situations'

(Cross et al. 1989; Isaacs & Benjamin 1991)

Many writers (for example in Bhugra and Bhui, 2007) have expressed concerns about the idea that capability or competence are about learning a canon of knowledge as though culture is a static body of facts applied to everybody in a designated group – positivism and 'essentialism'. This approach has given rise to a genre of 'Ethnic fact packs' (See for example: Dutt, 1994 and Karmi Ed, 1995).

These dangers may be minimised by Stier's division of competences into content- and process- based competences (Stier, 2003):

- Content knowledge about customs, world views, beliefs about health, illness, dietary requirements, religious observance etc
- Process knowledge (closely tied to communication) which is both intra- personal - the ability to reflect, solve problems and display empathy and inter personal which is, for example about the sensitivity to people and situations.

Clinicians and service users may, or may not, have shared knowledge of each other's values, beliefs and behaviour. If they have it, is characterised as 'concordance' (Cooper and Powe, 2000), 'cohesion' or 'social capital' (Ratcliffe, in press). If they don't share these things, it is argued that there is a need to develop or create them, or for people to change their values, beliefs and behaviour.

8.3. Assimilation and 'Expert patients'

Some people think it is the responsibility of the patient to conform to the values, beliefs or behaviour of the provider, or at least to make differences clear. The UK Citizenship test asks questions about health; the emphasis of one widely available Citizenship Study Guide is on what you should do as a patient - including 'bring your own interpreter or ask for one'. Elsewhere it explains that the Grand National, the FA Cup Final and Wimbledon tennis are important customs (Lancaster and Coull, 2007).

The Expert Patients Programme (EPP) reflects a different approach to the idea that service users may know a lot about what is best for them and that providers need to work in partnership with them,. An evaluation of their work reported that: of participants in their courses:

- More than half felt they were better at getting what they want from health care professionals
- 61% say they were more likely to speak out
- 71% were more willing to say exactly what they wanted (Expert patients programme, Online)

However the EPP website does not highlight linguistic or cultural barriers and how the programme might overcome them. By implication, the identity of being a patient with a long-term health condition is considered to be a more relevant factor.

8.4. Training and expertise in culture or faith

Content-focused knowledge development for healthcare workers may take the form of training on the 'culture' or 'faith of specific groups e.g.' What Muslims believe', or information such as a 'Guide to taking medicine in Ramadan'. It may also mean specifically recruiting clinicians because they are believed to have such knowledge. Process-centred knowledge development might focus more on introspection about the health providers own beliefs and values or how to ask patients questions and interpret answers in a culturally sensitive way.

Hamilton and Essat studied student nurses to assess their cultural competence. On 'content knowledge' they found a low-level of knowledge both among students just starting training and those in their third year. They also showed a low awareness of subjects that had been covered and many felt that what they had learned had not been useful (Hamilton and Essat, 2008).

8.5. Advisers and Linkworkers

Diversity and equality advisers and/or Linkworkers are employed specifically to act as cultural mediators, either at an institutional level or at a patient level. They may provide informal or formal training of the kind described in 8.4. above.

8.6. Community advisers

Many healthcare planners and providers turn to community advisers who might be religious advisers such as Imams or priests, or community-based advice organisations. They are often deferred to as either experts or authority figures. There is often little or no exploration of what the basis of expertise or authority is, and little recognition that there can be a diversity of opinion or practice within communities and faith groups.

9. Power

In this analysis, the barrier between healthcare provider and user is one of unequal power. The analysis is (usually) that the clinician is powerful (with hierarchies of profession, gender and seniority) and the patient is subordinate (Illich, 2001; Zola, 1977, Fitzpatrick, 2000).

9.1. Patient power

Some people might argue that asymmetric power is inevitable or even desirable – the practitioner is expert and ought to have authority. Against that, it may be argued that beliefs about superiority and inferiority or control, and lack of control, are getting in the way of meeting the patients' needs effectively. It could be argued that it is a matter of personal preference but the authors like Illich and Zola would broadly argue that it is a form of internalised oppression which requires intervention.

9.2. New professionalism

Across many professions it has been argued that they need to change from being 'experts on top' to 'enablers on tap' (Schön, 1983). They are taught to cultivate the skills of drawing out the service user's aspirations and working out with them how to meet them.

9.3. Advocates

Some healthcare systems specifically employ mediators whose job is to 'empower' patients. This may include 'Advocates' who work in 1-1 situations with patients and clinicians or facilitators of, for example, 'expert patient' groups who focus on sharing knowledge between patients. The role of advocates is discussed in the Organisation chapter.

9.4. Patient participation

Friends, neighbours or relatives may act as escorts to individuals as a 'second voice' or there are patient representative bodies which advise, inform or direct health care providers.

10. Conclusions

What emerges from the framework described above is

1. There are a wide variety of explanations of what the people-related barriers to health and healthcare are for Black Minority Ethnic, Refugee and Migrant communities.

2. The evidence for any analysis of causes or evaluation of the interventions is patchy.

3. For every intervention there are arguments for and against. Common themes in the arguments are:

- Cost
- Feasibility
- How mediation impacts on clinician responsibility
- How mediation impacts on patient autonomy - including privacy, choice etc.
- Whether there is a canon of knowledge that is objective about language, culture, power etc or whether it is subjective and relative and/or unique to individuals. Or it may be seen as dynamic - always changing- requiring bespoke interventions tailored to individuals and 'moments'.
- Running through all the four approaches to barriers, informal, *ad hoc* or unpaid mediators are used.

It is in this context that the UK TRICC project interventions took place.

References

Adams, K (2007) Should the NHS curb spending on translation services? *BMJ* 2007; 334: 398 22 February.

Alexander, C.; Edwards, R. and Temple, B. with Kanani, U.; Zhuang, L.; Miah, M. and Sam, A (2004*) Using interpreters to access services: user views.* http://www.jrf.org.uk/sites/files/jrf/1859352294.pdf (Accessed 1 Nov 2010)

Baker C (4th edn, 2006) Foundations of Bilingual Education and Bilingualism. Clevedon: Multilingual Matters.

BBC (2007) *Migrant English classes cuts row* http://news.bbc.co.uk/1/hi/education/6252779.stm (Accessed 2nd Nov 2010)

Bhugra, D & Bhui, K (2007) *Textbook of Cultural Psychiatry*. Cambridge University Press. Cambridge.

Brach, C and I Fraserirector, 2000, 'Can Cultural Competency Reduce Racial and Ethnic Health Disparities? A Review and Conceptual Model' in *Medical Care Research and Review* vol 57 supp 1, 181-217.

Bovaird T (2007) Beyond Engagement and Participation: User and Community Coproduction of Public Services *Public Administration Review* Volume 67, Issue 5, pages 846–860, September/October 2007 http://rural.carnegieuktrust.org.uk/files/rural/Beyond%20Engagement%20and%20Participation-%20T%20Bovaird.pdf (Accessed 1 November 2010)

Chiu L.F. (2010) *Is health literacy the other side of the cultural competence coin?* http://www.ausl.re.it/HPH/FRONTEND/Home/DocumentViewer.aspx?document_id=957 (Accessed 1 November 2010)

Cooper, L. and. Powe, N (2004) *Disparities in patient experiences, healthcare processes and outcomes – the role of patient-provider racial, ethnic and language concordance.* http://www.commonwealthfund.org/programs/minority/cooper_raceconcordance_753.pdf (Accessed 1 November 2010)

Council of Europe (2001) *Common European Framework of Reference for Languages: Learning, Teaching, Assessment* Cambridge: Cambridge University Press.

Cross T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care, volume I.* Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Cruz-Ferreira, M. (2010) *Multilinguals are…*London: Battlebridge.

Department of Health (Online) *Essence of Care 2010* http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_119978.pdf

Department for Children, Schools and Families [DCSF, later DfES, now DfE] (2006) *Collecting language data: over-reported and under-reported languages* http://www.standards.dcsf.gov.uk/ethnicminorities/resources/langdatacollection.pdf (Accessed 20 March 2010)

Dutt, G (1995) *Health Care for Bangladeshis Abroad*. London: G.C Dutt.

Expert Patients Programme (online) http://www.expertpatients.co.uk/about-us/facts-and-figures

Fitzpatrick, M (2000) *The Tyranny of Health: Doctors and the Regulation of Lifestyle*. London: Routledge.

Fortier, J. and Bishop D. *Setting the Agenda for Research on Cultural Competence in Health Care*. Brach C, editor. August 2004. Office of Minority Health and Agency for Healthcare Research and Quality. http://www.ahrq.gov/research/cultural.htm

Freire, P (1972) *Pedagogy of the Oppressed*, London: Penguin.

General Medical Council [online*] Good Medical Practice: communication* http://www.gmc-uk.org/guidance/good_medical_practice/relationships_with_patients_good_communication.asp (Accessed 1st Nov 2010).

Gidley, B. and Jayaweera, H. (2010) *An evidence base on migration and integration in London*. Mayor of London. http://www.london.gov.uk/sites/default/files/An%20evidence%20base%20on%20migration%20and%20integration%20in%20London.pdf (Accessed 15 Nov 2010).

Greenhalgh, T. and Hurwitz, B a (1998a) *Narrative Based Medicine* London; BMJ books

Greenhalgh, T. and Hurwitz, B (1998b) Why study narrative? In Greenhalgh, T. and Hurwitz, B, 1998 op cit.

Goode, T. Dunne, M. C. and Bronheim, S. (2006) *The evidence base for cultural and linguistic competency in healthcare.* Commonwealth Fund http://www.commonwealthfund.org/usr_doc/Goode_evidencebasecultlinguisticcomp_962.pdf (Accessed 1st Nov 2010).

Hamilton, M. and Essat, Z. (2008) *"be nice – smile as you do with everyone" – Learning Multi-cultural Nursing in Leicester.* Leicester: Mary Seacole Research Centre, De Montfort University

Hogarth, S. and Marks, L. (1998) The Golden Narrative in British Medicine in Greenhalgh, T. and Hurwitz, B 1998, op cit.

Illich, I (2001) *Limits to Medicine: Medical Nemesis - The Expropriation of Health*. London: Marion Boyars.

Isaacs, M. and Benjamin, M. (1991). *Towards a culturally competent system of care, volume II, programs which utilize culturally competent principles*. Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Karmi*, G.,* ed. (1995) The *Ethnic Health Factfile* London North West and North East Thames RHAs.

Kirmayer, L (2007) Cultural Psychiatry in historical perspective in Bhugra and Bhui, op cit.

Lancaster P. and Coull, M (2007) *Life in the United Kingdom – Citizenship Study guide.* Berkshire: Lancaster & Coull.

Lloyd, C (2009) *2007-08 Citizenship Survey - Identity and Values Topic Report* London Department for Communities and Local Government http://www.communities.gov.uk/documents/statistics/pdf/1319805.pdf (Accessed 3 November 2010)

Machlachlan, M and McGee, S. (2007) Psychology and cultural psychiatry in Bhugra and Bhui, op cit.

Nursing and Midwifery Council (NMCa Online) http://www.nmc-uk.org/Nurses-and-midwives/Specialist-Community-Public-Health-Nursing/SCPHN-competencies-for-Midwifery-PREP/(Accessed 1 November 2010).

Nursing and Midwifery Council (NMCb Online) The code: Standards of conduct, performance and ethics for nurses and midwives http://www.nmc-uk.org/Publications/Standards/The-code/Make-the-care-of-people-your-first-concern-treating-them-as-individuals-and-respecting-their-dignity/ (Accessed 1 November 2010).

Nursing Times (2007) Communication skills (Essence of Care benchmark) *Nursing Times* http://www.nursingtimes.net/whats-new-in-nursing/communication-skills-essence-of-care-benchmark/361127.article (Accessed 1 November 2010).

Nutbeam, D and Kickbush, I (200) Advancing health literacy: a global challenge for the 21st century *Health Promotion International,* Volume15, Issue3,op. 183-184 Oxford Journals http://heapro.oxfordjournals.org/content/15/3/183.full (Accessed 1 November 2010).

Oak, M (2007) Should NHS curb spending on translation service? No BMJ Online 24 February 2007 http://www.bmj.com/content/334/7590/398.full/reply#bmj_el_162432 (Accessed 27 October 10).

Phelan M and Parkman S (1995) How To Do It: Work with an interpreter *BMJ*; 311: 555 (Published 26 August 1995) http://www.bmj.com/content/311/7004/555.full (Accessed 29 Oct. 10)

Ratcliffe, P (in press) From community to social cohesion in Ratcliffe, P. and Newman, I. *Promoting Social Cohesion: Implications for policy and frameworks for evaluation* (in press) Bristol: Policy Press.

Schön, D. (1983) *The Reflective Practitioner. How professionals think in action*, London: Temple Smith.

Sunderland, H (2008) *ESOL today: politics, pedagogy and performance measurement* http://www.nrdc.org.uk/content.asp?CategoryID=1411(Accessed 2nd Nov 2010).

Szczepura, A. (2004) Access to healthcare for ethnic minority populations Postgrad Med J 2005; 81:141–147. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1743229/pdf/v081p00141.pdf (Accessed 1st Nov 2010).

Stier, J (2003) 'Internationalisation, Ethnic Diversity and the Acquisition of Intercultural Competencies', Intercultural Education, 14: 1, 77 — 91.URL: http://dx.doi.org/10.1080/1467598032000044674 (Accessed 1st Nov 2010).

Vizard, P (2005) *The Contributions of Professor Amartya Sen in the Field of Human Rights* CASE paper 91 http://sticerd.lse.ac.uk/dps/case/cp/CASEpaper91.pdf (Accessed 1 Nov 2010)

Working Group on English for Speakers of Other Languages (ESOL) (2000) *Breaking the Language Barriers* http://www.lifelonglearning.co.uk/esol/front.htm (Accessed 2nd Nov 2010)

Zola, I. (1977) Healthism and Disabling Medicalization in Illich, I Ed 1977 *Disabling Professions.* London, Marion Boyars.

4. The legal and policy context

Equality legislation

The 1976 Race Relations Act provided for genuine occupational requirements (GORs) and genuine occupational qualifications (GOQs). For a GOQ exception, employers have to show that they need someone of a particular background. Section 5.2. (d) refers to the holder of the job providing persons of that racial group with personal services promoting their welfare, and those services can most effectively be provided by a person of that racial group. In 1983 the House of Lords judges defined a racial group as a group that:

First it had to have a long shared history, of which the group was conscious as distinguishing it from other groups, and the memory of which it kept alive, and second it had to have a cultural tradition of its own, including family and social customs and manners, often but not necessarily associated with religious observance. In addition, the following characteristics could also be relevant, namely (a) either a common geographical origin or descent from a small number of common ancestors, (b) a common language, which did not necessarily have to be peculiar to the group, (c) a common literature peculiar to the group, (d) a common religion different from that of neighbouring groups or from the general community surrounding it, and (e) the characteristic of being a minority or being an oppressed or a dominant group within a larger community (Equal Rights Trust, Online).

The Race Relations Act 1976 is being replaced by the Equality Act 2010 but at the time of writing the guidance on the new law is only in draft. The draft guidance says:

There are two essential characteristics which an ethnic group must have: a long shared history and a cultural tradition of its own. In addition, an ethnic group may have one or more of the following characteristics: a common language; a common literature; a common religion or common geographical origin; or being a minority or an oppressed group (EHRC, 2010 para 2.33)

The ruling and guidance make it clear that, for example, having a shared or distinctive language is neither a necessary not a sufficient condition for being a 'racial group'. However, for a person from a particular racial group with a distinctive language, discrimination against them on the grounds of language could constitute indirect racial discrimination, though the example of language is not used (EHRC, 2010 para 5.4). The draft guidance uses an interesting example which highlights that the status of language is not clear:

A newsagent who has ordered specialist newspapers and journals for other customers may be in breach of the Act if they then refused to meet the request of their Pakistani customers to order weekly Pakistani papers (Para 11.24 EHRC 2010)

Clearly the newspapers could be in English, Urdu or other languages.

There is specific legal provision for the use of Sign Language for deaf people and legislation concerned with mental health (see Tribe, 2009 for example) and social care legislation also makes provision for independent advocacy and requires active involvement and understanding of the user.

The Race Relations Amendment Act (2000) placed specific duties on public authorities, among other things to:

- develop and implement a Race Equality Scheme
- monitor their policies to see how they affect race equality
- make sure that the public have access to the information and services they provide

The specific Race Equality duties are now part of a more general equality duty. It has been assumed that providing translation and interpreting services and services sensitive to cultural and faith diversity are, if not required by law are at least permitted by law. It hasn't been generally tested. In relation to translation, the BBC reported that the Department of Health had told them:

"No legal advice has been taken. It is clear that there is an obligation to provide information that is clearly understood." (Easton, 2006)

Human Rights legislation

The Human Rights Act prohibits discrimination on a wide range of grounds including 'sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status'. (EHRC, 2010b)
The Act also says that everybody should have access to public services and the right to be treated fairly by those services (EHRC, 2010b).
Under the right to a fair trial The Human Rights Act allows representation or an interpreter where appropriate. This includes the right to be informed promptly, in a language which he [sic] understands and in detail, of the nature and cause of the accusation against him (EHRC, 2010b).

Citizenship

An immigrant living in the UK is applying for naturalisation as a British citizen or for indefinite leave to remain (settlement) has to take the Citizenship Test. They can only take it if their level of English is ESOL Entry 3 or above (or, in Scotland, Intermediate Level 1 or above). If their level of English is lower than ESOL Entry 3 (or lower than Intermediate Level 1 in Scotland) and they wish to apply for naturalisation or indefinite leave to remain, they need to attend combined English language (ESOL) and citizenship classes instead before they can take the Citizenship Test (Home Office, 2010)

Regional or Minority languages legislation

The UK Government recognises a number of regional or minority languages Welsh, Scottish-Gaelic and Irish, Scots and Ulster Scots, Cornish and Manx Gaelic European Charter for Regional or Minority Languages. They are considered to need preservation by measures for instance by making provision for their use in public services (Council of Europe, Online).

Policy

There have been expressions of views such as 'Why don't they learn English?' among the public and in some sections of the media for many years. The translation of this into official policy is more recent: it begins with the Cantle report into disturbances in the north of England in 2001 which raised concerns about 'parallel lives' and a lack of English being a cause of segregation (Denham, 2001; Cantle, 2001). This was followed by the Commission on Integration and Cohesion which recommended that translation spending be redirected to English as a Second Language provision (COIC Annex D and Section 5.42). On the other hand the same report said:

> *"We recognise that language barriers can perpetuate inequalities. Taking health services as an example, if people don't know how to access services, they may not get the care they need. Even if they get to the right doctor, without good English they might not get the right diagnosis – or understand it – and may not take the treatments prescribed. There are clearly vulnerable groups who need particular support." (COIC, 2007, p. 167).*

As well as raising specific concerns about translation and interpreting, since then government advisers and policy makers have also increasingly emphasised that separate cultural provision and (some) faith provision was divisive. This was manifest in increased unwillingness to fund 'single strand' provision for Black and Minority Ethnic communities. A particularly significant case involved Southall Black Sisters (SBS), an organisation working with minority women facing domestic violence. SBS won a case against their local council which tried to cut their funding (Whitfield, 2008).

At the same time as these negative stances on linguistic and cultural diversity, there have been many statements of policy and practice that have endorsed action to improve access to public services by provision of bilingual staff, mediators and provision to meet specific cultural and faith needs. For example, National Service Frameworks for Diabetes and Older People include specific references to language (Department of Health, 2004). In mental health, the stress has been on culture and race equality rather than language (Bhugra and Bhui, 2007). The new Government, elected in May 2010, acknowledges the need for the changes it is planning in the NHS 'to tackle a range of issues, including support to patients with different language needs'. Culture is discussed in the context of choice within the Department of Health Equalities Impact Assessment of the proposed changes suggesting,

for example, that the idea of exercising choice is not culturally familiar to some communities.

References

Bhugra, D. and Bhui, K. (2007) Cultural psychiatry: the past and the future in Bhugra, D. and Bhui, K. (2007) *Textbook of Cultural Psychiatry.* Cambridge: Cambridge University Press.

Cantle, T – Chair (2001) *Community Cohesion – a report of the Independent Review team*. Home Office.

Commission on Integration and Cohesion (2007) *Our Shared Future* http://image.guardian.co.uk/sys-files/Education/documents/2007/06/14/oursharedfuture.pdf (Accessed 27 Oct. 10)

Council of Europe (online) *List of declarations made with respect to treaty No. 148* http://conventions.coe.int/treaty/Commun/ListeDeclarations.asp?NT=148&CM=&DF=&CL=ENG&VL=1(Accessed 27 Oct. 10)

Denham Report (2001*) Building Cohesive Communities: A Report of the Ministerial Group on Public Order and Community Cohesion*. London: HMSO

Department of Health Equality and Human Rights Group (2004) *Guidance on developing local communication support services and strategies* http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4082350.pdf (Accessed 28 Oct. 2010)

Department of Health (2010) *Equity and Excellence: Liberating the NHS- Initial Equality Impact Assessment (EqIA) July 2010* http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117350.pdf (Accessed 28 Oct. 2010)

Equal Rights Trust (Online) *Mandla (Sewa Singh) and another v Dowell Lee and others [1983] 2 AC 548* http://www.equalrightstrust.org/ertdocumentbank/Microsoft%20Word%20-%20Mandla.pdf (Accessed 15 Dec. 10)

Equality and Human Rights Commission (2010a) *DRAFT Code of Practice – Services, Public Functions and Associations Code* *http://www.equalityhumanrights.com/uploaded_files/EqualityAct/services_code_-_06.10.10.pdf* (Accessed 27 Oct. 10)

Equality and Human Rights Commission (2010b) *The Human Rights Act* http://www.equalityhumanrights.com/human-rights/what-are-human-rights/the-human-rights-act/ (Accessed 27 Oct. 10)

Home Office (2010) *Life in the UK Test* http://www.lifeintheuktest.gov.uk/htmlsite/background_10.html (Accessed 27 Oct. 10)

Tribe, Rachel (2009) Working with interpreters in mental health', *International Journal of Culture and Mental Health*, December 2009 pp 92 – 101 http://www.informaworld.com/smpp/section~content=a918039481~fulltext=713240928~dontcount=true (accessed 29 Oct 10)

Whitfield, L (2008) *Southall Black Sisters: The case against Ealing R (Kaur & Shah) v London Borough of Ealing* http://www.navca.org.uk/NR/rdonlyres/F216A6ED-3B6C-475E-8664-CDE7F085D303/0/SouthallBlackSistersThecaseagainstEaling.pdf(Accessed 27 Oct. 10)

5. The Organisational context

There are a variety of terms used to describe arrangements to overcome barriers to accessing public services for Black, Minority Ethnic and Refugee communities in the UK. Here we focus on people who play some kind of mediating role who we will call mediators.

Working definitions (based on Sanders, 2000 and 2003)

Interpreters and Translators

Interpreting is the transfer of the spoken word from one language into another. Translation is the transfer of the written word into another language.

Paid interpreters may be full-time or sessional. They may be physically present in a consultation or clinic or in contact on the telephone or through a webcam.

Informal and *ad hoc* interpreters may be family and friends, volunteers and healthcare staff employed to do other jobs, who are bilingual.

Advocates

> *Advocacy is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need. Advocates and advocacy schemes work in partnership with the people they support and take their side. Advocacy promotes social inclusion, equality and social justice (Action for Advocacy, Online)*

The roots of bilingual advocacy were in East London around 1980 (Winkler, 1991; El Ansari et al, 2009). The role of the health advocate is to inform, to empower and, if bilingual and if requested by the patient, to interpret for the patient, to improve the appropriateness and accessibility of health services, and to improve health outcomes. They work to ensure that the services remain responsive to the needs of particular communities and accessible on an equal basis.

An advocate challenges discrimination, negotiates, gives advice and information to enable choice and informed decisions, supports and empowers the service user. Advocates can act independently of healthcare providers and are accountable primarily to the service uses and communities (Baylav in Tribe and Raval, 2003)

Linkworkers

The roots of link working were in the Asian Mother and Baby Campaign in the 1980s (Sanders, 2003). A Linkworker is often a member of the service team. The first Linkworkers worked in maternity services. Their job is to assist the team in providing an improved service to the community in question through their knowledge of the local community. The aim is to increase other members' understanding and to improve the service offered to the

community in question. They befriend and inform service users and offer cultural information to service providers (Baylav in Tribe and Raval, 2003).

Bilingual Health Care Workers

A bilingual health worker or professional is a clinician (such as a nurse, doctor, therapist or health promotion specialist) who is able to provide their professional services in more than one language.

Community Health Educators

Community health educators are lay people who participate in interventions ranging from capacity building, through promotion of lifestyle changes to accessing information and services (Mighealthnet, Online).

Plain English

Even when the service provider and service users both speak English, there are issues about the use of professional and technical terms, formal language and jargon. The Plain English Campaign has promoted the use of “Language that the intended audience can understand and act upon from a single reading” (Plain English Campaign, Online).

Models of mediation

Mediation is not necessarily 1-1 or face to face. The kinds of mediation and where they take place is presented in the following matrix.

Model	**Face-to-face in consultations and clinics**	**Remote (interactive)**	**Written and remote (non-interactive)**
Linguistic	Interpreters	Telephone and webcam, video	Plain English; Glossaries
Communication	Linkworkers	Communication skills training	Symbols and signs Protocols and checklists
Knowledge	Advisers and assistants (with or without therapeutic roles)	Consultants, Cultural Brokers, Awareness & Competence trainers Multi-lingual help lines	'Fact Packs', DVDs
Power	Bilingual advocacy Community Health Educators		

There are differences, at least in theory, between the different models:

- The scope and nature of independent judgements the mediator can make
- Whether accountability is to service users and/or service providers
- Whether it is 1 -1 or group activity
- Separation or integration of communications role with a therapeutic or other service role
- Responsibility for policy advice and change
- Whether the mediator's primary job to give communication support

In each role, the mediators may be paid (by a variety of agencies) or unpaid, trained or untrained. They may work for statutory, private or voluntary organisations.

The potential differences may be understood through an example. A service provider might use a term such as 'disabled people'. This might be intended to convey the social model of disability in which someone is physically, sensorily or mentally impaired but also discriminated against by the organisation of society. It is very different to words that convey stigma, tragedy, illness or being a passive victim. Different mediators might take different views about how to express what the service provider said – using the words, what they meant by them, as the service user might understand best or express I - trying to negotiate a shared understanding or trying to get the service user's perspective across (Sanders, 2003). Thus what might be seen as an 'error' in one model of mediation would be seen as the exercise of professional judgement in another model (Examples of this are given throughout Tribe and Raval, 2003).

However, it should be noted that in practice, job titles may not reflect what people do, so the models may overlap in practice.

Guidelines and Standards

There are UK and international standards for most of the models intended to achieve and maintain standards (For example: Tribe and Raval, 2003; Silvera & Kapasi, 2002; DH, 2004: Royal College of Speech and Language Therapists, 2007; Tribe and Thompson, 2008; U.S. Department of Health and Human Services, Online). However, there is evidence that standards are not implemented or monitored and that, for example, career paths for mediators are, at best unclear and at worst non-existent. More fundamentally, there is no consensus on what is good practice – internationally, nationally or at the interface between users and providers. Focusing on the latter in relation to nurses and doctors:

Although the trust provided interpreting services in the main South Asian languages spoken by local communities the district nurses rarely utilized them. They regarded the service as inadequate because of under-resourcing and difficult to access. Interpreters had to be booked in advance, with 2 days notice usually required (Gerrish, 2001).

The freelance interpreters from the community-based interpreting service saw their role solely in terms of language translation in situations where the health professional and patient did not speak a common language. By contrast, the link workers perceived that interpretation was one aspect of a much broader role in which they also provided information to patients, acted as a cultural broker and patient advocate (Gerrish et al, 2004).

[Interpreters] multiple (and inherently conflicting) roles also include those of advocate, cultural adviser, negotiator, broker of trust, professional friend, teacher, taxi service, and citizens' advice bureau […and…] bilingual parrots (Greenhalgh, 2007)

Multilingualism [By clinicians and staff in general practices] was seen as better than a triadic conversation' (Greenhalgh et al, 2007)

Tribe and Thompson also highlight the different perceptions among mental health practitioners about whether interpreters are an opportunity for better interventions or *'a barrier – a nuisance'* (Tribe and Thompson 2009).

A report from the Department of Health in 2004 observed that

'None of the currently established models of provision adequately fulfil the organisational requirement to provide an accessible and effective means of communication support at all times.' (DH, 2004)

A variety of reasons have been put forward for this:

- Services not keeping pace with demographic change(DH, 2004)
- Fragmented responsibility for commissioning, delivering and providing information about services (DH, 2004)
- The institutional structure of, for example, general practice making the routinisation of innovation very challenging (Greenhalgh et al, 2007)
- Ambivalence or hostility to the idea of third party involvement in clinical consultations (Tribe and Raval, 2003)

Training and development for mediators and clinicians

Training for the different paid mediator roles has been arranged over many years (Leather et al, 1996; Tribe and Sanders in Tribe and Raval, 2003). There are university courses for public service interpreters (de Pedro Ricoy, 2010). The London Open College Network accredits courses for bilingual advocates and community interpreters. Some agencies such as Barking and Dagenham Translating and Interpreting Service, Making Training Work and Manor Gardens Welfare Trust provide training for volunteer advocates and interpreters but this is not quite the same as training for informal and *ad hoc* interpreters. The volunteer interpreters are often doing the training as a pathway into paid jobs.

It has long been recognised that clinicians need training to work with interpreters (Phelan and Parkman, 1995; Tribe and Raval, 2003; Tribe, 2009; Jacobs et al, 2010).

The lack of a career structure for mediators has been a source of concern and it no surprise that less than five per cent of interpreters in one survey said that they looked on it as a career (Nijad in Tribe and Raval).

Costs

The BBC said its research showed the cost of translation and interpretation in public services is £100m, of which over half spent by NHS. They reported that that NHS Trusts spend £55m on translation and that Barts Hospital in East London alone spends £1m a year and Guy's Hospital in South London spends almost £600,000 a year (Easton, 2006). It should be noted that the basis on which the calculation of the total figure was made has not been made public. It is probably safe to assume that it is based on gross costs – not taking into account the savings that might result from improved health care, speedier and more accurate diagnosis, treatment, advice or information.

References

Action for Advocacy (Online) *About Advocacy* http://actionforadvocacy.org.uk/index.jsp (Accessed 29 Oct. 10)

Baylav, A. (2003) Issues of language provision in healthcare services in Tribe and Raval, op cit.

El Ansari, W.; Newbigging, K.; Roth, C. and Malik, F (2009) The role of advocacy and interpretation services in the delivery of quality healthcare to diverse minority communities in London, United Kingdom *Health and Social Care in the Community* (2009) 17(6), 636–646

Easton, M. (2006) Cost in translation *BBC Online* http://newsvote.bbc.co.uk/mpapps/pagetools/print/news.bbc.co.uk/2/hi/uk_news/6172805.stm; http://newsvote.bbc.co.uk/mpapps/pagetools/print/news.bbc.co.uk/1/hi/uk/6174303.stm (Accessed 27 Oct. 10)

Gerrish K; Chau, R ; Sobowale, A and Birks E (2004) Bridging the language barrier: the use of interpreters in primary care nursing *Health & Social Care in the Community* Volume 12, Issue 5, pages 407–413, September 2004

Greenhalgh, T (2007) Translation services -Let's talk about critical consciousness *BMJ Online* http://0-www.bmj.com.emu.londonmet.ac.uk/content/334/7592/490.2.full (Accessed 27 Oct. 10)

Greenhalgh, T.; Voisey, C .and Robb, N (2007) Interpreted consultations as 'business as usual'? An analysis of organisational routines in general practices *Sociology of Health & Illness* Volume 29, Issue 6, pages 931–954, September 2007

Jacobs, E.; Diamond, L.; Stevak, L. (2010) The importance of teaching clinicians when and how to work with interpreters. *Patient Education and Counseling* 78 (2010) 149–153

Leather, C.: Wirth, S.; Hook, E. (1996). *The Training and Development Needs of Bilingual Support Workers in the NHS in Community Settings* (London: Centre for International Child Health, Institute of Child Health)

Mighealthnet (Online) *Community Health Educators* http://mighealth.net/uk/index.php/Community_Health_Educators (Accessed 29 Oct. 10)

Nijad, F (2003) *A day in the life of an interpreting service* in Tribe and Raval, op cit.

de Pedro Ricoy, R (2010) Training Public Service Interpreters in the UK: A fine balancing act *The Journal of Specialised Translation* Issue 14 – July 2010 pp 100 -120

Phelan M and Parkman S (1995) How To Do It: Work with an interpreter *BMJ*; 311: 555 (Published 26 August 1995) http://www.bmj.com/content/311/7004/555.full (Accessed 29 Oct. 10)

Plain English Campaign (Online) http://www.plainenglish.co.uk/ (Accessed 15 Dec 2010)

Royal College of Speech and Language Therapists Specific Interest Group in Bilingualism (2007)*Good Practice for Speech and Language Therapists working with clients form Linguistic Minority Communities* http://www.rcslt.org/members/publications/linguistic_minorities (Accessed 29 Oct. 10)

Sanders, M. (2000) As Good as your Word. A Guide to Community Interpreting and Translation in Public Services (London: Maternity Alliance).

Sanders, M. (2003) Language Support Strategy for Tower Hamlets - A Literature Review. London: Praxis

Silvera, M. & Kapasi, R. 2002. A standards Framework for Delivering Effective Health and Social Care Advocacy for Black and Minority Ethnic Londoners, a Consultancy Partnership project by SILKCAP and OPM funded by the King's Fund .London: King's Fund

Stapleton, E (2007) What about the Deaf community? *BMJ Online* 26 February 2007 http://www.bmj.com/content/334/7590/398.full/reply#bmj_el_162432 (Accessed 27 Oct. 10)

Tribe, R and Raval, H. Eds. (2003) *Working with Interpreters in Mental Health.* Hove: Brunner-Routledge.

Tribe, R. and Thompson, K. (2008) *Working with Interpreters in Health Settings Guidelines for Psychologists* British Psychological Society http://www.ucl.ac.uk/clinical-psychology/traininghandbook/sectionfiles/Appendix_6_BPS_guidance_on_working_with_interpreters.pdf (Accessed 29 Oct. 10)

Tribe, R. and Thompson, K. (2009) Opportunity for Development or Necessary Nuisance? The Case for Viewing Working with Interpreters as a Bonus in Therapeutic Work *International Journal of Migration, Health and Social Care* Volume 5 Issue 2 September pp4 -12.

Tribe, Rachel (2009) Working with interpreters in mental health', International Journal of Culture and Mental Health, December 2009 pp 92 – 101 http://www.informaworld.com/smpp/section~content=a918039481~fulltext=713240928~dontcount=true (accessed 29 Oct 10)

U.S. Department of Health and Human Services- Office of Minority Health (On line) *National Standards on Culturally and Linguistically Appropriate Services (CLAS)* *http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15*(Accessed 28 Oct. 10)

Winkler, F (1991) *Experiments in Health Advocacy* London: City and Hackney Community Hackney Council.

6. Ethical issues

There are potential ethical issues in any consultation where a third party is present – whether a researcher, a medical/nursing student, trainee or a mediator. Here we focus on the issues most frequently raised in relation to informal and *ad hoc* interpreters and other mediators in healthcare.

Phelan and Parkman set out many of the ethical arguments against informal and *ad hoc* interpreters in their 1995 BMJ article:

Friends or relatives -The perceived advantages of using people known to the patient are that they are readily available, that they may be knowledgeable about the patient's problems, and that their presence may be a reassurance to the patient. However, the risk is that someone close to the patient will not stop their own views of the situation colouring their translation. For the best of motives they may try to protect the patient from bad news, or decide to tell them later in private. Information about side effects may be withheld in the belief that it will improve compliance. Occasionally, more sinister reasons may be behind altering what is said. A violent husband may want to hide the true cause of his wife's bruises. Incidents of child or sexual abuse may be hidden. In addition, the patient may be inhibited from discussing embarrassing issues or disclosing past events, such as an abortion, in front of relatives.

Untrained volunteers - Informal lists of staff or volunteers who are prepared to act as interpreters are often held by hospitals. Although helpful at times, this arrangement cannot guarantee that someone will be available, especially in an emergency or outside normal working hours. Usually they will not have received any training in interpreting, and though some may have an instinctive understanding of what is required, others may be inept owing to a lack of empathy or a poor grasp of the language. Patients may worry about confidentiality when using an interpreter who is not known to them, especially if they are both members of a small cultural community. When available, however, volunteers should be used in preference to someone who is known to the patient.

(Phelan and Parkman, 1995)

The issues raised by Phelan and Parkman have been explored and developed further in research and by professional and regulatory bodies.

Completeness and accuracy of interpreting by informal interpreters

Flores categorised interpreter errors in paediatric consultations as:

Omission: The interpreter did not interpret a word/phrase uttered by the clinician, parent or child.

Addition: The interpreter added a word/phrase to the interpretation that was not uttered by the clinician, parent or child.

Substitution: The interpreter substituted a word/phrase for a different word/phrase uttered by the clinician, parent or child.

Editorialization: The interpreter provided his or her own personal views as the interpretation of a word/phrase uttered by the clinician, parent or child.

False Fluency: The interpreter used an incorrect word/phrase, or word/phrase that does not exist in that particular language

Flores et al found the most common error was omission (Flores et al., 2003). In a Systematic Literature Review of medical interpreting he found that more of most kinds of errors were made by informal and *ad hoc* interpreters than professional interpreters, except for false fluency. It is important to note though that the most dissatisfied patients were those who needed an interpreter but did not get one of any kind (Flores, 2005). Shannon's work on the status of language and translation suggests that the notion of 'accuracy' is not value-free: we need to bear in mind that where language status is asymmetric, the subordinate language may bend to fit the demands of the dominant language (Shannon, 1996).

As long ago as 1984 it was being argued that the use of informal interpreters is suitable only as a short-term measure for emergency GP consultations. One UK study found that at least a quarter of all questions asked were mistranslated or not translated at all, even by people who doctors considered to be the best interpreters. The highest degree of shared perception between users and practitioners was around diagnosis—'technical task' communications - and the greatest divergence was around perceptions of what information was given or received in relation to the health lifestyle of the patient, and their psychosocial circumstances (Cohen et al, 1999).

Neutrality

Healthcare providers in general are expected to exercise only professional judgements, not to allow personal interests to conflict with the patient's interests or to be involved emotionally with the patient. For example doctors are told that good medical practice includes:

Wherever possible to avoid providing medical care to anyone with whom you have a close personal relationship'

You must not unfairly discriminate against them by allowing your personal views to affect adversely your professional relationship with them or the treatment you provide or arrange.

You must not express to your patients your personal beliefs, including political, religious or moral beliefs, in ways that exploit their vulnerability or that are likely to cause them distress (GMC On line).

It is difficult to see how these conditions can be met by a friend or relative acting as an interpreter, though a member of staff employed in another capacity but called on to interpret, could comply.

Use of children as interpreters

The use of children as interpreters has been condemned for even longer than the use of informal interpreters generally. As far back as 1982 Rack said it was 'unethical, unprofessional, uncivilised and totally unacceptable' (Quoted in Cohen et al, 1999). Nevertheless when Cohen et al carried out their research in East London in 1997[6] they found a majority of GPs (24 out of 38) surveyed had recent consultations with adult patients where a child had undertaken the role of informal interpreter. GPs reported that typically it happened 2-3 times per week. In one instance a GP reported having a child of five act as an informal interpreter, but on average the youngest reported age was between six and eight years old. Only two GPs (out of 38 GPs) suggested that parents may actively prefer their children to interpret on their behalf, rather than have a Bilingual Health Advocate.

The decision by GPs in the Cohen study, to use children as interpreters was a pragmatic one based on

- Whether the consultation was straightforward, complex or sensitive;
- Perception of the child's competence to act as a communication mediator and the nature of this competence. Competence was assessed in various ways including perceptions of linguistic skills;
- The likelihood that the child had experience of similar problems or experiences; relevant to the problem for which the adult patient was seeking medical help;
- In certain circumstances the gender of the child.

The preferences of the children and the parents were not as significant as these factors, though they did think about the impact on the children. Free and colleagues interviewed 77 young interpreters, of whom more than two-thirds were aged 9 -15. Although the young people reported disadvantages to interpreting, the researchers highlighted that the interpreters felt there were benefits to them in interpreting and also that the patients asked them to do it out of choice as well as necessity. The researchers argued that guidance to practitioners to focus on the patients not the interpreters and GPs expressions of

[6] The same area as the TRICC UK carried out its needs assessments in 2009-10.

disapproval of children as interpreters made them feel ignored or discounted (Free et al, 2003).

The benefit to children of acting as interpreters is taken up by Shannon in her work on Spanish speaking children in the United States. She shows that for at least some, being a 'language broker' is a valuable opportunity to extend their second language (English) skills (Shannon, 1990a). However Shannon's work also shows that young speakers of a minority (and low valued) language may have specific learning needs: to develop their language skills they may need to be taught in a different way to either a 'Foreign' language or as one might teach a native speaker where the language is dominant (Shannon, 1990b).

There is an extensive literature on children as carers. Much of that work suggests that though 'caring' has a positive value for children and young people it also has negative aspects. Putting interpreting into the context of young carers highlights that the way children's activities are 'framed' has a big influence on whether the activity is seen as 'normal', an opportunity, a right, a responsibility an undesirable but acceptable necessity, a form of exploitation or abuse.

A tool developed for measuring children's caring activities clusters caring activities into six areas:
(1) Domestic tasks
(2) Household management
(3) Personal care
(4) Emotional care
(5) Sibling care
(6) Financial/practical care

Under the last heading, in the short version of the questionnaire, the questionnaire asks young people

If they interpret, sign or use another communication system for the person you care for

and in the longer version:

Interpret for someone you live with because English is not their first language and Take someone you live with to the doctors or hospital (Joseph et al, 2009).

However it appears that though the longer questionnaire has been used the answers have not been collated anywhere yet (Becker, 2010).

Confidentiality

Clinicians, commentators and service users have expressed concerns about any third party involved in consultations, especially around sensitive issues such as sexual health, mental health, continence, and end-of-life. In some cases that is seen as an argument for paid

formal mediators. Others see it as an argument for 'keeping it in the family'. As Gerrish noted, Chamba and Ahmad (2000) identified a concern among some South Asian parents caring for severely disabled children that professional interpreting was not confidential but that some parents in the same study considered that professional interpreters enabled them to express themselves more freely and provided confidentiality from family and friends.

Informed Consent

It is generally understood that without mediators, obtaining informed consent may not be possible or complete. However, some people (for example Raval in Tribe and Raval, 2003) have raised concerns that (informal) interpreters may be a barrier to informed consent because of their own interests, emotions and values.

Clinician responsibility

Clinicians' responsibility has been seen as an argument both for and against involvement of third parties of the various kinds.

Doctors have a duty to:

make sure, wherever practical, that arrangements are made to meet patients' language and communication needs (GMC Online)

Some GPs justify the use of informal interpreters by the need to diagnose and treat patients promptly or at least assess whether their need is urgent. Delays in waiting for paid and trained mediators are seen as a neglect of duty (Cohen et al, 1999).

Nurses have expressed doubts about whether they can make an adequate diagnosis without interpreters (e.g. ability to assess pain) but they also expressed concern about standards of interpreting: some nurses expressed a lack of confidence in the detail and accuracy of the translation provided by the interpreters (Gerrish, 2001).

Some practitioners think that a third party can damage the therapeutic relationship. One of the nurses in Gerrish's study said it is '*hard to build a close relationship through a third person … to show empathy, to encourage them to talk*' (Gerrish, 2001). Others have reported more positive experiences of co-working (Various authors in Tribe and Raval, 2003).

Adams has argued that translation is causing health problems:

' an important contributory factor to much […] psychological suffering is a sense of being alienated from the wider mainstream culture…near total dependence that may result from being unable to seek help beyond their community can drive women into depression. What we are seeing is, at least in part, the medicalisation of problems that are actually social or cultural in origin, with some of the costs being borne by the health service'. (Adams, 2007)

Cutting translation services has also been seen as “tough love” to help non-English speakers help themselves (Mathews, 2007).

Patient responsibility

Makarand Oak, an Indian born Consultant Obstetrician and Gynaecologist working in Scotland asked ‘if it is beyond human capability to learn to say and describe health problem in three months’ (Oak, 2007). His view may be an extreme one but there is certainly a more widely held view that if patients cannot speak English, they bear some responsibility for bringing their own interpreter.

Choice

It was the policy of both the last government and the present one that choice in healthcare is important. In the Equality Impact Assessment for the present government’s first policy statement on the NHS, both choice and information were prominent issues (Department of Health, 2010).

Alexander and colleagues, looking at the use of interpreters across all contexts, found a preference among users for using family and friends to act as interpreters for them but not in important legal and medical matters. They also wanted interpreters to play a ‘pro-active’ role, more than passing on words with knowledge of systems and the ability to ‘make a case’ as well as technical language ability. The reasons for not wanting professional interpreters included:

- Practical issues (E.g. availability; whether language matching sufficiently close)
- The social and personal characteristics including attitudes of the interpreters
- The fear that that professional interpreters, or bilingual staff interpreting, work in the interests of the service provider not the service users (Alexander et al, 2004).

However, there are practical difficulties in offering service users a choice of who will act as mediator: for example, how to give effect to preferences in continuity of particular mediators or service providers (Gerrish, 2001). Gerrish and colleagues found lack of continuity both in terms of the patients visited and the community nurses with whom interpreters worked. This was detrimental to establishing rapport and trust in the tripartite relationship (Gerrish et al, 2004). Similar issues have been found, but with potentially even more serious consequences, in mental health settings (Tribe and Raval, 2003).

This may exacerbate an inequality in access already affecting Black Minority Ethnic and Refugee communities. Differences in waiting times, the frequency of referrals to secondary care and the likelihood of receiving follow-up services are likely to affect adversely members of minority ethnic communities (Nazroo, 1997).

Professional and government guidance

Some professions have issued guidance on the use of informal and *ad hoc* interpreters.

The Royal College of Speech and Language Therapists says:

> ***The role of bilingual relatives:*** *It is imperative that bilingual relatives should not be used as translators. Therapists need to define the role of bilingual relatives in the management process of bilingual/non-English speaking clients so that it is in line with the role of relatives of English speaking clients and is different from the role of bilingual personnel. The key difference is that their role is supportive rather than primary. It would be useful to establish guidelines within speech and language therapy services to show how the therapist can facilitate the session in the presence of (i) the interpreter and (ii) the relative.*

The guidance given to psychologists is less clear cut but still raises concerns:

> *Bear in mind in any work that you do with a non-professional that they may not be as skilled in English, or indeed in their native tongue and they may have little or no experience of, or training in interpreting. They may be unclear about such issues as confidentiality, boundaries and the use of good interpreting skills. They may also have their own agenda about the client and wish to tell you more or less about the client than the client themselves would wish*
>
> (Tribe and Thompson quoting Thompson & Woolf, 2004).

Official government advice on healthcare for refugees is not to use informal and *ad hoc* interpreters for 'clinically significant events':

> *In some cases, refugees may request that family members, friends or untrained members of their community interpret for them. The perceived advantages of using people known to the patient are that they are readily available, that they may be knowledgeable about the patient's problems, and that their presence may be reassuring. However, the risk of relying on someone close to the patient, in what may be a highly personal and confidential situation, is that they may not be able to interpret accurately and may allow their own views of the situation to colour their translation. It may also be difficult, or even impossible, to discuss certain issues, such as sexual health, rape, torture, domestic violence and child protection, in their presence.*
>
> *Family members, acquaintances and untrained persons should not be asked to act as interpreters at clinically significant events. Children should never be asked to interpret on behalf of family members, as it would not be appropriate to ask them to convey a person's experience of torture or human rights abuse.*
>
> (Home Office, Online)

The reality

Life and death

The ethical issues of what kind of mediation is needed in health and social care are brought out very clearly in the case Victoria Climbié, an eight year old girl from the Ivory Coast, killed by the adult who were supposed to be looking after her in February 2000. The case illustrates that it is not simply a question of one dimension: language, communication, culture and power are all relevant.

Victoria's main language was French but though she was seen by health and social services on a number of occasions because of concerns about her welfare Victoria never was spoken to alone with the assistance of a French interpreter. The official Inquiry into her death recommended that:

> *When communication with a child is necessary for the purposes of safeguarding and promoting that child's welfare and the first language of that child is not English, an interpreter must be used. In cases where the use of an interpreter is dispensed with, the reasons for so doing must be recorded in the child's notes/case file.*
>
> (Laming, 2003)

When the woman who was supposed to be looking after her was interviewed, it was noted that

> *Although an interpreter was present, Kouao's command of English was good and she would often reply in English before the interpreter had time to do so. Ms Arthurworrey* [A Social Worker] *recorded, "Marie-Therese presented as smart in appearance, proud and a woman who articulated very well."However, her grasp of the English language would fail her whenever she was asked specific child protection questions. Then she appeared not to understand, was evasive and would turn to the interpreter for support.*
>
> (Laming, 2003)

The issues that health and social services failed to deal with were more than simply language however:

> *Medical practitioners who noticed marks on Victoria's body considered the possibility that children who have grown up in Africa may be expected to have more marks on their bodies than those who have been raised in Europe.*
>
> (Laming, 2003)

Both White and Black and Minority Ethnic staff behaved in ways that stopped them expressing "respectful uncertainty "about the explanations for Victoria's injuries and neglect. As the lawyer for the Inquiry said:

"Fear of being accused of racism can stop people acting when otherwise they would. Fear of being thought unsympathetic to someone of the same race can change responses."
(Laming, 2003)

A practitioner's perspective

However much guidelines recommend good practice, there is no doubt that the practice often falls short of what is desirable. This viewpoint was given by an obstetrics and gynaecology doctor to the BBC in September 2010:

I totally failed to give a non-English speaking Polish lady any information about her condition as there were no interpreters available until much later in the day, when I was tied up in theatre. It wasn't an emergency, so not a priority but it still felt substandard to me.

I dealt with an angry Somali partner who was kept waiting while we waited for an interpreter. He felt that his English was good enough to carry his wife through the consultation, eventually I saw them and we managed.

An interpreter might have helped with the language barriers, but I'm sure would have thrown up other difficulties as we ended up discussing some sexual difficulties which they may not have otherwise disclosed.

In our trust, we are lucky to have a fantastic translation service and dedicated team of in-house interpreters, but due to the nature of inner-cities the service is totally over-run and frequently needs to use bank and agency staff.

Various tactics are being piloted such as using 'yes/no answer' computer programs and increased use of staff as interpreters.

Asking closed questions when taking a history in my eyes is just poor communication and using an already stretched team of staff also raises concerns.

Translated leaflets are often not the answer if there are cultural differences in health knowledge and understanding.

More funding for interpreting services is desperately needed and increased numbers of interpreters would allow improved flexibility.

Adequate time also needs to be allowed to use the interpreters, so that clinic slots are longer and staffing levels reflect the time demands that good communication with high numbers of non-English speaking patients really require.

Staff can't be expected to become fluent in the many different languages we encounter either. But training in working with interpreters should be more available, alongside better information for staff regarding differing health beliefs and behaviours dependant on culture and background.

The language barriers we face on our ward rounds are just the tip of the iceberg in terms of the real barriers to health faced by those with limited English proficiency.

The NHS needs to do more to support doctors and health care professionals in facing these challenges and improving care for this.

(Wright, 2010).

References

Adams, K (2007) Should the NHS curb spending on translation services? *BMJ* 2007; 334: 398 22 February

Alexander, C.; Edwards, R. and Temple, B. with Kanani, U.; Zhuang, L.; Miah, M. and Sam, A (2004*) Using interpreters to access services: user views*http://www.jrf.org.uk/sites/files/jrf/1859352294.pdf (Accessed 1 Nov 2010)

Becker, S. (2010) *Personal communication* 18 November 2010.

Cohen, S.; Moran-Ellis, J. and Smaje, C. (1999) Children as informal interpreters in GP consultations: pragmatics and ideology *Sociology of Health & Illness* Vol. 21 No. 2. pp. 163–186.

Department of Health (2010) *Equity and Excellence: Liberating the NHS- Initial Equality Impact Assessment (EqIA) July 2010* http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117350.pdf (Accessed 28 Oct. 2010).

Flores, G.; Laws, M. B.; Mayo, S.: Zuckerman, B.; Abreu, M.; Medina, L. and Hardt, E. (2003) Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters *Pediatrics* Vol. 111 No. 1 January 2003, pp. 6-14 http://pediatrics.aappublications.org/cgi/content/full/111/1/6 (Accessed 31 Oct 2010).

Flores, G (2005) *Impact of Medical Interpreter Services on the Quality of Health Care: A Systematic Review Med Care Res Rev* 2005; 62; 255 http://mighealth.net/eu/images/3/3b/Flores2.pdf (Accessed 31 Oct 2010).

Free, C.; Green, J.; Bhavnani, V. and Newman (2003) Bilingual young people's experiences of interpreting in primary care: a qualitative study. *British Journal of General Practice*. Vol 53 (492): 530–535.

General Medical Council (Online) *Good Medical Practice http://www.gmc-uk.org/guidance/good_medical_practice/good_clinical_care_avoid_treating_those_close.asp* (Accessed 29 Oct 2010).

Home Office (On Line) *The Integration of refugees – Positive Practice for Health Professionals* http://nrif.homeoffice.gov.uk/Health/General/accessingservices/languageandcommunication/familyinterpreters.asp?oi=00-00-03-04 (Accessed 31 Oct 2010).

Joseph, J.; Becker, F. and Becker, S (2009) *Manual for Measures of Caring Activities and Outcomes for Children and Young People* Essex: The Princess Royal Trust for Carers

http://saulbecker.co.uk/v1/downloads/young_carers/Young%20Carers%20Outcomes%20Manual%20April%202009.pdf (Accessed 16 November 2010)

Laming, H. (2003) *The Victoria Climbié Inquiry Cm 5730* London: Department of Health and Home Office. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_110711.pdf (Accessed 29 Nov. 10)

Matthews P (2007) Translation services - English classes are being cut *BMJ* 2007; 334 8 March 2007

http://www.bmj.com/content/334/7592/490.3.full (Accessed 31 Oct 2010).

Nazroo J. (1997) *The Health of Britain's Ethnic Minorities: Findings from a National Survey*. London: Policy Studies Institute.

Oak, M (2007) Should NHS curb spending on translation service? No BMJ Online 24 February 2007

http://www.bmj.com/content/334/7590/398.full/reply#bmj_el_162432 (Accessed 27 October 10).

Phelan M and Parkman S (1995) How To Do It: Work with an interpreter *BMJ*; 311: 555 (Published 26 August 1995) http://www.bmj.com/content/311/7004/555.full (Accessed 29 Oct. 10).

Raval, H (2003) An Overview of the issues in the work with interpreters in Tribe and Raval, 2003 op. cit.

Royal College of Speech and Language Therapists - Specific Interest Group in Bilingualism (2007)*Good Practice for Speech and Language Therapists working with clients form Linguistic Minority Communities* http://www.rcslt.org/members/publications/linguistic_minorities (Accessed 29 Oct. 10).

Shannon, S (1990a) English in the Barrio: The Quality of Contact among Immigrant Children *Hispanic Journal of Behavioral Sciences* 1990 12: 256 http://hjb.sagepub.com/content/12/3/256 (Accessed 29 October 10).

Shannon, S. (1990b). Spanish for Spanish speakers: A translation skills curriculum. In A. Padilla, H. Fairchild and C. Valadez (Eds.), *Foreign Language Education: Issues and Answers.* (pp. 223-237) Newbury Park, California: SAGE.

Shannon, S (1996). A reconsideration of Natural Translation for a theory of translation. In Coulthard M. & Odber de Baubeta, P. (Eds.). *The Knowledges of the Translator.* Lampeter, Dyfed, Wales, U.K.: The Edwin Mellen Press. 99-120.

Tribe, R. and Raval, H Eds (2003) *Working with Interpreters in Mental Health*. Hove: Brunner-Routledge.

Tribe, R. and Thompson, K. (2008) *Working with Interpreters in Health Settings Guidelines for Psychologists* British Psychological Society http://www.ucl.ac.uk/clinical-psychology/traininghandbook/sectionfiles/Appendix_6_BPS_guidance_on_working_with_interpreters.pdf (Accessed 29 Oct. 10)

Wright, C (2010) NHS 'failing those who don't speak English http://www.bbc.co.uk/news/health-10951417 (Accessed 27 October 10)

7. The use of informal and *ad hoc* interpreters in three communities in East London

Background to the audit

The aim of this study was to audit the extent of the use of *ad hoc* interpreters in three communities in London. The research team had all been involved in planning or providing mediation services by paid staff in the past. We believed that extensive and long-established services would have reduced the use of *ad hoc* and informal services and particularly the use of children. In Tower Hamlets where two of the audits were carried out, the number of Community Linkworkers, Bilingual Advocates, Interpreters and other Language Support Workers officially employed to work in the voluntary or statutory sectors, is estimated to be over 200 (Ahmed, 2010).

Background to the communities

London has probably the greatest number of speakers of different languages of any city in the world. A recent publication found that there are 233 languages spoken by London's school children, comprising about 40% of the children (Eversley et al, 2010; see also Social Context Chapter 2).

Turkish speakers

The communities

Although large scale migration of Turkish speaking communities (primarily of Turkish, Kurdish and Cypriot origins) to the UK is post World War II, the historical connections of Turkish and Kurdish people to the UK go back much further. In 1586 a conversion of a 'Turk' (in fact of Greek origin) to Protestant Christianity in London was recorded (Matar, 1998)

There were a number of Turkish people living in London in 17th century. Some of the seventeenth century coffee houses had Turks at least working in them and had names such as 'The Turks Head' because of their association with Ottoman Empire (Ansari, 2004). Daniel Defoe's novel "Roxana" written in 1724 is built around the idea that it is plausible that a Turkish woman could be living in London (Defoe, 1982).

The first Kurdish newspaper *Kurdistan*, which began publication in Kurdish (Kurmanji) and Turkish in Cairo in 1898, was briefly published in Folkestone by the Badrkhan family, the early 1900s.

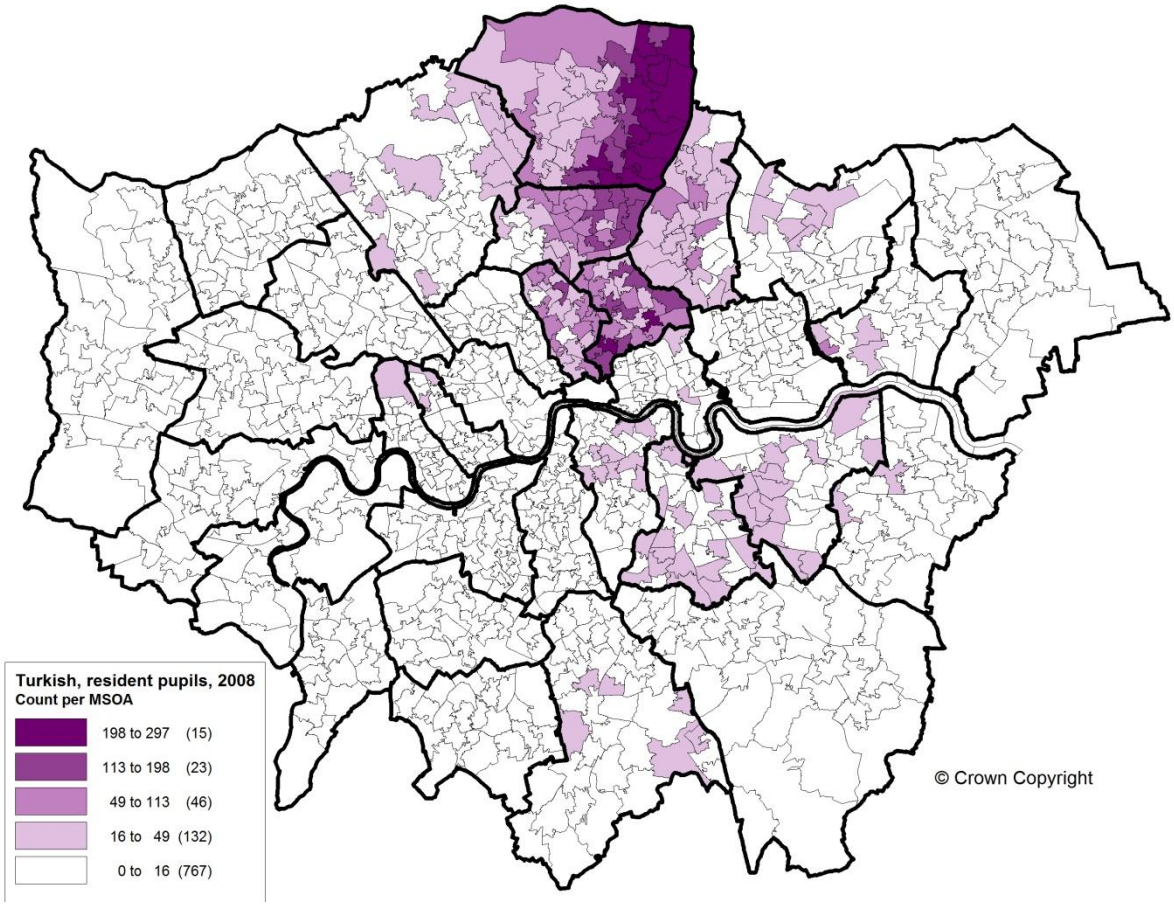
Turkish Cypriots began to migrate to the UK at the end of World War II, largely as a result of the conflict between the communities in Cyprus in the 1950s and 1960s but also with the active recruitment of labour by the British government. In the late 1960s and early 1970s many students (either on graduate or postgraduate courses) as well as skilled workers came from Turkey to the UK through a labour agreement between the Turkish and British Governments. Many worked in the clothing Industry in London. They were later joined by

their families. This agreement however, was discontinued after a while. From the late 1970s, and particularly after the military coup in Turkey in 1980, others fled the country with some seeking political asylum in the UK. Kurdish people have been migrating to the UK since the 1970s from Iraq, Iran, Turkey and Syria.

The Turkish and Kurdish languages

Turkish is a Turkic language with an estimated 50-60 million speakers across the world. It is the official language of Turkey and, with Greek, also an official language in Cyprus. Kurdish (Kurdi) is a group of related *Iranic* Indo-European languages with 15 million or more speakers in Turkey, Iraq, Iran and other countries of western Asia. The northern and central/southern dialects groups are sufficiently different from each other to be considered distinct languages. The main northern variety is Kurmanji, spoken in eastern Turkey and northwest Iran, and also in northern Iraq where it may be referred to as Bahdini. The main central variety is Sorani, spoken in northern Iraq where it has official status, and in northwest Iran where it is known as Kurdi. Gorani and Zaza or Dimli, two languages spoken in Turkey and Iran and more distantly related to Kurdish, are sometimes misleadingly referred to as Kurdish (Sanderson in Eversley et al, 2010).

The number of Turkish speakers (16,778) has grown only very slightly (7%) between 1998/9 and 2008. Two-thirds of the Turkish speaking community live in the four neighbouring north London boroughs of Enfield, Haringey, Hackney and Islington; Enfield accounts for half of these, having replaced Haringey over the last decade as the borough with the largest number.



Source: Eversley et al (2010)

In addition there are at least 3000 speakers of a Kurdish language recorded. However, many of the Kurdish speakers are likely to speak Turkish. It is believed that Kurdish is an under-reported language and the option may not always have been offered (Eversley and Sanderson, 2010).

The Bangladeshi community

After English, Bengali is the second most widely spoken language among school children, spoken by nearly 50,000 children.[7] Clearly for every child who speaks Bengali there will be one or more adults who do, too. In fact the ratio is likely to be a little over two adults for every Bangladeshi child under 16.

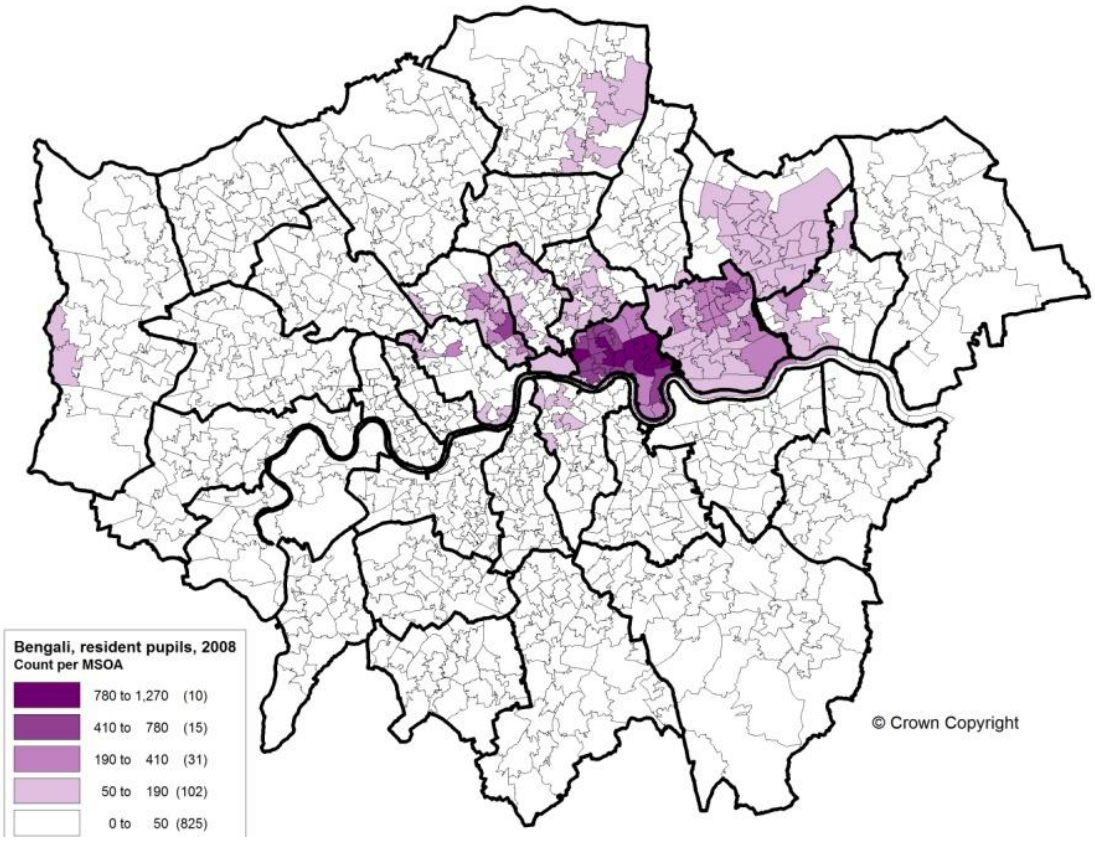
The Bengali speaking community mostly originates from Sylhet in north east Bangladesh. The Bengal-London connection goes back at least 400 years and is intimately tied up with the history of the East India Company and the British Empire with the export of tea and a

[7] Turkish is spoken by little under 17,000 pupils

large number of seamen from the area ((Lascars') working in the merchant and Royal Navies (Ullah and Eversley, 2010). The language spoken by most of the settlers is Sylheti which does not have a (widely used) written form.

Bengali speaking pupils in London (46,681 including Sylheti and all other varieties) are concentrated broadly in an area immediately north of the river Thames in London. From Westminster in the west to Barking & Dagenham in the east, there are nine boroughs with more than 1,000 Bengali speakers each and which together account for over 80% of the Bengali-speaking community. Tower Hamlets is home to just over 43% of the London Bengali community, although this figure represents a decrease when compared to the borough's 47% share in 1998/99.

However, when we analyse the data on ethnic origin –'Bangladeshi' with the data on language – 'Bengali' or Sylheti' in Tower Hamlets, an interesting pattern is revealed. The borough council's analysis of the school census data shows that the number of Tower Hamlets pupils who are of Bangladeshi origin has increased in the last decade while the proportion of the Bangladeshi community describing itself as Bengali-speaking is declining (Tower Hamlets, 2008; Baker and Eversley, 2000).



Source: Eversley et al (2010)

This raises some important questions for languages policy. For example, while the first generation of Bangladeshi settlers (mostly post World War II) may not have spoken fluent English, the third and fourth generations generally do. There are still some people, especially first generation migrants, who do not speak English fluently. A survey of Bangladeshi adults in the 1990s found that only 75% of Bangladeshi men and 40% of Bangladeshi women said they spoke English fluently (reported in Tackey and Casebourne, 2006). On the other hand, from the evidence about school children it appears that many younger people will not be able to interpret for them because they don't speak Bengali/Sylheti. This has direct implications for the use of informal and *ad hoc* interpreters. The problem is compounded if mediating communication is seen not simply a matter of linguistic competence but cultural competence and also the ability to mediate power relationships.[8]

The Somali Community

The Somali-British community was initially nearly exclusively male based on Somali seafarers. There is evidence of their presence and settlement in UK in the 1880s (Kleist, 2005). With the rundown of the Merchant Navy in the 1960s, many Somali seamen moved to cities further north, such as Sheffield, Manchester and Birmingham, where the steel industry had expanded and labour was in great demand.

During the 1960s and 1970s, Somali students from the former British Protectorate of Aden (now Republic of Yemen) came to study in the UK. Some of these students decided to settle in the UK, others returned to Somalia after finishing their studies.

The majority of Somalis currently living in the UK, however, arrived during the 1980s and the 1990s seeking asylum from the civil war in Somalia. As majority of the Somalis who arrived in the late 1990s were refused refugee status, those who arrived in the UK in last few years are mainly as result of family reunion with their spouse or children. Therefore, a vast majority of Somalis living in the UK are British citizens.

Population

Somalis are not categorised as a separate group in the UK Census and their numbers are therefore uncertain. The 2001 census recorded about 33,000 Somali-born residents living in London. However many people of Somali origin were not born in Somalia but in the UK , other European countries or other countries in the Horn of Africa or Great Lakes region.

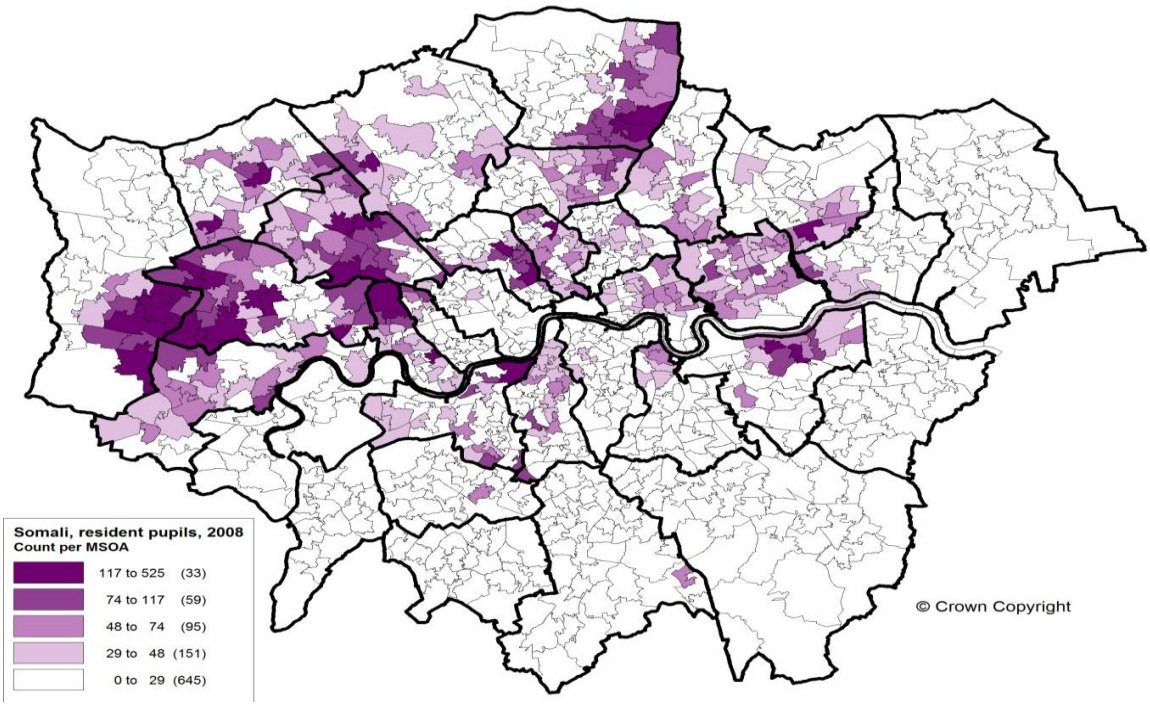
[8] See Chapter3 on Capability, Competence and Critical Health Literacy

In Tower Hamlets, identifying the Somali residents is just as challenging. Estimates range from 0.7% - to 5.0% of the population, representing 1,353 – 12,000 Somalis living in Tower Hamlets. (THPCT, 2008).

Numbers of Somali population using Somali Born Data, 2001 Census

	Somali population in numbers	**Total Population**	**Percentage (%) of population**
Tower Hamlets	1,353	196,106	0.7%
London	33,831	7,172,091	0.47%
England	42,548	49,138,831	0.09%

Somali pupils in London 2008



Source: Eversley et al (2010)

The number of Somali speaking pupils in London has increased to 27,126 in 2008 from just over 8,200 in 1998/9. In 1998/9 the largest community was in Ealing, as it still is, but there

are 14 boroughs with more than a 1,000 Somali speaking pupils accounting for 72% of the Somali speaking pupil population. As the maps suggests there are distinct concentrations of Somali speakers within individual boroughs. The number of children who are described as Somali by ethnicity is a little over 20,000, of whom just over three-quarters (76%) say their home language is Somali, nearly 800 describe their home language as English, more than 400 as Arabic and more than 400 as a Swahili language. The fact that more than 25% of Somalis speakers are not described as from the Somali ethnic group and nearly 25% of those who are described as ethnically Somali do not say they are Somali speakers should make us cautious about using Somali language speakers as a proxy for the number of Somalis.

Methodology

The researchers

Community workers from each of the communities were recruited and trained to administer a short questionnaire. Although the questions were written down and the answers collected in English, the questions were asked and answered in the relevant language. As the questions were very straightforward this was not thought to pose any problems.

The settings

Turkish community in Hackney (2009): Four general practices with substantial numbers Turkish speaking patients.

Bangladeshi community in Tower Hamlets (2009): nearly half of the participants were contacted through the social networks of the researcher and in the Health Centre waiting areas with the permission of the Practice Managers or a senior member of staff. 30% were contacted through attendance at a Bengali health awareness event. It was a full day event organised by a community group in 2009. The rest were contacted by attending an event organised at a Health Centre to promote awareness of immunisations.

The Somali community in Tower Hamlets (2010): the participants were recruited randomly with the help of 5 Somali community workers (Four female and one male). Subjects were recruited from a variety of settings: GP/hospital waiting rooms, Somali lunch clubs, mosques and during work and social gatherings.

Ethics

The Chair of the East London and *The City Research Ethics Committee (1)* advised that the project was an audit and review by an NHS Research Ethics Committee was not required.

Interviewers gained the informed consent of all participants prior to the interview and all the participants were informed about the objectives of the study.

It was further explained to the participants that all the information collected will be kept confidential. Permission was taken from parents of the children under 18 prior to the interview.

The results

Turkish community

Use of an interpreter (n = 53)

17 out of 53 participants said they needed an interpreter and stated that they used *ad hoc* interpreters regularly. The number of female patients was greater than male patients. There were no participants below 19 years old. Among this group, a few also said that whether they try to use an interpreter provided from NHS depends on the availability of an interpreter and the level of concern with respect to their health.

Patient profile

Patients	Age group : 19-54	Age group : 55-74
Male	6	2
Female	8	1

10 participants stated that they do not use any interpreter at all or only on rare occasions. 'Rare occasions' referred to involvement with the police or court cases.

(Almost) Never use an interpreter

No Interpreter	Age group : 11-16	Age group : 17-18	Age group : 19-54
Male	0	0	5
Female	2	1	2

Have done ad hoc interpreting

36 participants stated that they do *ad hoc* interpreting regularly for family, friends or neighbours at least once a month but in many cases, once a week. The majority of those were again females aged 19 to 54 years old. However, it must be noted that 11-16 years old had also performed a high number of *ad hoc* duties to their family and friends.

Ad hoc interpreters	Age group : 11-16	Age group : 17-18	Age group : 19-54
Male	3	0	3
Female	12	1	17

Two of the female participants (aged 11-16) stated that their parents spoke English well and never interpreted for anyone.

Bangladeshi community

Use an Interpreter (n = 50)

Patient Profile

Patients	
Male	29
Female	21

Use an Interpreter	Do not use an Interpreter
46	4
8	1

Who and at what frequency

Who have you used	In the last week	In the last month	In the last year	Ever (but not in the last year)	Total
A relative	7	7	11	4	29
Friend	1	3	3	4	11
Neighbour	1	2	7	4	14
Member of NHS staff who is not employed as interpreter/advocate	2	5	6	4	17
Interpreter / advocate provided by the NHS	10	17	14	4	45

Informal and ad hoc interpreting

Have you interpreted for your family members, friends or neighbours? (n =50)

***Ad hoc* interpreters**	
Male	17
Female	33

Have Interpreted	Have not interpreted
41	9

For whom and at what frequency?

	In the last week	In the last month	In the last year	Ever (but not in the last year)	Total
A relative	14	19	29	4	68
Friend	3	4	9	4	20
Neighbour	7	8	14	4	33

What age groups did they come from?

Age	Under 11	11 - 16	17/18	19 - 54	55 - 74	75 +
Number	1	8	9	28	4	none

Somali community

Use of an interpreter (n = 50)

Patient profile

Patients	
Male	44
Female	6

Use an Interpreter	**Do not use an Interpreter**
44	6
8	1

Who is *ad hoc* interpreter?	**No of patients**
A relative	18 (36%)
Friend	6(12%)
Neighbour	4 (8%)
Member of NHS staff who is not employed as interpreter/advocate	5(10%)
Interpreter / advocate provided by the NHS	30(60%)

Have Interpreted	**Have not interpreted**
48	2

***Ad hoc* interpreters**	
Male	20
Female	30

Age range of the Somali *ad hoc* interpreters						
Age	**Under 11**	**11 - 16**	**17/18**	**19 - 54**	**55 - 74**	**75 +**
		3	5	37	4	1

***Ad hoc* interpreters and their relationship with patient**

Those they interpreted for	No of *ad hoc* interpreters
A relative	37(74%)
Friend	29(58%)
neighbour	26(52%)
Stranger	9(18%)

Participants' comments

Although it was not a primary purpose of the audit to collect qualitative data from participants, a number of revealing comments were made.

Why use an interpreter?

Bangladeshi community

Most of the patients said that they needed an interpreter in their interaction with the health (and other public) services as they spoke little or no English and did not have enough confidence to face the health professionals.

Bilingual healthcare staff

Turkish community

One practice has a Turkish speaking doctor on site to provide a health service to the Turkish speaking community. The practice manager is also Turkish. In another practice a GP has started learning Turkish but the practice also has Turkish interpreter

Paid Mediators versus informal and *ad hoc* interpreters

Turkish community

It was reported that paid NHS interpreters were either from Iran, Iraq or most often, Cyprus. It was said that sometimes the NHS interpreter did not know the meaning of certain words. This resulted in patients specifically asking for a Turkish speaking interpreter or opting for a family member rather than using an NHS service. The main reason for using *ad hoc* interpreters was the issue of "trust". Most of the participants said that the information they share is personal and would prefer someone close to them, in particular a family member. A few service users complained about the availability of NHS interpreters at the practices.

They said that even if they wished to use an interpreter from the surgery, it is not always possible in terms of time arrangement, such as clashing with other patients' appointments or lateness from the interpreter resulting with the patient missing their appointment.

Patients complained that they cannot access an interpreter on the day they wish to see their GP. Patients feel that health does not wait until an interpreting service is available. Once they need to see their GP they would like to be able to go any time they need it, not on the days arranged by the practice. It is noted that in a few surgeries the NHS interpreter is available only on certain days of the week.

Case study: Turkish woman

After arriving in the UK 11 years ago, she asked her children to interpret. They are now aged 21 and 19 but while her husband had a routine health check, doctors had told their (then) 15 year old daughter that her father's illness was cancer. In this case the mother still feels guilty for bringing her daughter in to the hospital. She wanted to point out clearly that the hospital staff were insensitive to share such information with a 15 year old girl, while giving her the burden to deal with the emotional trauma. The girl did not share this information with either of the parents but opened up to a neighbour upon her return from the hospital.

Bangladeshi community

Patients said that whether they try to use an interpreter provided from NHS depends on the availability of an interpreter in their GP surgery or hospital. Many also said that if they are very concerned in respect to their health, they would seek out a professional interpreter but if it is something less significant, then they would be happy to take their children or relatives. The issue of trust was always in the background of these statements. Comments included that they "*felt more comfortable with their children compared to the professional interpreter*" and that "*I felt safe*". They also relied on their family members to remember information (e.g. dates, symptoms etc) "*in case they forgot*". Trust was not only in a social, but also in the linguistic sense – "*I feel the professional interpreter cannot translate word for word*", reflecting their expectations as well as dependence on the family member.

Somali community

The use of strangers to interpret:

I was stopped by a Stanger and forced to interpret for them' (Male, 17/18 years)

'It's really important to provide an interpreter in labour Ward, because I couldn't find anyone to interpret for me so I asked another patient to interpret for me. I was very emotional and I really needed someone to explain to me what was happening to me' (Female 19-54 years)

Use of children to interpret:

Some of the mothers who used their children as *ad hoc* interpreters reported being uncomfortable having to discuss sensitive health issues in front of their children.

'My boys have been interpreting for me since they came to the country. They are now grown-ups. I found it particularly difficult to rely on them to convey female matters to doctors but I have no choice' (Female, 55-74 years)'

Use of non professional interpreters:

The results of the audit show that the use of relative, friends and neighbours seems to be widely accepted by healthcare professionals.

'I always interpret for my mother and I have to take time off work. There are no interpreters in DSS or housing' (Female, 19-54 years)

'Is not easy to get an interpreter whenever I need, so I prefer to ask friends' (Female, 19-54years)

The use of NHS health advocates/interpreters:

'I always get an advocate when I need one. I feel happy about the follow up as I have multiple complaints and visit often' (Female, 55-74 years)

''I'm usually happy to see someone from my country speaking my language and understands my culture to interpret for me' (male 19-54years)

It was recognised by most participants that interpreting services in hospitals are generally inadequate and inappropriate reliance is placed on family members to interpret. Little was known about how to access interpreters/advocates working in the hospitals.

' I speak little English so I do sometime understand what the doctors is saying to me but I find it hard to get an interpreter during hospital and emergency appointments in hospitals' (Female, 19-54 years)

The views of young *ad hoc* interpreters

Turkish Community

Young Turkish ad hoc interpreters reported that they felt a massive amount of responsibility and pressure coming from the person they interpreted for. Most stated the difficulties and the psychological pressures arose from lacking the medical terminology and not having had the necessary training for interpreting in the medical field. Most stated that the interpreting they are asked to do was not only for their family but also for neighbours and friends of their families. On many occasions, they felt extra pressure, as the people they were interpreting for did not believe them. These young people not only had to interpret for their family and friends, but were also given the responsibility to reassure the patients regarding their illnesses or other important health issues. They felt that this was acceptable to an extent for their own families but in some cases, they had to the same for someone who was not a relative but only a neighbour or a friend of their parents. When asked how they cope with such pressure, they laughed and seemed to look at this matter as if it was something ordinary after years of practice.

A few *ad hoc* interpreters stated that as they got older, their responsibility was greater with respect to working or studying, in effect they were not able to do as much interpreting as they used to. This may be a driver to push Turkish speaking patients to use NHS interpreters. However, it was clear at the end of the research that not all participants (*ad hoc* interpreters and patients) were happy with this change. The 11- 16 age group seemed to approach *ad hoc* interpreting as if it is their usual routine.

Bangladeshi community

Most of them saw it as their "duty" to interpret whenever their elders asked them to, but those of the school age group also resented having to miss school and spend long hours in surgeries or hospitals, especially when there are so many interpreters around.

Some of the most typical comments from male and female Bengali young people who were frequently asked to interpret for their relatives were:

'I felt really embarrassed when I was translating for my mum about women problems' (Male).

'I felt pressured by my family that I always have to interpret for them' (Female).

'I don't have any medical knowledge at all therefore I find it hard to understand when the professional uses any sorts of medical words. And I don't have the courage to ask them to explain. Also, often I use the same English word because I don't know the Bengali word for it' (Female).

'Sometime I have to miss school in order to interpret for my mum at hospital' (Female).

Somali community

'I have been interpreting for my mother since I was 11years old'.

I like to interpret for mother because I feel it is a part of my job' (Female, 16 years)

'I like to help my mother and I don't want other people to know her illness. Sometimes they use hard language and I find some words difficult to understand'

'I do it to help my relatives' (Male, 17/18 years)

References

Ahmed, N. (2010) personal communication, April

Ansari, H (2004) *The Infidel within - Muslims in Britain since 1800*. London: Hurst.

Baker, P & Eversley, J, Eds, (2000*). Multilingual Capital. The Languages of London's Schoolchildren and their Relevance to Economic, Social and Educational Policies* London: Battlebridge Publications.

DCLG (2009) *The Bangladeshi Muslim Community in England - Understanding Muslim Ethnic Communities*. London: DCLG

Defoe, D (1982) *Roxana Or, The Fortunate Mistress*. Penguin. London.

Eversley, J.; Mehmedbegovic´, D.; Sanderson, A.; Tinsley, T.: von Ahn, M.: and Wiggins, R.D. (2010) *Language Capital - Mapping the languages of London's schoolchildren* London: CILT

Eversley, J and Sanderson, A (2010) Commentary on the 2008 school census language data in Eversley et al, op cit.

Greater London Authority (2009) *Turkish, Kurdish and Turkish Cypriot Communities in London*. London: Greater London Authority

Hitchins, K (2006) *Kurdish Nation-formation in Turkey 1890s -1938 from a comparative perspective.* Kurdish Institute of Paris http://www.institutkurde.org/en/conferences/kurdish_studies_irbil_2006/Keith+HITCHINS.html#_ftn15 (Accessed 8 November 2010).

Kleist, Nauja (2005) *Nomads, sailors and refugees A century of Somali migration Sussex Migration Working Paper no. 23* http://www.sussex.ac.uk/migration/documents/mwp23.pdf

Matar, N. (1998) *Islam in Britain 1558 -1685*. Cambridge University Press.

Sanderson (2010) A-Z guide to the languages that can be recorded in the school census in England in Eversley et al, op cit.

Tower Hamlets Primary Care Trust (2008) *Somali Population in Tower Hamlets: A Demographic Analysis*. Public Health Department

Tackey, N; Casebourne, J. Et al (2006) (quoting PSI Fourth Survey of Ethnic Minorities) *Barriers to employment for Pakistanis and Bangladeshis in Britain* Department for Work and Pensions. Research Report No 360 http://research.dwp.gov.uk/asd/asd5/rports2005-2006/rrep360.pdf

Tower Hamlets, LB EMA Service (2008) Key Ethnic Minority Achievement Statistics and Information. LBTH

Ullah, AA and Eversley J (2010) *Bengalis in London's East End.* Swadhinata Trust

8. Training

1. Introduction

The UK TRICC training programme was designed for, and delivered to, two broad target groups:

- Bilingual people from migrant backgrounds already or potentially involved in healthcare mediation directly or indirectly
- People responsible for taking care of migrants and minorities

The interventions ranged from formal, accredited education through to discussion in informal forums. The kinds of mediation (see Chapter Five) covered ranged from the primarily linguistic through communication to cultural and faith knowledge and explorations of power relationships.

2. Aim

The aim of the training was to develop and enhance the intercultural and bilingual awareness and competencies of informal and *ad hoc* interpreters. This work was mainly focused in the field of health and social care.

3. The participants

There were five groups of participants:

1. *Staff and volunteers from NGOs and a Primary Care Trust*: Most of these participants were from Somali and Bengali/Sylheti linguistic communities. They were bilingual and used their dual language skills in their work as paid employees or volunteers interpreting for people they generally did not know. Crucially they were *not* recruited or trained as interpreters. A few were refugee health professionals from their own countries seeking alternative employment in the UK. Three were not bilingual but were interested in linguistic and cultural issues relevant to the multi-cultural community they were working in (i.e. East London).

2. A group of *students at a further education college* on health and social care related courses leading to Higher Education. They were bilingual in a variety of languages. They were called on to interpret as informal volunteers for friends, family, neighbours.

3. *Nursing students*: They were not specifically identified as a group of bilingual students but half spoke more than one language and some had been called on to use a language other than English. The significant issues of mediation for them were cultural and faith capability and competences.

4. *Imams* (mostly) of Bangladeshi origin: prayer leaders at mosques in Tower Hamlets. They were called on primarily as linguistic mediators but also to give health related advice and information from an Islamic perspective appropriate to the Bangladeshi community.

5. *Health and healthcare managers and practitioners* who were specifically interested in issues of Islam and Health – language was not a central preoccupation.

Common issues

Whether paid, unpaid, formal or informal, linguistic, cultural or faith mediation there was an assumption that the mediators were capable of the task and that the task was clear. For example, it was assumed that being 'bilingual' was sufficient to be a competent interpreter or that being familiar with Islamic beliefs and practices equipped people to advise on health issues in relation to their faith. These experiences reinforced the earlier research that underpins this training programme, which found that bilingual staff, carers and relatives were often called on to interpret, negotiate and mediate between clinicians and patients.

The earlier research that underpins this training programme highlighted the widespread practice of informal and *ad hoc* mediation and the need to equip these target groups with at least the core essential skills and tools to undertake an interpreting intervention to contribute to accurate and appropriate health outcomes.

Numbers and characteristics of specific groups

The events organised are summarised in the following table:

UK TRICC Training programme

Group	Further information	Numbers	Dates
Tower Hamlets College	Access Course students	7 learners	12 /3/10 – 23/4/10.
Health Trainers	Bilingual staff working for NHS Tower Hamlets	Course 1 8 learners Course 2 11 learners	30/9/10 – 4/11/10 1/10/10 – 5/11/10
Women's Health & Family Services	Bilingual staff working for NGO	18 learners	25/08/10 – 29/09/10
Refugee Women's Association	Bilingual staff working for NGO	6 learners	18/10/10 – 10/11/10
City University	Graduate Entry Adult Nurses in training	8 participants	29/09/10
Tower Hamlets Council of Mosques	Imams (Advisers to informal and *ad hoc* interpreters)	17 participants	25/10/10
NHS Tower Hamlets	Clinical leaders (users of informal and ad hoc interpreters)	27 participants	25/10/10
Total		102	

Informal and ad hoc interpreters working for NGOs and NHS

Eighteen Bilingual Community Workers and Health Advocates employed by Women's Health and Family Services (WHFS), a community-based women's organisation, providing a range of advocacy and related services to women and their families in Tower Hamlets, East London, underwent the training. WHFS presently has projects in a variety of areas ranging from advocacy work to Diabetes, Maternity and Child Health, Audiology and health in Old Age. Volunteers also attended the training sessions. All of the participants in this mixed gender, mixed age group were bilingual in Bengali and Somali.

Nineteen Health Trainers employed by NHS Tower Hamlets were also given training in cultural and linguistic competencies. The Health Trainers aim to deliver healthy lifestyle activities and smoking cessation to their respective communities in Tower Hamlets, employing innovative and creative ways to support clients in making healthier life choices. All but three of the participants in this mixed gender, mixed age group were bilingual in Bengali and Somali.

The final group in this category to be trained was six service users and volunteers from Refugee Women's Association (RWA), a well established community based organisation providing advice, guidance and counselling to refugee women and women asylum seekers, from both a central location and on an outreach basis. Out of the six women participants, three were doctors in their own countries (Afghanistan, Burma and Iran) one was an accountant (Somalia) and one was a teacher (Lithuania). All of them came to Britain with no, or very little, English and learned it here.

In total, 43 *ad hoc* and informal interpreters undertook training. With the exception of trainees who were not bilingual, a common characteristic amongst all participants, including those whose English was not very good, was that they had been called upon to interpret at some point. This had occurred not only for their families and friends, but also in their professional roles as Community Workers, Health Trainers or Advisers. They mainly reported that they undertook this role even though they did not always feel confident or qualified to do so because they *"wanted to oblige as they felt sorry for the service users"* or because they *"could not possibly refuse a person in authority such as a doctor or an elderly family member".*

Further Education students

The participants were seven bilingual adult College students enrolled in Pathway to Nursing, Pathway to Science, Access to Nursing, Education and Teaching, Youth, Community and Social Care courses. Between them they spoke nine languages other than English. They all had experience of *ad hoc* interpreting with their family members, friends and relatives, some as interpreters and some had been interpreted for.

Their comments on their previous experience included:

They (doctors) were just asking my brother-in-law and he was answering for me without even asking me!

They (doctor) was asking about sexual habits and intercourse between my older sister and my uncle. It was too embarrassing for me. Also for her (…) I wanted to walk out.

I had to interpret for my old uncle. Although I was not a child, I just could not do it. I refused to interpret, but the doctor kept forcing me.

This is important job…should be done professionally.

I wish I could have said No.

They are not thinking of mediation as a career but saw enhancing their skills as useful in whatever job they ended up in.

Student Nurses

Eight students from City University participated in the workshop. All students had undertaken first degrees - in subjects ranging from sociology, criminology, and psychology to health studies, sport science and history. All the students were undertaking a two year accelerated course in nursing and were approximately six months into their training.

Four out of eight participants had at least one other strong second language acquisition. In all of these four cases English was not the primary mother tongue. Two participants had experience of interpreting for others, having been used as informal/*ad hoc* interpreters by colleagues and family members. Two participants also had experience of commissioning interpreters for patients in their care. Four participants had little or no experience of contact with interpreters.

Health and Healthcare managers and practitioners

27 people participated in the first part of the seminar, representing a range of interests across health, education and local governance. More specifically this included clinicians such as general practitioners, nurses, physiotherapists, educationalists, public health specialists and health planners in Tower Hamlets.

Imams

Seventeen Imams attended the workshop. They were all from mosques associated with the Tower Hamlets Council of Mosques which has forty five members. They were all Bangladeshi men.

Needs

Non-Governmental Organisations (NGOs)

At the start of each training programme, participants were asked to describe their experiences of interpreting to date and to consider and share what they hoped to gain from participation on this course and what they expected from the course (For a full list of all the expectations, see Appendix One).

There were inevitably some common and shared expectations but it was also very interesting to note the different needs and expectations within and between groups. Individuals had different needs and expectations of the programme which varied significantly with regard to enhancing knowledge, skills and understanding relevant to improving cultural and linguistic competences. These differences were inevitably shaped by the nature of the work that each target group undertook as well individuals' own subject positions and current status. For example, the expectations of the refugee women who were qualified as health professionals in their own countries but were currently unemployed, focused on

Getting a qualification and improving [my] chances of getting a job

Improving [my] English, getting an accreditation and an extra certificate

Conversely the Community Workers, Bilingual Advocates and Health Trainers, already in employment tended to, focus on fine tuning and honing what they already knew, and exploring further what they wanted to know more about:

What is the distinction between an interpreter and translator or a bilingual health advocate?

I want better understanding of different cultures in relation to current role as a Health Trainer

Learn to work towards equality

Gain an understanding of the legal and ethical framework and the broader agenda in interpreting work, including protection by law.

However, a recurring theme amongst all the target groups and training programmes was how to maintain boundaries without causing offence or appearing rude to either patient or the clinician. Many participants indicated that saying "no", refusing people in authority (due

to age, seniority or status in society) was difficult, almost unacceptable, in many of their cultures:

I want to improve communication and setting boundaries

It would be good to learn how to say no and that it is okay to do so

learn to tackle tricky issues in a professional manner with new techniques

This was further evidence of the widespread practice of informal interpreting but more importantly the need to equip staff with strategies to handle it professionally and skilfully.

Specific questions raised before and during training: Although a short and intensive training course, participants were actively encouraged to constantly raise issues that needed clarifying or further discussing. The trainers created opportunities for questions to be asked and each issue, as long as relevant to the topic at hand, was addressed appropriately.

Some of the main issues were the "distinction between interpreting and bilingual advocacy", "dependency/detachment", "boundaries", "importance of terminology and vocabulary in interpreting", "difficulty of interpreting and dealing with difficult/sensitive situations" and "keeping self and others safe".

Another important issue which came up repeatedly was that of "trust/comfort/ease and empathy" which the participants felt was the basis of open and effective communication between the service user and the interpreter. The matching of gender, age and geographical location relating back to respective home countries, was seen as important issues that contributed to building trust and empathy between both parties.

The issue of gender came up as an important issue and participants retold cases from their own experiences showing that the demands on women were higher and more persistent than those on men. Whilst men were almost solely expected to interpret in an accurate and objective way, women were expected to perform additional tasks, ranging from "holding the baby" to "buying food or magazines from the shop" for someone in hospital.

The importance of body language, physical and eye contact was also raised together with confidentiality and ethical issues, especially within confined small communities.

Finally, accuracy and knowledge of terminology was flagged as a concern for some learners. Young people were familiar with a term in English but did not necessarily know the corresponding term in their own language. Some learners stated that the limitations of a particular language may mean that there may not in fact be an equivalent word.

The Further Education students

The learners hoped to:

Learn interpreting skills
Get accreditation for the future
Learn to interpret accurately and appropriately
Learn technical terminology
Increase their language awareness and understand themselves and communities better
Learn to express things in book language and in folk language
Learn to set and protect boundaries (be able to say no and not get involved)

Nursing students

The students were asked to complete a short questionnaire at the beginning of the session – see Appendix Two. The participants recognised that they had little or no understanding of the different types of interpreting models and that they did not know the law and regulations concerning interpreting.

Health managers and practitioners

In advance of the workshop, all attendees were asked to identify at least one pressing issue relating to the impact of faith, in particular Islam, on their sphere of health work. A diverse range of issues emerged. A small sample is outlined below. What is of particular note is that these are not the kinds of issues that can easily be addressed with a "fact pack" or a cultural checklist, which, until relatively recently, was all that was available. Additionally participants also commented that they were immediately reassured that their needs were being, at the very least, acknowledged by the holding of this seminar:

I find it difficult educating the Muslim patients as they give up as soon as they hear about their condition, and not willing to do anything themselves and believe that it's all to do with Allah; I work with end stage heart failure and heart disease patients and would like to be able to combine faith with health and to have further knowledge

I am interested in the interplay of culture, religion and socio-economic circumstances in the beliefs about stroke and rehabilitation. I'm also interested in working together with Imams and finding ways how religion can be helpful in the rehabilitation process

I am particularly interested in concepts of ill health, recovery and the role of health professionals in the context of Islam. The concept of active and empowered patients taking responsibility and control over their illness is one of the key principles my work will be based on. How can this concept be married up with religious and cultural concepts of the Islamic population?

I am concerned about the presentation of depression and how it is expressed in the Muslim population we serve – and how faith might impact this. I have the feeling it is rather

different from the way some other groups of patients present, but I'm not sure quite what I'm looking for, and would value your thoughts

How can we help advise people who don't wish to take medications or alter their lifestyle to influence a chronic disease, as they believe that Allah will take care of it, or it is his decision what happens and they can't influence this?

Is there any way we can help counsel women who, for very difficult reasons, have had to have terminations of pregnancy but feel extremely guilty as a result because of their faith?

The Imams

The Imams were not explicitly asked what their needs and expectations were. It was felt by the workers at the Council of Mosques that an informal forum was needed to explore what their needs might be and also begin to meet some of the needs. In retrospect the needs identified can be described as:

- Identifying which aspects of Islam are most relevant to health and healthcare
- Thinking about the role of Imams
- How to promote health enhancing behaviour in areas such as diet and exercise
- How to deal with complex areas such as mental health

6. Aims of training

Each of the courses had specific aims:

NGOs, Health Trainers and Further Education College

The courses aimed:

- To enhance learners' language and cultural competencies
- To familiarise learners with terminology of the public agencies they will be working in
- To train learners in community interpreting skills and techniques
- To raise learners' awareness of culture-specific issues around health
- To raise learners' awareness of public services and a range of health and social care settings
- To train learners in collecting, collating and analysing relevant local information

City University

To explore issues of communication with healthcare students currently undertaking professional training.

- To enhance their own understanding of cultural competency
- To understand how communication is mediated through culture and faith

- To develop an understanding of, and an awareness about, how their one own values, culture and beliefs can impact on their decisions about patient care.

Health managers and practitioners and Imams

- To explore the issues of cultural, faith and linguistic mediation for Muslims in Tower Hamlets including the relationship between culture and faith
- To increase their knowledge of how Islam might impact on healthcare and specifically the role of Imams
- To promote concordance between health care providers and public health promoters on the one hand and users or populations to maintain and improve health and make health care effective.
- To encourage employers, schools, colleges, universities and mosques to work together to enhance capabilities.

7. Organisation of training

ppre Community Interest Company

The training was organised by associates of ppre, a not-for-profit research and education company. ppre associates have been involved in research and development around equalities and specifically issues of language and culture and healthcare for many years. The training events were primarily facilitated by Akgul Baylav and Gita Malhotra. More information about the ppre associates involved in the training is in Appendix Seven.

Partners

Each training course or event was organised with an external partner. The partners were:

- Three community based organisations - Women's Health and Family Services, the Refugee Women's Association and Tower Hamlets Council of Mosques
- Two education bodies – Tower Hamlets College – a further education college and City University, School of Community and Health Sciences which trains nurses and other health professionals
- NHS Tower Hamlets - a Primary Care Trust in East London
- Making Training Work, a training organisation which undertook to arrange accreditation of training through the Open College Network.

8. Learning Methods

The overall learning strategy of the programme followed the approach of Paulo Freire – based on experiential learning and drawing out the knowledge of the participants rather than treating them as bank customers making withdrawals from the 'bank' of educators (Freire, 1972). This was done by using participants' personal experiences and local examples.

With the NGOs and Further Education students, it was possible to incorporate the use of Forum Theatre (The background to Forum Theatre is explained in Chapter 9). For the other groups it was felt that time was too limited to use Forum Theatre. Role plays were extensively used, however.

Case studies and examples were used with all groups – examples are given in Appendix Three. The participants were encouraged to bring real life cases to the training. The emphasis given to maintaining confidentiality gave them confidence that 'what was said in training stayed in training". As such the training groups were able to explore each other's examples of work situations that they had found challenging – framing the problems and the solutions. Several participants anecdotally commented that they had been looking for the 'right answers' and realised this wasn't always possible. They also said they would talk to colleagues more about finding solutions to challenging interpreting scenarios in the workplace after witnessing how discussing cases could assist so positively rather than struggling on their own.

Small group work was used with all groups (except the Imams). A gentle sense of competition was often used to encourage the learners to participate actively and "perform well" in their teams.

Discussion triggers of various kinds were used, e.g. watching and discussing a training DVD entitled "The Right To Be Understood". This was used with the NGOs to prepare for and to structure/conduct an interpreted consultation. Group work centred on "What happens when different parties interpret – advantages and disadvantages of having friends/family members, including children, and professional community interpreters to interpret for a service user who does not share the same language and culture with the providers of services." This proved to be particularly useful in highlighting different aspects within the social and cultural context of interpreting.

For the longer courses different exercises were used, such as "Designing the Ideal Interpreter" and quizzes on various aspects of interpreting and on ethical issues of interpreting. The participants found short scenarios using a quiz format both enjoyable and challenging.

Most of the 'community' participants (bilingual and non bilingual learners) both lived and worked locally and were therefore familiar with the backgrounds, living conditions and aspirations of their communities and clients. Many of the community workers, volunteers and health trainers were second and third generation migrants. Most of the Imams and some of the students were first generation migrants. We did not specifically ask the health managers and practitioners about their backgrounds but some volunteered that they were not familiar with the backgrounds of many of their patients.

The backgrounds of the participants influenced the learning methods. For all the informal and *ad hoc* interpreters the issue of recognition of their skills was important. Therefore accreditation was built in. Accreditation requirements influenced learning methods. For example, the second and third generation migrants understood and spoke English and their respective community languages but they were less confident and capable in writing in a community language and therefore in compiling specialist terminology in a second language. They needed to do this to compile a Bilingual Glossary in Public Services for the accredited Unit. Those who anticipated difficulties in writing their assignments were offered the option of transliterating or reading it onto a tape. It was felt that all the groups needed some didactic input but this was generally organised as a response to needs identified by the participants. Inputs included:

- Theoretical issues such as Modes and Models, Skills and Techniques of Interpreting, Issues relating to Interpreting – e.g. verbatim vs. summary, first vs. third person interpreting, confidentiality, dependency/detachment/boundaries, intervention skills as well as legal and ethical aspects of interpreting (NGOs)
- Background to the social, organisational context, professional contexts and approaches to mediation (College and University students, health managers and practitioners)
- An introduction and some insights into notions of authority and the core beliefs and pillars of Islam (health managers and practitioners)

9. The Programmes

NGOs, Health Trainers and Further Education College (20 hours each, including the Forum Theatre session)
The arrangements needed to accommodate and work around participants' availability and tight work schedules.

Typically the key topics that were covered in each programme included:

What is interpreting?

- Modes of interpreting
- Models of interpreting
- Legal, ethical issues

Knowledge and Skills in interpreting

- Importance of language and culture in communicating in health settings
- General/Specialist terminology (including own language)
- Planning and conducting the interpreted consultation

Experience of Interpreting

- Categories of issues (e.g. confidentiality)
- Reconciling personal and family and community priorities
- Power relationships with users and service providers
- Managing and coping strategies

Interpreting in communities

- Knowledge of communities (own and others)
- Feelings towards communities (own and others)
- Inequalities in society
- Understanding of community dynamics as it relates to their job and function (formal/informal)

City University (4 hours)

- Self assessment of students knowledge: Statements about Interpreting
- Icebreaker exercise: students counting 1-2-3 mono-lingually, then bilingually, then tri-lingually
- Aims and expectations of the day
- Student experiences
- Types of mediation
    - Language
    - Communication
    - Knowledge
    - Power
- Summary, conclusions and evaluation: repeating analysis of statements about interpreting

Health managers and practitioners (3 hours)

- In advance of the workshop, all attendees were asked to identify at least one pressing issue relating to the impact of faith and Islam in their sphere of health work
- Setting the scene and context with an examination of the factors that can act as barriers to access to healthcare and healthy living for black minority ethnic and refugee communities (John Eversley)

- Presentation by a local Mawlana (Islamic scholar) Mawlana Shams Adduha Muhammad describing core thinking and beliefs in Islam including notions of authority and where these come from
- Professor Aziz Sheikh, Professor of Primary Care Research and Development at Edinburgh University: brief introduction to the history of Muslims in the UK and what is and is not known about the health profile and experiences of Muslims in the UK
- Collation of list of issues for health managers and practitioners and responses by Professor Sheikh and Mawlana Shams
- Discussion of Case Studies (See Appendix and responses by Professor Sheikh and Mawlana Shams
- Evaluation using 'Spider's Web' tool

Imams (2 hours)

- Invitation to Imams to discuss what they thought the relationship between health and Islam is, followed by free ranging discussion covering
- Theology focusing on the example of the Prophet
- Putting Islam into practice in the UK
- The role of Imams
- Diet and Exercise
- Mental health and well-being

Professor Sheikh, Mawlana Shams and John Eversley asked questions and offered observations but there were no formal presentations.

10. Learning Outcomes: what the programmes intended to achieve

NGOs and FE College

The learning outcomes for the training programme for NGOs and the FE College were that the learner would:

- Have an insight into cultural and language competencies in general and enhancement of their own competencies in particular

- Have gained an understanding of the environment they will be working in

- Have gained interpreting skills and be able to interpret competently and confidently in this environment

- Be able to identify information relevant to their work and analyse it from the viewpoint of their "clients"

- Have accumulated specialist vocabulary relevant to health and social care related public services and have devised a system whereby they can improve and add to their vocabulary

- Be able to understand the ethical and legal aspects of working, making use of their bilingual/bicultural skills.

The way the training programme was designed and delivered was intended to allow learners to demonstrate and share how specific aspects of learning related to their work and how they could and would adapt certain learning outcomes (e.g. techniques, skills and terminology) to their day-to-day work as Community Workers, Bilingual Advocates, Health Trainers and RWA Advisers.

For example, Health Trainers give advice about healthy lifestyle, physical and mental well being and healthy eating. They have one to one or group sessions with clients and work out personal health improvement plans with them. They feel they cannot impose their own thoughts or pace onto their clients and have to respect the way their clients want to/can take on their advice and encouragement. For them, it is always the client who is paramount, and as trainers they are guiding them or more metaphorically: the client is in the driving seat but it is the Health Trainer who has the accelerator and brake pedals. Therefore, the skills and techniques one group of Health Trainers identified as relevant to their roles included:

Motivating people and empowering them, giving options and negotiating, inspiring, monitoring, leading by example, reading between the lines, listening and reflecting back, patience and never judging people against own parameters

Another group of Health Trainers highlighted the following learning as relevant to their work: "Evaluating, guiding, being resourceful, directing, and referring.", "Being pro-active,

sign posting and questioning, engaging in different ways, empathising, empowering and being culturally aware" were also pointed out as useful and relevant activities to the work of health trainers which they reinforced during the course of the training.

Some of the learners said that:

Being aware and proud of your own culture and language is so important because we have always to consider the clients 'cultural backgrounds and faiths.

They also stated that they now realise that there is not just one way to resolve things and take them forward. Now, if they have a sensitive or difficult case, they feel confident to bring it to the safe environment of their office and act it out with their team members, thus reaching different solutions for desirable health outcomes for the client.

Significantly one of the learners suggested that

Monitoring is not necessarily ticking boxes, there can be a human approach to things and health improvement can be observed as a result

The RWA volunteers, almost all of them qualified and experienced professionals from their own countries, also expressed that they could confidently take away learning from this training into their social and volunteer activities when they are seeking employment advising their clients in the office or undertaking outreach work. Organisational skills, writing in English to fill forms and documents, recruiting women onto RWA courses, understanding the concerns and aspirations of refugee women (empathy), teaching and overall communication skills were but a few of the points they highlighted as relevant to their activities.

11. Evaluation of training

NGOs and FE College

The training was evaluated in five ways:

- A recap from the previous session at the beginning of the second and third sessions;
- Conventional assessment for three fold evaluation: baseline, at the end of formal training and one month after the end of the training (copy of the evaluation form in Appendix Four);
- One day session in Forum Theatre to evaluate and consolidate the learning to date;
- Facilitators' own reflections and discussions;
- Informal verbal feedback from the learners and their line managers helped the Facilitators to gauge the level of satisfaction (and anxiety) of the learners throughout the courses

1. The great majority of learners retained key points from the training– some of their feedback comments when asked *"Tell us one thing you remember from the last session"* were as follows:

"Cultural considerations, knowing and being proud of own culture and understanding that cultural information should be imparted both ways

importance of accuracy, vocabulary/terminology, confidentiality and that it can be broken under certain circumstances

a clear understanding of their role as an interpreter, of responsibilities and boundaries

the importance of being assertive and the Right to say NO

that it's OK not to know but can ask to find out and/or clarify if do not understand

the importance of a working knowledge of the system and the procedures, including what help/support is available in the community so that (they) can refer clients.

In another group, some of the comments included

"that interpreting is a serious and difficult activity and that small mistakes may have big and dangerous consquences

that there are different types of interpreting which require different skills which can be developed via training

that it is not only a verbal activity but body language plays a great role in communication across cultures

trust/comfort/ease/empathy are essential in communication

importance of keeping safe self and others

2. The detailed results of a three part evaluation are presented in Appendix Four.

The three stages were:

1. At the beginning of the training to get a baseline of the participants' experience and competencies in interpreting
2. At the end of the training the questions to assess the immediate impact of the training
3. After three months, the participants were asked follow up questions about the medium term impact.

The results broadly were that although the participants felt that they were doing a good job before hand, they had a number of concerns. Immediately after the training and three

months after they felt the training had addressed those concerns. The result seems to be both that they were doing more interpreting and feeling that they could say 'No' to doing it more easily. In the language of the analytical framework for the project, the training seems to have addressed both capability (including confidence) and competence.

3. The Forum Theatre sessions also presented opportunities for evaluating and consolidating learning, with three main objectives:

a. To look at power relationships

b. To review our approaches in dealing with them

c. To explore a range of solutions

Specific feedback is given in the chapter on Forum Theatre (Chapter 9).

4. The Facilitators' reflections and discussions took place throughout the training programmes. As a result of these reflections, for example, a change was made in the day-to-day delivery of the programme to include in every session a slot where discussion took place on how to construct the accredited unit/s because the participants showed some concern and insecurity as to how to go about it.

5. Direct feedback from the participants was invaluable. Individual learners repeatedly said that they were "*enjoying the course*", "*learning a lot*", "*they had no idea that it would be so difficult but also worthwhile*", they are "*now aware of the equalities perspective of interpreting and bilingual advocacy*". Some of the managers also informally reported that "*they are getting a very positive feedback from their team members*" and "*everyone is enjoying themselves*". Finally, one manager said, "*The atmosphere in the office has changed. There is more buzz now – They (team members) talk more, they discuss more and they help each other more!*" and "*They are almost revitalised, helping each other to complete their assignments*".

City University

Evaluation of the event took place in three ways

1. Learners were asked to re evaluate the impact of the workshop by completing the same questionnaire that had been used at the start of the day. Again they were asked to what extent they agreed with a range of statements, with the opportunity of providing written comments as well. All the students reported a positive shift in their understanding of both the law and regulations concerned with interpreting and of interpreting facilities available locally. Several students reported that they had little or no experience of working with interpreters to date in their work as student nurses and therefore only answered 'neutral' on a set of questions both before and after the workshop.

Of particular note was that as a result participation in the workshop, which focused on understanding how power, knowledge and communication operate and impact on delivery of healthcare, almost all participants in their 'after' responses expected the interpreter to also act as a cultural mediator, possibly demonstrating an understanding of the complexities of language and power.

After the event none of the participants thought that it was the patient's responsibility to organise an interpreter if they needed one. They all thought that it was the responsibility of the clinician or the service as "patients had a right to be understood". Finally, as a result of the training programme, the majority of respondents also identified an improved understanding of the difference between formal and informal interpreting.

2. At the close of the day, participants were asked to say one thing that they would take away from the day or would like to comment on. Below is a summary of the comments made:

- I definitely feel more informed about this agenda of interpreting informally
- I've realised that there is more than one way of looking at something
- I think I will be try to be more open minded when I am with a patient especially in the community where we are going to for our next health placement
- Some of my own perceptions about why patients do what they do have been challenged.
- I think I need to give proper thought to cultural issues and try and understand why a patient is behaving they are – a way that might not be familiar to me.

3. When the training was complete the university lecturer who had taken part also gave feedback to the training facilitators indicating the following:

- The students evaluated the session positively and were really looking forward to using the knowledge acquired in their practice;
- The lecturer felt that the training had provided the learners with he right information to work on becoming patients' advocates.

Health managers and practitioners

Participants were invited to use the 'Spider's web' – see Appendix Six. Almost all indicated they had found the seminar very interesting and relevant to their work. 22 out of 27 indicated the seminar had been what they expected and a similar number stated they had found it useful.

Seven out of the 27 participants had also provided more detailed written feedback. Interestingly the comments almost exclusively reflected a desire for further sessions on looking at issues of faith and cultural competency and a call for more support, as illustrated in the sample below:

- *I would welcome further discussions, maybe by our individual organisations, to look at the case studies more closely and get more idea on how to deal with difficult situations. A lunchtime forum would be better for GPs*
- *Would be good to set up a multidisciplinary group across Tower Hamlets to better tackle these challenges*
- *It would be helpful to have a named contact at the London Muslim Centre / Council of Mosques for clinicians and managers to consult in specific questions for assistance guidance or sign posting*
- *Is there scope for one of the Protected Learning Time education slots for clinicians at Mile End Hospital?*
- *But who should we consult on [regarding] medical issues if there is such variety of advice from imams?*
- *Am very interested in Islam and health and social impacts on lesbian and gay and bisexual Muslims and also on older adults in rehabilitation?*
- *Has helped with raising these issues of faith in teaching students*

A DVD of the presentations and the discussion has been made which will be used in further work with practitioners and managers. A short version of it will available on YouTube so that anyone searching for material on Health and Islam can find out about more (see also below).

Imams

Evaluation of the session with the Imams was planned, using the Spider's web. However, it did not take place. The discussion went on longer than expected and the Imams had to leave hurriedly for afternoon prayers.

A DVD of the discussion has been made which will be used in further work with the mosque. A short version of it will available on YouTube so that anyone searching for material on Health and Islam can find out about more.

12. Accreditation

The training programme for NGOs and Tower Hamlets College was a reduced version of longer 20 week Community Interpreting course accredited by a UK awarding body, the Open College Network (OCN). The university students' session was part of the 'Communication Skills' section of the core curriculum.

The completion of an assignment towards a Unit accredited by Open College Network on "Creating a Bilingual Glossary" was a distinctive, innovative aspect of the training programme.

This was chosen for a number of reasons:

- As an incentive to learning. Every participant from the NGOs wanted to achieve accreditation to demonstrate their learning. Although the Further Education students were encouraged by their mainstream tutors to “go for it” as an additionality as it would enhance their chances in future, only two chose to do so.
- To focus learners on how to use different sources
- For many: to “brush up” their written skills in their own languages
- To learn to value the resources within themselves and their own communities such as their parents, elderly relatives and neighbours.

The task was to compile a list of 200 words relating to two or three public services, e.g. health, education, social services and benefits, housing etc. and to present them in an accessible way. They were also asked to do a small list of 10 words in standard and colloquial terms in their own language to understand the real nature of working and effectively communicating in their respective communities.

Those students who did not write their own language were given the opportunity to transliterate or to read their glossaries onto an audio-tape. This was possible because, after all, community interpreting is a verbal activity and as long as they know the terms and pronounce them in a clear and understandable way, they would be able to do their jobs.

The learners who were not bilingual had the opportunity to gain accreditation by completing a different unit on *Research Skills In The Community*. This involved them giving an account of why interpreting is important in relation to their job (in a multi-ethnic, multi-cultural context), what resources there are in the community for referring their clients for additional support and help and what resources there are to look for information and how to access them. Two of the three non-bilingual learners have completed this Unit and said how much they enjoyed it and benefited from it.

Reference

Freire, P (1972) *Pedagogy of the Oppressed*, London: Penguin.

9. Forum Theatre

Background

Forum Theatre is a participatory theatre form, one of the elements of "Theatre of the Oppressed." It was developed in Latin America by Augusto Boal as a way of working with theatre to tackle the overriding problems experienced by ordinary people. Significantly for the people working with minority language speakers it specifically developed in a context where people were described as 'illiterate' because they were unable to express themselves in a particular language, in this case Spanish – because Boal was in exile from his native Brazil in Peru and Chile. (Boal, 1979).

It has been seized on, developed and adapted all over the world. Currently practitioners are applying it internationally and in the UK in Health Promotion, Theatre for Development, Community action and development, work in prisons, in health, Theatre in Education (TIE) and schools work, Drugs and HIV awareness, Domestic Violence, with homeless people in participation processes and in many other areas. It has developed into various strands – though they are often intertwined – Legislative Theatre (policy-making), the Rainbow of Desire (therapeutic) and Forum Theatre (educational). Education in this context is used in the way that Paolo Freire used the term – "education as liberation" (Freire, 1972).

Theory

Forum Theatre explicitly draws on theories about the theatre and education. (Often unconsciously) it also draws on theories about policy-making and management of change.

There are several key ideas:

Oppression or Resistance

Boal originally wrote in Portuguese. The term he used is usually translated as 'Oppressed'. In Boal's terminology, the word 'Oppressed' carries the notion of resistance rather than an accepted connotation of passivity or victimhood. He draws a distinction between the 'Depressed', the 'Repressed' and the 'Oppressed'. The 'Depressed' person is crushed (for the time at least). The 'Repressed' is (literally or metaphorically) in front (e.g.) of a firing squad and it's too late. Boal reflects on the way in which people may be neither free nor externally repressed. Boal commented that after the visible, physical repression he had seen in Brazil:

> *In Lisbon , in Paris there appeared oppressions that were new to me - 'loneliness', impossibility of communicating with others' fear of emptiness…I was … asking, mechanically, 'where are the cops?'. (Boal, 1995a)*

The cops, he decided were in the head: hence the development of therapeutic techniques within Theatre of the Oppressed. The concept is very similar to that of Franz Fanon's

internalised oppression (Fanon, 1967). However, the 'Oppressed' is the person who wants to do something. Boal's notion of oppressed incorporates the notion of 'bafflement' but also action.

Language

From his earliest experiments in Peru and Brazil, Boal was acutely aware of the way that language was a tool that could be used to reinforce or change power relationships. Physical imagery and photography have been used by Boal to overcome the restrictions of language. He says '…By learning a new a language, a person acquires a new way of knowing reality and of passing that knowledge to others…' (Boal, 1979).

Reframing

Unlike role- play in which a 'part' is acted out as if there is a consensus on how the role is perceived, Forum Theatre specifically explores conflict. In this it takes after Goffman's understanding of human interactions (Goffman, 1986) and Schon and Rein's understanding of policy controversies (Schon and Rein, 1994).

The techniques for reframing draw on the tradition of Bertolt Brecht of 'making the familiar strange – Verfremdungseffekt' (Willett, 1964).

Reflection

Core to Paolo Freire's approach to learning was that it needs to be drawn out of the learners by a process of reflection rather than drawn from the 'bank' of an "expert" (Freire, 1972). Forum Theatre came into being while working with Freire when a member of the audience went on stage after actors failed to convey the image on stage that she wanted them to. The transition from spectator to participation as 'Spectactors' is important. The idea that reflection is *more than a mechanical process* is also in management theory (Schon, 1991). Although it is not a conscious part of Boal's thinking, Schon's distinction between 'Espoused Theory' - what people think they are supposed to think – and 'Theory-in-Use' is a useful one.

Two techniques are particularly used by Forum Theatre to achieve this: extrapolation of everyday experience into the imagination and unrestrained context of theatre and the use of metaphors. Again this fits with management theory (Morgan, 1997).

Transformation

Reframing and Reflection are combined in Forum Theatre to '(re)construct reality' (Berger and Luckmann, 1972). The idea that small or everyday events can 'cause' much bigger transformations is shared with contemporary writers on the management of organisations and change (Morgan, 1997).'Flux and transformation' have a much longer history (going back to Heraclitus) and wider applications in theoretical physics (quantum mechanics) with ideas of small changes being capable of setting off much bigger ones and post-Darwin biology with ideas of systems that are not separable from their environment – ecology or autopoiesis.

Forum Theatre's techniques for promoting transformation often involve small changes to what someone does or say which sets off a change in a train of thought or action.

The practice

A typical session begins with exercises and games aimed at initiating a playful, creative approach to what may be serious issues. Examples are given in Appendix Five.

Then, a scenario or a set of images or tableaux is prepared by the group around what is of interest and importance to them. When the work is shown to an audience or worked within the group, everyone is encouraged to intervene to change the situation or resolve the problems. It is a theatre form that is entirely determined and developed through participation.

A classic Forum session involves the replacement of the principal character in a scenario, the one who represents the group, by members of the audience. Thus, take turns to be in someone else's shoes and experience life through their eyes. This is called by Boal "pluralisation" and is central to the reflexive processes of Forum and Theatre of the Oppressed as a whole.

The "Spectactors" practise or rehearse change by exploring the alternative courses of action open to the protagonist of the piece and carrying the experience through into everyday life.

A facilitator who becomes the "Joker" for the Forum, the enabler or mediator for the group, conducts the session.

*The nature of the society is reflected in its smallest cells. The great themes are inscribed in the smallest personal themes. (*Boal, 1995b).

Forum Theatre in the TRICC UK project

Aims

To bring about reflection on the relationship between the theory and practice of *ad hoc* interpreters

Objectives

- To evaluate and consolidate the learning so far
- To look at power relationships
- To review participants' approaches in dealing with them
- To explore a range of solutions

The programmes

At the beginning the participants were not very clear about what they were there for, as the process is hard to envisage for people with no previous experience of it.

Each workshop was introduced by a set of ground rules agreed by participants. One of the facilitator's ground rules is always "have a go!" which, when agreed to by a group, can boost confidence and motivation to join in.

The first Forum Theatre event with TRICC did not allow time for reflection. Later events (generally lasting about five hours) allowed the participants to explore the metaphorical nature of their experiences and stories. This involves using image and theatre, made by the group, to see their own experiences in relationship to others', to "pluralise" those experiences so that each acquires a significance greater than it has singly. This is both a reflexive and a creative process and combines the advantages of both.

Introductions

The group were asked at the outset to name their roles in their work and then to deconstruct them in terms of their capacities and capabilities; for example: translator, listener, negotiator, empathiser, holder of boundaries etc.

Games

Following this, two games, *Zip Zap Boing!* and *123!* encouraged spontaneity, fun and opened up the potential for surprising, unanticipated discoveries. The image games and, always, a blind exercise called simply Follow the Sound, fuelled a reflexive process around issues of how to respond both to vulnerable others and to a vulnerable self. (Examples of all the exercises used in Forum Theatre can be found in Appendix Five).

The experience of these games referred directly and indirectly back to the roles/capacities session and raised questions about the relationship between values and practice, which were followed through as the workshop progressed.

Images

The exercises used in the Forum Workshop sessions are described in Appendix Five.

A transitional image exercise, *Occupy the Space*, brought the experiences of exercising or being on the receiving end of, power relations, having to trust or be trusted into the room through evoking both physical and cognitive recall.

From this process of the embodying of ideas and experiences in a general way, participants divided into small groups of 3 or 4 and each created a "snapshot" image of an actual moment when they had experienced an obstacle to realising their intentions. They did this in the first instance in silence without explaining the image to the others. They showed the images unexplained, to the whole group. Group process of projecting meaning onto

ambiguous images helps recognition of ambiguities and exploration of differences and convergences. Themes of power, anxiety, confusion, puzzlement, desire for action, aspiration, commitment, passion for change emerged.

Scenarios

Groups were next asked to get back together, explain the images and select one to convert into a scenario, with improvised dialogue, for working as a Forum Theatre piece with the whole group.

The scenarios were very diverse. Two groups, independently from each other, chose scenes about family relationships in the Bengali community. It emerged that those scenes, which at first sight did not relate to the work they were doing, were in fact strongly connected to the participants' work. In families, parents' power over children in marriage and education, and men's power over women, can lead to problems around mental health and happiness. These things affected group members and their clients. Not only that, but people's learned behaviour at home might affect their reaction to power in the outside world.

Others chose to work on scenes with doctors and patients or with service users they were working with. The themes around work showed the gap between values and practices where people's ethical aspirations do not percolate through to their practice. Interactions become "automatic", over-determined by everyday habits, assumptions and practices and by box ticking and under resourced work cultures.

Evaluation

Whatever their background, as group members began to identify and then "re-rehearse" their behaviours and practices, they became more able to analyse and characterise the problems and to propose alternative ways of working, to consciously explore the ethics and values behind what was needed. The move from "good feelings" to an ethical practice became possible. Their confidence increased and particularly in two of the workshops, participants began to allow their personalities a freer range, to trust themselves to think, reflect and act.

Participants talked freely about how they felt about Forum Theatre and what they got out of it. The participants from NGOs said:

Learning experience relating to day to day experiences
Quite nervous at beginning, warmed up soon
Benefitted great deal from it
Walking around made me notice how negativity affects group mood
Freeing space/body language,
Separate what makes angry and work commitment
Detachment

Listening is important otherwise you may lose out on important clues
Images can help shape and create
It is our responsibility to create a safe atmosphere
Families' fears/hiding issues forgetting things out
Practice different emotions
Non verbal communication very important
Portraying and understanding communication
Being alert and responsive
Different power relationships change situations
How to use power with clients
Importance of reflecting and correcting
Self reflection plus looking at other people's behaviour
Know mistakes and correct and move on
You can change the situation
Everyone put in their best, very fine work through hard work
It was good to work in partnership and group work
Acting liberates, Conflict issues etc can be acted out and you know what it means better by putting yourself in other's shoes
Replay conflict or difficult scenarios in work context in my office and we may find solutions through friends' support and strength
We did have a go and it was fantastic/ enjoyable!

The Tower Hamlets College students used the Forum Theatre session to evaluate what they had learned. They said that interpreters needed to

- Be flexible in approach but accurate in detail
- Learn from mistakes
- Not to touch without permission
- To reflect on situation and own performance
- Know boundaries of role and competence
- Be sensitive
- Recognise the power of the interpreter and that the interpreter has power to change things
- Understand the complexity of Language and that speaking to the health professional and to the client is different; the importance of moving from technical to simpler language, depending on the level of the client
- Know that the interpreter can talk to the client privately at any point confidentially
- Each case has a different level of complexity

- Know the interpreter often has to work with uncertainty and unpredictability

An example of Forum Theatre in use as part of the TRICC project is in a DVD on You Tube (Moarefvand, 2010).

References

Berger, P and Luckmann T (1972) *The Social Construction of Reality.* Penguin.

Boal, A (1979) Theatre of the Oppressed Pluto

Boal, A. translated by Jackson, A (1995a) *Rainbow of Desire*, Routledge.

Boal, A. (1995b) *Notes TIPP (Theatre in Prison and Probation Centre) at Manchester University 1995*] reprinted in http://www.nationaltheatre.org.uk/download.php?id=4502 (Accessed 16 December 2010)

Fanon, F (1967) *Black Skin White Masks.* Grove Press, New York.

Freire, P (1972) Pedagogy of the Oppressed. Penguin

Goffman, E (1986) *Frame Analysis.* Northeastern University Press.

Moarefvand, M (2010) Developing Skills - a 15 minute DVD about developing the skills of informal and *ad hoc* interpreters http://www.youtube.com/watch?v=B_qdJVzShIE

Morgan, G (1`997) *Images of Organization*. Sage.

Schon, D (1991) *The Reflective Practitioner* Avebury.

Schon D and Rein M (1994) *Frame Reflection – Toward the Resolution of Intractable Policy Controversies*. Basic Books.

Willett, J. (1964). Ed. and Trans *Brecht on Theatre* London: Methuen

Appendices

Appendix One

Expectations of the Training Programme with NGOs

- To feel confident in own practice by the end of the course
- To understand the framework they need to work within
- To learn how to say No and that it is okay to do so
- To gain an understanding and knowledge of cultural and ethical aspects related to interpreting
- To become familiar and confident with terminology and vocabulary
- To learn to tackle tricky issues in a professional manner with new techniques
- To have a clear and improved understanding of interpreting and the role of the interpreter
- To understand the distinction between the role of the interpreter and the bilingual advocate
- To gain an accredited qualification
- To develop a good professional practice of interpreting in health and social care settings
- To begin to develop strategies to effectively challenge and to also cope with own frustration
- To gain an understanding of the legal and ethical framework and the broader agenda in interpreting work, including protection by law
- To develop strategies for managing emotional involvement and other related issues such as dependency, detachment and boundaries
- To improve English and get accreditation and extra certificate
- - To improve chances to get a job
- - To increase chances of further education
- - To gain access to Open College Network courses
- - To get a job as interpreter
- - To get a booster to further career

Appendix Two

City University workshop Statements about Interpreting

Promoting cultural and linguistic competences

29 September 2010

To what extent do you agree with the following statements?

Statements

1 = Totally disagree 2 = Somewhat disagree 3 = Neutral 4 = Somewhat agree 5 = Totally agree

1. I am familiar with the law and regulations concerning interpreting	1	2	3	4	5
2. I am familiar with interpreting facilities in the UK	1	2	3	4	5
3. I expect an interpreter to translate literally	1	2	3	4	5
4. Besides translating, I expect an interpreter to be a cultural mediator	1	2	3	4	5
5. I think it is the patient's responsibility to arrange an interpreter	1	2	3	4	5
6. I understand the difference between informal and informal interpreters	1	2	3	4	5
7. I am usually satisfied with the work of interpreters	1	2	3	4	5
8. I explain to the patient what the task of the interpreter is/ It is easy for me to explain to the patient what the task of the interpreter is.	1	2	3	4	5
9. I would discuss with the interpreter about his/her task.	1	2	3	4	5
It is easy for me to discuss with the interpreter about his/her task.					
10. I discuss how to work with interpreters with my fellow students	1	2	3	4	5

1 = Totally disagree 2 = Somewhat disagree 3 = Neutral 4 = Somewhat agree 5 = Totally agree

Space for comments

Appendix Three

Case Studies

Scenarios used with interpreters

What would you do if you were an interpreter and:

1. The client gave you some information and told you to keep it confidential

2. The client gave you information which was not relevant to the question asked by the professional

3. The client swore or said offensive words

4. The Professional said something to you during an interview and told you not to pass the message on to the client

5. The professional said something which showed that s/he does not understand the requirements of the client's culture

6. The professional asked you to interpret in Arabic, your first language is Persian but you understand some Arabic

7. You have been asked to attend a psychiatric ward with Mr B who is having an appointment with his psychiatrist. Due to his mental health problems and stress, Mr B keeps rambling on emotionally and incoherently.

Case studies used with health managers and practitioners

1. Mr Sarwar, a 49 year old Bangladeshi taxi driver, suffered a stroke two years ago, which has left him with a major right-sided weakness of his arm and leg. He has a minor speech impediment and incontinence. He continues to smoke 25/day, stating that he will stop "when Allah wills." Of at least equal concern to his GP and neurologist is that his compliance with statin therapy and aspirin are poor. What can be done to help him quit smoking and improve compliance?

2. Rachna, a 15-year old GCSE student makes an appointment to see her school nurse. Tearfully, she confides that she might be pregnant as her last period was four months ago. The only other person she has told is Katrina, a classmate. The pregnancy test is positive. What issues might it be helpful for the school nurse to be aware of?

3. Mrs Begum, a 24 year old recent migrant from Bangladesh, consults for the third time with problems of aches and pains in her arms and legs, poor sleep and tiredness all the

time. Suspecting a diagnosis of depression, the GP prescribes an anti-depressant and arranges a review four weeks later. At review, she is no better. Why might this be the case?

4. There is a local recruitment drive to try and recruit a more diverse nursing and allied health professional workforce (i.e. dieticians, physiotherapists and occupational therapists, etc). There is a particular need for female practitioners who can communicate effectively with the high proportion of Bengali-origin patients. What factors should those planning the recruitment drive take into account?

5. Jamal, a 13 year boy consults with his father to ask about whether he should fast. Looking through his medication history reveals that he has been getting through an average of two blue (reliever) inhalers a month, suggesting poor asthma control. His father also expresses concern that he is not doing well at school and spends too much time sleeping.

6. Mr and Mrs Malhotra attend the antenatal clinic following a pre-natal diagnosis of a major congenital anomaly. They have three other children, one of whom has severe cerebral palsy. Mr Malhotra went to discuss the problem with the local Imam who said that "He will pray for the family and that everything will be fine, Inshallah." The issue of a termination comes up in the discussions with the obstetric staff. Reassured, Mr Malhotra is unwilling to contemplate a termination. In contrast, Mrs Malhotra appears apprehensive. She says little in the consultation. What issues is it important for the obstetric/midwifery staff to be aware of?

7. Mr Akmal, a 37 year old shop-keeper attends to enquire if it is ok for him to go on Hajj. Reviewing the notes, you notice that his diabetes tends to be poorly controlled. He is obviously overweight, but otherwise appears in reasonable health. What should you advise him?

8. The local health promotion team have had a three month run of weekly outreach work trying to promote cardiovascular health. This has centred on the opportunity for drop-in sessions after Friday prayers at mosques throughout Tower Hamlets. At a debrief meeting one month into the campaign, the health promotional teams express concerns about the "complete lack of interest". Why might this be the case? Should they abandon the campaign? What might they do differently?

Appendix Four

Evaluation of NGO training

The evaluation of the NGO training was in three stages:

1. At the beginning of the training. The questions were designed for the tutor to gain an idea about the baseline of the participants' experience and competencies in interpreting for their family and friends so that training could be adjusted to suit their needs in order to improve their bilingual communication and interpreting practice
2. At the end of the training the questions were intended to assess the immediate impact of the training
3. After three months, the participants were asked follow up questions about the medium term impact.

1.1. Participants personal details

The 24 participants on the three courses were Bilingual Community Workers, Volunteers and Health Trainers with a Primary Care Trust in East London. Not all provided personal details.

Age

Age	19 - 54
	15

Sex

Male	Female
6	9

1.2. Language used

Language	Number
Bengali (inc Sylheti)	7
Arabic	2
Urdu	1
Hindi 2	2
Swahili	1
English	1
Somali	6
Dutch	1

1.3. Interpreting experience

Have you interpreted for any of the following?

For	In the last week	In the last month	the last year	Ever
A relative	5	9	4	1
Friend	2	4	6	2
Neighbour	3	2	6	1
Work	2	1	1	

(*) One person who had not done any interpreting indicated “n/a”

1.4. Interpreting context

Was it in (Number most frequent as 1, second as 2, etc.)

GP Surgery/Health Centre	1
Hospital	2
School or College	5
Housing	4
Benefits	3
Legal	6
Other BT (phone company) Gym, Community Centre Various	 1 x 1 x 7

One person who had not done any interpreting indicated "n/a"

1.5. Feelings about interpreting <u>before</u> the training

Did you feel **comfortable** about being an interpreter?

Strongly agree	Agree	Unsure	Disagree	Strongly Disagree
5	8	0	1	0

One person who had not done any interpreting who indicated "n/a"

Did you feel that you did a **good** job? (Competent)

Strongly agree	**Agree**	**Unsure**	**Disagree**	**Strongly Disagree**
5	8	1	0	0

If you had concerns about being an interpreter what were they about?

	Strongly agree	**Agree**	**Unsure**	**Disagree**	**Strongly Disagree**
Being able to say not to doing it	0	6	0	4	4
Vocabulary (knowing right words)	0	10	1	2	1
Dealing with embarrassing or painful issues	5	6	1	2	0
Dealing with cultural differences between service user and service provider	5	3	1	4	1
Impact on other activities e.g. study, work, leisure	2	1	4	3	3
Other	0	0	0	2	0

2. Efficacy

Evaluation of the effects of training at the end of the training session:

2.1. The training helped with?

	Strongly agree	Agree	Unsure	Disagree	Strongly Disagree
Being able to say no when asked to do it	6	6	1	0	0
Dealing with embarrassing or painful issues	3	9	1	0	0
Vocabulary (knowing right words)	6	5	2	0	0
Dealing with cultural differences between service user and service provider	7	5	0	1	0
Impact on other activities e.g. study, work, leisure	6	6	1	0	0

Other, please state	1. This course has helped me gaining skills and experience in understanding the importance of interpreting and very importantly enabled me to be confident and competent. 2. Lots of skills including vocabulary in English to Bengali Interpreting in Bengali and the difference between translating and advocating 3. It's made me more confident to talk with others

2.2. What did you find helpful/useful in the training?

	Very useful	**Useful**	**Unsure**	**Not very useful**	**Not at all useful**
Information given by tutor	10	5	0	0	0
Information given by other students	4	9	1	0	0
Learning skills	9	6	0	0	0
Sharing experience	10	6	0	0	0
Confidence building	10	6	0	0	0
Other, please state	Friendly teaching and helpful behaviour Forum Theatre One to one support Encouragement Overall the training was very useful				

2.3. What is the most important or useful aspect of the training you are going to take away? (open question)

- Importance of interpreting
- Different ways to interpret
- Fun learning and new skills
- Forum theatre
- Difference between interpreting/advocacy and translation
- Awareness of the importance of competency in interpreting and understanding the relevance of cultural differences
- Communication with others and learning from other individuals
- Everything that I learn from the training I will take away specially the glossary
- Skills and competences
- This training enabled me to know more about my position as an interpreter
- Glossary
- The big picture of the interpreting industry that help me to further involvement of higher training/study
- the different types of interpreting
- Sharing experiences and ideas
- Others ecperiences of different issues in dealing with service users and how it affected their work
- Being able to say No
- Sharing experiences
- Sharing information with others.
- Confidence building activities helped too.

2.4. What aspects of the training did you particularly like? (open question)

- Forum theatre
- Research
- Compiling the glossary
- The insights of the Forum Theatre
- Being given increased awareness of the importance of interpreting
- Role plays
- Everything about the training was good but one thing I really enjoyed was the theatre
- Sharing experiences, information given by the tutors
- The role plays
- The role plays
- Quiz based evaluation and the assignment making
- Role plays and group discussion
- Role plays
- All of the course was enjoyable
- Watching the vido and learning the different techniques of interpreting
- Teamwork was enjoyable

2.5. Can you suggest any improvements to the training? (open question)

- To give more assignments to trainees
- n/a
- Maybe to talk about the legislation on the issues e.g. NHS, immigration and housing
- It was great experience for me
- Nothing at all. Everything was good and the tutors were excellent and professional
- Have more time to hand in work
- Handouts could be written more clearly
- Introduce models and theory
- More time for the group discussions
- Exchange information between the health Advocates
- No
- More time
- Provide refreshments

2.6. Is there any further training you would like? (open question)

- Yes, I will get my opportunity to get any higher training in interpreting. I will do that.
- Not sure.
- I would like to get one day/short training on current changes with the services
- Learn how to read and write in Bengali
- Anything that will enhance my job role will be good
- Learn how to read and write in Bengali
- Thank you for a brilliant training
- I want to gain skills, experience and qualifications in sports-science, fitness and health/social promotion and care
- Level 2 of the same training
- Level 2 of the same training
- Yes
- I would like to do the Level 2 of the interpreting course
- No

2.7. Adoption, Implementation Maintenance

During the final session using Forum Theatre the students gave their feedback. This is presented in Chapter Nine of the report.

3. Evaluation of the impact of training 3 months after the training

This was conducted by phone

3.1. Personal details

Age

Age	**19 - 54**
	14

Sex

Male	**Female**
4	8

3.2. Language used

Bengali/Sylheti	6
Somali	5
Urdu	2
English	1

3.3. Interpreting experience

Have you interpreted for any of the following?

For	In the last week	In the last month	the last 3 months
Relative	4	6	19
Friend	4	2	7
Neighbour	2	2	2
Colleague	1	0	0

Some of the participants contacted said “Not really” to this question because they had exams and course work to finish.

3.4. Interpreting context

Was it in (Number most frequent as 1, second as 2, etc. None as 0).

GP Surgery/Health Centre	1
Hospital	2
School or College	5
Housing	4
Benefits	3
Legal	0
Other Please specify Gym	1

3.4. If you have been interpreting, do you feel more confident about the following?

	Strongly agree	Agree	Unsure	Disagree	Strongly Disagree
Being able to say not to doing it	6	5	0	0	1
Vocabulary (knowing right words)	5	7	0	0	0
Dealing with embarrassing or painful issues	7	4	1	0	0
Dealing with cultural differences between service user and service provider	8	4	0	0	0
Impact on other activities e.g. study, work, leisure	7	5	0	0	0
Other, please state	0				

One course participant said that he refused one request which he had been unsure about at the beginning of the training.

3.5. Looking back, in what way has the situation most improved? (open question)

- Knowing the rights and responsibilities of an interpreter and the actual nature of this work
- Learning new terms
- More confident in using different words
- Confidence
- Knowing my work frame has helped. I know when I can say no and can do this more confidently

3.6. Looking back, what was most helpful/useful about the training?

	Very useful	**Useful**	**Unsure**	**Not very useful**	**Not at all useful**
Information given by tutor	11	1	0	0	0
Information given by other students	4	5	0	0	0
Learning skills	9	3	0	0	0
Sharing experience	9	3	0	0	0
Confidence building	9	2	0	0	0
Other, please state	0				

3.7. Is there any further training you would like? (open question)

- None
- Through our research we found that in community settings a lot of translations are wrongly spelt and many being transliterated. We will take this issue up with our Line Manager as well as the local (Tower Hamlets) PCT.
- Read and write Bengali
- Read and write Bengali
- Probably – Diploma in Interpreting
- Yes, any higher training about interpreting
- No
- Interpreting course levels 2 & 3 in the future

Appendix Five

Forum Theatre exercises

Hypnosis

- In pairs. Hand 4-6 inches from and parallel with partner's face. Keeping the distance is the main focus.
- Partner follows the hand wherever it leads.
- Leader to move at a reasonable speed, not so fast that impossible to follow.
- Try to stretch and develop the capabilities of the partner. Stay with your hand: if you explore floor level, keep your head and shoulders level with the back of your hand.

Follow the Sound

- Partners. A and B
- A agrees a guide sound with B: needs to be of the voice rather than mechanical like a click.
- B shuts eyes and follows sound. Only moves when she can hear sound.
- A leads and becomes more elusive, loud, soft, far, near, stops etc.
- This can be done as a rainforest exercise or with some kind of a journey in mind e.g. guiding round obstacles.
- It's a trust exercise and requires the blind person to be attended to and kept from collision also to be challenged in a way appropriate for that individual.
- Swap over.

Go towards

- Partners. Shake hands, eyes closed, step back an agreed number of steps.
- Eyes closed, find handshake again.
- Go further away, repeat a few times.
- Embrace; step away, and as above.

Occupy the Space

- Ask group to walk fast round the room covering the space evenly: if you see a space move into it, cover gaps.
- Ask group to move round room briskly looking into each other's eyes neutrally and holding the gaze: glance and keep moving.
- Ditto, acknowledging each other, with big smiles.

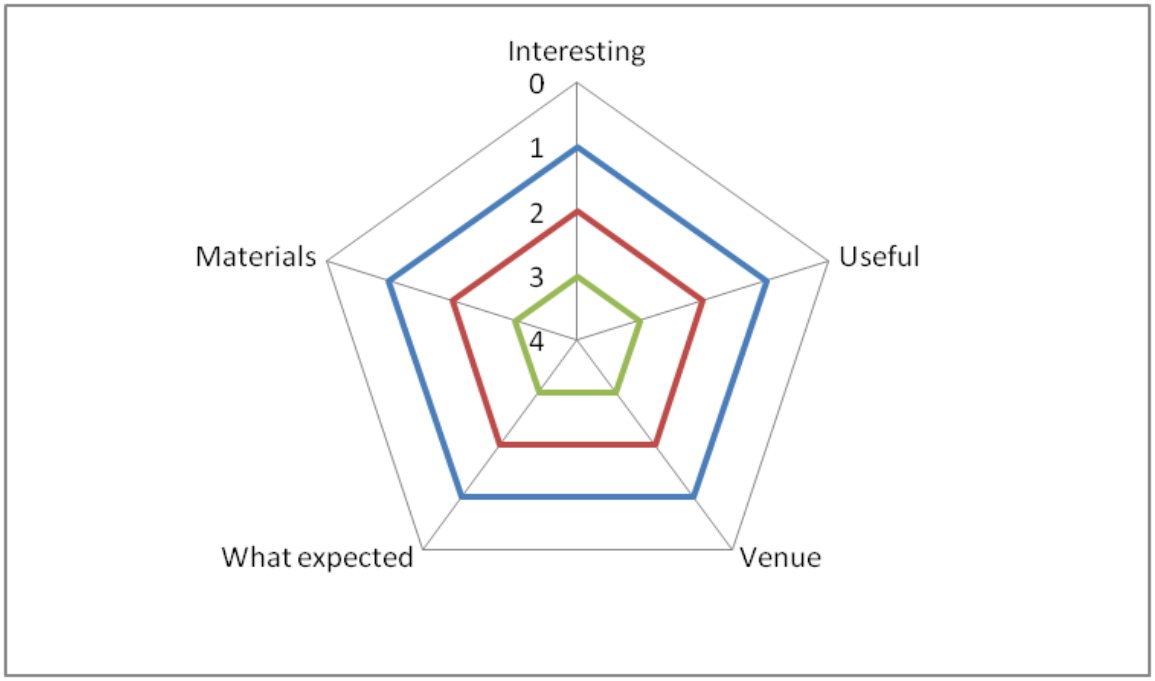
- Ask ditto but this time to look and quickly look away.
- Ask half the group to hold gaze, the other half to avert eyes after quick glance.
- Swap round.
- Group as it walks, takes on the character of a service provider/power holder, a service recipient; briefly finding and holding the intuited characteristics, walking like them, sitting like them etc.
- Deconstruct, discuss, name with the group.

Discussion

Deconstruct these exercises with the group. Why do we enjoy power so much? Do we all? What was it like to be the person led? The leader? How did it feel? What did you think? How differently did people behave from how you expected? What did you have to do to adapt? What does it remind you of? How do these feelings relate to your work?

Appendix Six

Spider's web



Appendix Seven

Background on ppre associates

Akgul Baylav is a retired NHS Manager and Educationalist, with over 25 years experience in public services, mainly in North and East London. Her portfolio included ethnic minority services, development, commissioning and equality and diversity within primary care. In 1987, she carried the concept and practice of advocacy to primary care settings, notably for minority ethnic, homeless and traveller communities. In 1990, she set up and delivered the first ever Bilingual Health Advocacy course and ran it for ten years as well as community interpreting courses for Making Training Work (MTW) and Translation and Interpreting Services (TIS). She is the author of several articles in the medical press. Presently she is the Coordinator of a Bilingual Mental Health service at TIS in East London.

Gita Malhotra has 20 years experience of working in a range of public sector environments in London particularly with ethnically diverse communities. She has a clinical background in nursing and is also a Social Anthropology graduate. Her roles have included being an Associate Director in workforce development, specifically to improve ethnic representation in the NHS workforce and in developing employability strategies for a large regeneration company in east London.

John Eversley, who oversaw the overall design of the programme, was involved in setting up some of the first bilingual healthcare support projects in London in the early 1980s. In local government he was involved in getting funding for bilingual professionals in Social Services and Housing. While an NHS Director he was responsible for the development of advocacy services. He is the co-editor of two books on the languages of London's school children. He worked with the refugee organisation Praxis on developing a communications strategy commissioned by the Tower Hamlets Local Strategic Partnership.

Other specialist associates were brought in to facilitate the use of Forum Theatre (Frances Rifkin) and to help students develop glossaries (Zeenat Jahan and Hibu Gureye).