REPORT OF HSE WORKING GROUP
TO DEVELOP A MODEL FOR THE IMPLEMENTATION OF TRAINED INTERPRETERS IN THE IRISH HEALTHCARE SYSTEM

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CONTENTS

FOREWORD

Language barriers present a major obstacle to members of diverse ethnic and cultural communities accessing health and using health services. Provision of interpreting services forms a key part of supporting these service users to achieve optimal health outcomes.

As the demographic profile of Ireland has changed, the importance of quality interpreting has become increasingly evident. However, implementation of the routine use of trained interpreters in clinical settings is challenging, with difficulties in this area also highlighted in WHO Europe's Strategy and Action Plan for Refugee and Migrant Health. The experience of the HSE in attempting to develop a model for provision of interpreting services is similar to that in other jurisdictions.

Implementation of Section 42 of the Irish Human Rights and Equality Commission Act 2014, which places obligations on public bodies to ensure that equal opportunities and treatment are provided to all service users, provides further impetus to finding solutions that support both service users and staff in assuring effective, responsive communication.

This report describes an innovative approach to developing a model for use of trained interpreters in Ireland. Building on a rich collaborative partnership between HSE Social Inclusion and Professor Anne MacFarlane and colleagues of the Public and Patient Involvement Research Unit, Graduate Entry Medical School in the University of Limerick, and drawing on the expertise of a range of partners across both statutory and voluntary sectors, the participatory methodology used in this initiative has resulted in a clear picture of a way forward in promoting and implementing a quality interpreting service in the HSE.

Conclusions of this project resonate beyond Ireland – it is worth noting that as part of a collaborative partnership between the Public and Patient Involvement Research Unit, Graduate Entry Medical School, University of Limerick, and WHO Regional Office for Europe, a version of this report has been submitted to the WHO Europe Migration and Health Programme. It focuses on the approaches used for a health system response to developing a model to implement trained interpreters, and will be considered with respect to actions to progress the Strategy and Action Plan for Refugee and Migrant Health.

I welcome this report as a novel, evidenced contribution to the complex area of interpreting provision and am confident that its findings will point the way forward for us to proactively work toward actioning its recommendations. I commend all who were involved in this project. In particular, I would like to thank Professor MacFarlane for her expert input and generous support to this initiative. I confirm my commitment to ensuring implementation of findings of this report in the quest to ensure that all our service users – regardless of language barriers – may enjoy equal access to, and participation in, our health services.

Diane Nurse
National Lead: Social Inclusion
December 2017

ACKNOWLEDGEMENTS

The work in this report is based on a novel development in the Irish Health Service Executive's (HSE) National Office for Social Inclusion. An inter-sectoral working group was established to develop a model to support the implementation of trained interpreters in routine healthcare in the Irish setting. The members were:

SUMMARY

Increasing diversity in the population of Ireland due to changing patterns of inward migration[1] means that growing numbers of Irish residents speak foreign languages and may not be fluent in English. Therefore, they are interacting with the healthcare system without a shared language and cultural background, which presents challenges and risks for their care (van den Muijsenbergh et al., 2014). In daily practice, however, formal supports are lacking and untrained interpreters (family members including children, friends and paid interpreters who are not qualified) are commonly used. Given the central importance of communication in healthcare consultations (di Blasi et al., 2001), this is a contemporary healthcare issue that warrants close attention. This fits with the HSE commitment to person centred, safe and effective healthcare via, for example the Value in Action programme, the Health Information and Quality Authority's National Standards for Safer Better Healthcare (HIQA, 2012) and the Public Sector Equality and Human Rights Duty (Irish Human Rights and Equality Commission Act 2014).

> If there is no trained interpreter and you cannot explain the problem, how can you [migrant] clarify the problem, how can you get quality care from the GP? (MacFarlane et al., 2009a).

> ... sometimes what we [midwives] were doing was say your husband spoke English, well we'd ask him to help us ... then we were kind of finding some of the things were a bit personal and it really wasn't that suitable and ... we were kind of a bit dubious then thinking maybe that really isn't very ethical, you know to go that route (Tobin and Murphy-Lawless, 2014).

As part of the ongoing commitment to intercultural health issues, the Irish Health Service Executive's (HSE) National Office for Social Inclusion established an inter-sectoral working group in December 2016 to *develop a model to support the implementation of trained interpreters in routine healthcare in the Irish setting.* The specific objectives were to identify:

- levers and barriers to the routine use of trained interpreters in the Irish healthcare setting

- relevant actions to overcome the barriers.

The Working Group comprised 11 individuals representing a combination of healthcare, education, community interpreting and academic settings. The process for working together was informed by the principles of Participatory Learning and Action research methodology (Chambers, 1997; O'Reilly-de Brun et al., 2017) and Normalisation Process Theory (NPT) (May and Finch, 2009; McEvoy et al., 2014). A series of questions were explored in an iterative way to draw on stakeholders' knowledge and expertise. This generated a list of 140 levers and barriers to implementing trained interpreters in the Irish healthcare setting. The Working Group condensed these into 10 themes reflecting levers and 10 themes reflecting barriers. Analysis of the levers and barriers led to the development of an action plan with 19 tasks assigned to one or more Working Group members, with a defined time period for follow-up. The majority of the strongly interrelated actions involved gathering more information in the networks of the Working Group members about:

- policy and legal context (n = 6 actions)

- research evidence (n = 2 actions)

- international training and practice (n = 10 actions)

- innovative ways of disseminating information to government and policy makers (n = 1 action).

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1   There is no universally accepted definition of 'migrant' (WHO, 2016a). A general definition is any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of the person's legal status, whether the movement is voluntary or involuntary, what the causes for the movement are and what the length of the stay is (International Organisation for Migration, 2011).

A review of progress on these actions led to three conclusions.

1. The scale of the work is such that it is necessary to *focus primarily on healthcare service settings* rather than undergraduate educational settings for healthcare professionals at present.

2. To support the implementation of trained interpreters in the Irish healthcare setting, there needs to be an increase in the demand for and supply of trained interpreters. This will require a *series of strategic and sequential interrelated actions.*

3. A fundamental and urgent first step for improving the conditions for implementing trained interpreters in the Irish healthcare system is to *raise awareness about the problems with the status quo* among all relevant stakeholder groups.

The three recommendations for 2018 from the Working Group are as follows.

Focus on awareness raising about clinical risks associated with the status quo

- Raise awareness and provide information to all relevant stakeholders about the clinical risks associated with untrained and informal interpreters, using a 'cascade' model from the National Office for Social Inclusion focusing on

  » Inter-sectoral committees and groups concerned with refugees and migrants

  » HSE senior managers and clinical leads

  » Regional HSE offices and their HSE services

  » HSE networks across the community and NGO sector involved in migrant health.

Focus on policy levers

- Explore the implications of the Public Sector Equality and Human Rights Duty (Irish Human Rights and Equality Commission Act 2014) for contractual arrangements with commercial interpreting agencies.

- Liaise with CORU (Health and Social Care Professionals Council) regarding the implications of the Public Sector Equality and Human Rights Duty (Irish Human Rights and Equality Commission Act 2014) for education and accreditation of healthcare professionals in Ireland.

Focus on knowledge gaps

- Develop a model for step-wise changes to the education, accreditation and employment conditions for trained interpreters to increase knowledge about how to improve the supply of trained interpreters in Ireland.

- Review the model for interpreting put in place as a pragmatic response by the Department of Justice and Equality for Syrian refugees to increase knowledge about how effective recent interventions for interpreting have been.

- Analyse the gaps in interpreting service provision in the HSE from an anticipated mapping of services in social inclusion and use this knowledge to develop an appropriate action plan to increase interpreting service provision.

- Support participatory action research projects that promote migrant community and health sector engagement to enhance knowledge about strategies to support the implementation of trained interpreters in healthcare settings.

The Working Group have agreed to progress these interconnected recommendations during 2018 in order to improve the access to, and participation in, the Irish health services for migrants who require the services of trained interpreters. They will not lose sight of other findings from their analysis to date and will remain alert to timely actions depending on changes to the broader context around immigration, integration and healthcare development.
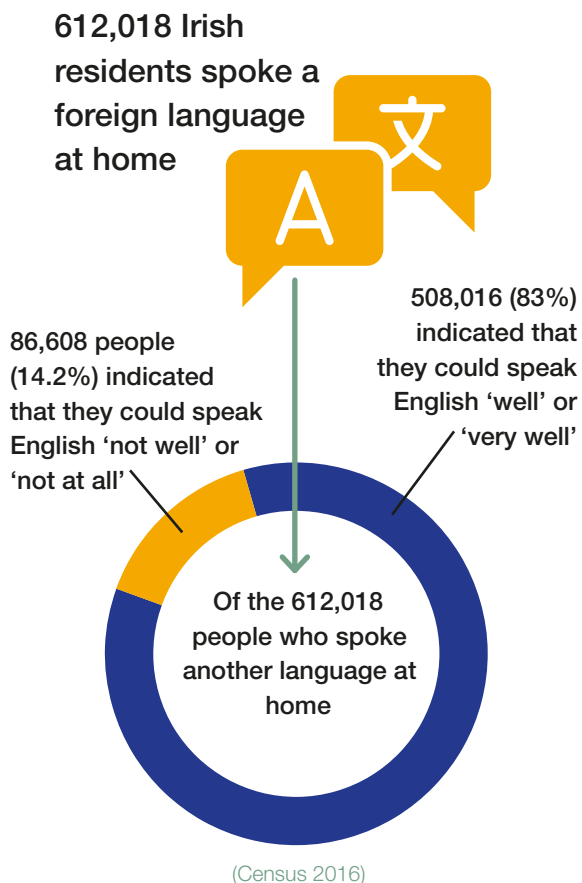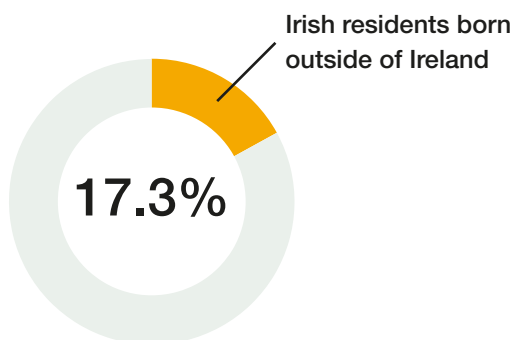
INTRODUCTION

The HSE National Office for Social Inclusion supports equal access to health services in Ireland for people from vulnerable groups. The overall aim of social inclusion is to improve access to mainstream and targeted health services for people from disadvantaged groups and to reduce inequalities in health.

Social Inclusion holds a remit for a range of marginalised groups and issues including homeless service users; asylum seekers, migrants, refugees, Travellers and Roma; addiction; and domestic, sexual and gender-based violence. Intercultural health falls within the remit of the National Office for Social Inclusion. As part of the implementation of the HSE National Intercultural Health Strategy (HSE, 2008), an inter-sectoral working group was established in December 2016 by the National Lead for Social Inclusion. The purpose of this group was to focus on *developing a model to implement trained interpreters in the Irish healthcare system*. The rationale for this was that the increasing diversity in the population of Ireland means that growing numbers of Irish residents speak foreign languages and may not be fluent in English. Therefore, they are interacting with the healthcare system without a shared language and cultural background, which presents challenges and risks for their care (van den Muijsenbergh et al., 2014). Given the central importance of communication in healthcare consultations (di Blasi et al., 2001), this is a contemporary healthcare issue that warrants close attention. This fits with the HSE commitment to person-centred, safe and effective healthcare via, for example, the Value in Action programme, the Health Information and Quality Authority's National Standards for Safer Better Healthcare (HIQA, 2012) and the Public Sector Equality and Human Rights Duty (Irish Human Rights and Equality Commission Act 2014).

The aim of the working group was to develop a model to support the routine use of trained interpreters in the Irish healthcare system. The specific objectives were to identify:

• levers and barriers to the routine use of trained interpreters in the Irish healthcare setting

• relevant actions to overcome the barriers.

This is a report of the work conducted by the Working Group during 2017. International and national patterns of migration are presented in Section 1, with a focus on relevant policies regarding linguistic diversity, health and access to healthcare. Section 2 summarises key findings from the academic literature about the use of trained interpreters in healthcare. Section 3 describes the approach and findings of the Working Group. Section 4 provides a conclusion and a list of recommendations from the Working Group.

612,018 Irish residents spoke a foreign language at home

Irish residents born outside of Ireland

17.3%

86,608 people (14.2%) indicated that they could speak English 'not well' or 'not at all'

508,016 (83%) indicated that they could speak English 'well' or 'very well'

Of the 612,018 people who spoke another language at home

(Census 2016)

SECTION 1. MIGRATION AND HEALTH SYSTEM ADAPTATIONS – POLICY CONTEXT

1.1 International and national patterns of migration

Migration is a global phenomenon and occurs for a variety of reasons such as work, education, family reunification and fleeing from disasters and conflict. There is no universally accepted definition of 'migrant' (WHO, 2016a). A general definition is any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of the person's legal status, whether the movement is voluntary or involuntary, the causes for the movement and the length of the stay (International Organisation for Migration, 2011). One of the defining features of contemporary migration is the rise in the numbers of people who are forcibly displaced. According to the Office of the United Nations High Commissioner for Refugees (UNHCR, 2017), approximately 65.6 million people were forcibly displaced worldwide by the end of 2014. This is the highest number recorded since the Second World War. In terms of the overall impact of migration on population diversity, it is estimated that 75 million international migrants live in the European Region, amounting to 8.4% of the total European population and one third of all international migrants worldwide (see WHO, 2016b).

While Ireland has a long history of emigration, there has been a dramatic increase in inward migration since the late 1990s. There was a pronounced surge in asylum applications between 1998 and 2003. While this has declined since then, the latest Census reflects the global increase in relation to forced displacement, showing an increase in asylum applications. Figure 1shows the number of asylum applications 2012 – 2016 and Figure 2 shows the top 5 countries that applications are coming from. The government has also committed to accepting at least 4000 refugees under the Irish Refugee Protection Programme.

Figure 1. Number of asylum applications 2012–2016
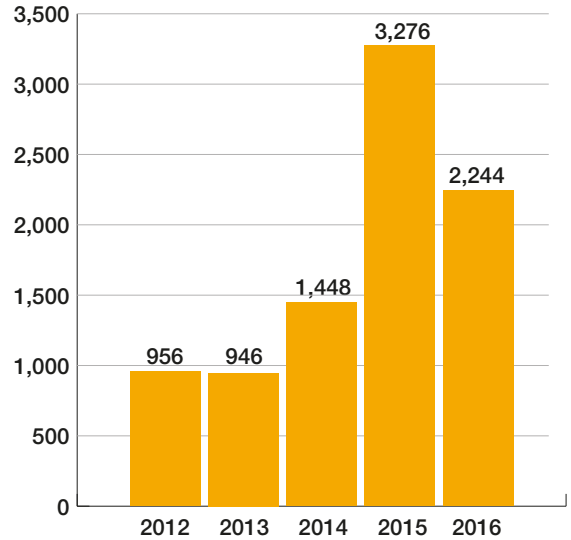
Figure 2. Top 5 countries – asylum seeker applications
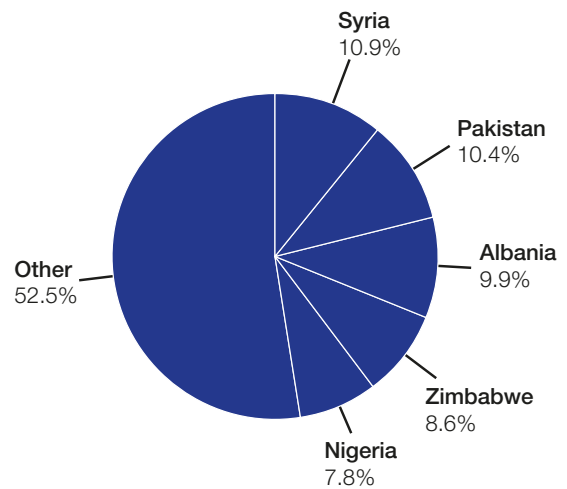
Source: INIS (2017) Immigration in Ireland: Annual Review 2016. Available from: http://www.justice.ie/en/JELR/INIS_Immigration_in_Ireland_Annual_Review_2016.pdf/Files/INIS_Immigration_in_Ireland_Annual_Review_2016.pdf

The EU enlargements that occurred in 2004 and 2007 led to major inflows of economic migrants from other countries: 133,258 social insurance numbers were issued to migrant workers from Accession States between 1 May 2004 and 30 September 2005. In the UK, a country whose population is 15 times that of Ireland, the figure for the same period was 293,000 (MacEinri, 2007).

The overall impact of changing patterns of inward migration is reflected in the latest Irish Census. In April 2016 there were 535,475 non-Irish nationals from 200 nations living in Ireland – 11.6% of the population. This represents a 1.6 percentage point decrease on the 2011 Census figures, although it must be noted that the numbers of migrants who have attained dual nationality has increased, and this affects the figures (Central Statistics Office, 2017).

The highest nationality groupings recorded in the Census were:

Polish: 211,515

UK: 103,113

Lithuanian: 36,552

Romanian: 29,186

Latvian: 19,933

Brazilian: 13,640

Of interest for this report is the ensuing linguistic diversity in Ireland. The range of languages spoken at home (other than English and Irish) is shown in Table 1 (Source: Central Statistics Office, 2017).

1.2 Health policy context

There are many public health implications of migration. Some health issues are shared with the host population, such as management of chronic conditions, while others are more specific to migrants as a result of their experiences in their countries of origin, in transit to host countries and during the period of settlement and integration (see Box A.1 in the Appendix). The challenge of communicating with healthcare providers without having a shared language or cultural background is specific to migrants.

International policies stipulate that healthcare needs to be culturally appropriate (Council of Europe, 2000; WHO, 2010). This means that a healthcare system needs to be relevant and responsive to the needs of its culturally diverse population. The recent WHO Strategy and Action Plan for Refugee and Migrant health (WHO, 2016b) provides a comprehensive health policy for refugee and migrant health in the WHO European region. There are nine strategic areas (Box A.2 in the Appendix). Strategic area 5 focuses on the need for strengthening health systems and their resilience by adapting healthcare systems to offer culturally sensitive healthcare. The importance of overcoming language barriers and improving access to interpreters is explicitly mentioned.

Table 1. Languages spoken at home

Language	Total	Born in Ireland	Born elsewhere
Polish	135,895	27,197	108,698
French	54,948	36,810	18,138
Romanian	36,683	7,396	29,287
Lithuanian	35,362	6,481	28,881
Spanish	32,405	14,680	17,725
German	28,331	16,077	12,254
Russian	21,707	5,494	16,213
Portuguese	20,833	2,829	18,004
Chinese	17,584	4,691	12,893
Arabic	16,072	4,071	12,001
Other	212,198	58,197	154,001
Total	**612,018**	**183,923**	**428,095**

WHO Strategy and Action Plan for Refugee and Migrant Health

Strategic Area 5: strengthening health systems and their resilience

Health systems should aim to offer culturally sensitive healthcare, overcoming barriers such as language, access to interpreters …

In Ireland, the HSE Social Inclusion Office has produced an exemplary first National Intercultural Health Strategy 2007–2012 (HSE, 2008). This also emphasised the need for adaptations to the health service so that services are culturally sensitive. The specific challenges associated with language barriers and the value of interpreters in healthcare was discussed. There are important examples of HSE initiatives to provide interpreter and translation services, for example at the point of entry at reception centres for asylum seekers. Furthermore, as part of the implementation of that strategy, several innovative projects were established to support communication with service users who are not proficient in English (see Box 1).

Box 1. HSE projects to support communication with service users who are not proficient in English

Development of an *Emergency Multilingual Aid* helps to address language barriers in emergency settings while awaiting the services of an interpreter. A mobile phone app has been developed based on this aid. **www.hse.ie/eng/ services/Publications/SocialInclusion/EMA. html**

Launch and evaluation of a *free pilot interpreting service* for general practice. **www.lenus.ie/hse/handle/10147/212690**

Establishing a health research partnership to develop a *guideline for communication in cross-cultural general practice consultations.* **www.lenus.ie/hse/handle/10147/212769**

Development of the *HSE Intercultural Guide* to support and guide culturally competent service delivery. A mobile phone app has been developed based on this aid. **www.hse.ie/ema/**

More recently, under the International Refugee Protection Programme (IRPP), resources were provided by the Department of Justice and Equality for an Arabic–English Interpreter/Translator and Cross Cultural Worker (ITCS) to assist with day-to-day communications between Syrian refugees and key service providers, which would include healthcare service providers.

The second Intercultural Health Strategy is due to be launched in early 2018. It is expected to reflect the changed landscape of intercultural health since the first publication in 2007 and to re-emphasise the importance of interpreters in healthcare. However, despite the strength of this strategy development, which puts Ireland ahead of many other European countries (see MIPEX, 2017), knowledge of relevant strategies at practitioner level is poor, uptake of available interpreting services is low, and funding for migrant-sensitive services was cut during the economic recession ((MacFarlane and O'Reilly-de Brún, 2009; O'Donnell et al., 2016). There have been some improvements in funding for this area of work in 2016–2017 and there are expectations of core funding from 2018 onwards.

The HSE National Office for Social Inclusion established a Working Group in December 2016 to develop a model to support the implementation of trained interpreters in routine healthcare in the Irish setting. This is the focus of the present report and represents the ongoing commitment from the HSE to be responsive and action-oriented in relation to improving communication in healthcare consultations with migrants.

SECTION 2. SUMMARY OF ACADEMIC LITERATURE

There is international evidence that when migrants and their healthcare providers meet without a shared language and cultural background, there are communication problems (van den Muijsenbergh et al., 2014). Informal supports are commonly used and these involve the use of family members (including children) and friends as interpreters, reliance on body language and bilingual or multilingual aids. These are all problematic and cannot replace the use of a trained interpreter for accurate and comprehensive support (see Box 2).

The reliance on informal supports, however, is the status quo in healthcare settings and it disrupts the process of clinical assessment and diagnosis, presents clinical risks, compromises the scope for person-centred care and has cost implications. For example, patients in hospital settings who required the assistance of an interpreter but were not provided with it experienced more severe adverse events and unplanned revisits (Bischoff and Denhaerynck, 2010; Divi et al., 2007; Ngai et al., 2016).

Box 2. Problems with informal strategies for supporting communication in cross-cultural consultations

Family members and friends are not trained as interpreters and are unlikely to have appropriate medical vocabulary, leading to inaccurate and incomplete transmission of information.

Using **children** as interpreters has additional problems:

- A child may not be available (during school hours) or may be missing out on schooling.

- The authority of parents may be compromised by a reliance on their child to interpret.

- There may be emotional trauma, fear or shame on the part of the parent and/or child – both may be embarrassed.

Body language is an everyday communication tool the general practitioner (GP) may use to signal friendliness/comfort to a service user, but is unreliable as a diagnostic support.

Different cultural backgrounds can lead to misunderstanding of body language.

Bilingual or multilingual materials, including computer translational tools, cannot provide accurate renditions of symptoms to both parties and cannot cope with psychological/mental health/social health issues or the complexity of cultural interpretations of health and illness.

Source: summarised from MacFarlane et al., 2009b; Flores, 2005.

> If there is no trained interpreter and you [migrant] cannot explain the problem, how can you clarify the problem, how can you get quality care from the GP? (MacFarlane et al., 2009a).

> I [migrant] take my daughter who has good English, with me to see the GP but I don't go to see the doctor if the complaint is of a personal nature (MacFarlane et al., 2009a).

> My son, who had diarrhoea, was given medication for constipation [migrant referring to GP consultation] (MacFarlane et al., 2009a).

> ... Sometimes what we [midwives] were doing was say your husband spoke English, well we'd ask him to help us … then we were kind of finding some of the things were a bit personal and it really wasn't that suitable and … we were kind of a bit dubious then thinking maybe that really isn't very ethical, you know to go that route. (Tobin and Murphy-Lawless, 2014).

The use of trained interpreters is an effective formal support because it facilitates accurate communication (Flores, 2005). There are, however, challenges in integrating interpreted consultations into clinical care because of the logistics involved in organising three-way consultations in busy clinical settings and a lack of training among healthcare providers to work effectively with trained interpreters (Hadziabdic et al., 2011; Gerrish et al., 2004).

In Ireland, as the quotes show, the available research resonates with the international literature.

> You know when they [migrants] come in you are not going to be able to communicate as effectively as you would with someone who has English as their first language and they're not going to get the [GP] service that you would like to give them because of that (Pieper and MacFarlane, 2011).

- Refugee and asylum seekers and other migrants who have limited English have to rely on informal strategies to 'get by' – they are relying on informal interpreters, including children; Google Translate; and body language. This leads to inaccurate diagnoses and problems with treatment which, in turn, makes it difficult for them to trust the quality of the care provided. This is particularly problematic in primary care (MacFarlane et al., 2009a; O'Reilly-de Brun et al., 2015).

- The use of family members as interpreters in primary care and hospital settings is problematic and there are specific ethical tensions when children or spouses are involved (MacFarlane et al., 2009a; Tobin and Murphy Lawless, 2014).

> It's just, you [midwife] try to do it visually; you know, smile and reassure them, rub them, things like that; you know, try to make them at ease, show them how to breathe, things like that … she had no English at all and she was on her own, very young, 17 year old girl … she didn't know what was going on, you know and she was in pain (McCarthy et al., 2013).

- Healthcare providers in community and hospital settings report concerns about the quality of care they can provide without the support of a trained interpreter (Pieper and MacFarlane, 2011; McCarthy et al., 2013; Boyle, 2016; O'Brien et al., 2012).

- There are challenges in accessing trained interpreters in Ireland because of a lack of trained interpreters in the country – paid interpreters are not necessarily trained or working to a professional code of ethics (O'Reilly-de Brun et al., 2015; Phelan, 2017).

> I mean the fundamental problem with interpreting as we know is that there are no set standards, there is no quality control, so the interpreter you get is very random. You may get somebody who has been trained but that's fairly unlikely … (MacFarlane and O'Reilly de Brun, 2009).

- There are logistical difficulties in organising interpreted consultations in busy clinical environments in primary care and hospital settings (Teunissen et al., 2017; McCarthy et al., 2013; Tobin and Murphy-Lawless, 2014).

- Healthcare providers across settings lack skills to work with trained interpreters (Tuohy et al., 2008; McCarthy et al., 2013; MacFarlane et al., 2009c; Tobin and Murphy-Lawless, 2014).

- The opportunity to work with a trained interpreter is transformative and 'eye-opening' for primary care providers and migrants as they experience quality communication exchange (Teunissen et al., 2017).

> I [GP] gave her a treatment, without an interpreted consultation (…) that wasn't at all appropriate. So today (after working with a trained interpreter) we revised that, I told her to get rid of that (previous) prescription (Teunissen et al., 2017).

> In my case, it's easy to trust [the GP] when the interpreter is present, because I knew that she would be able to convey everything that I meant and that I would be understood (Teunissen et al., 2017).

SECTION 3. HSE WORKING GROUP: APPROACH AND FINDINGS

The HSE Working Group to develop a model to support the implementation of trained interpreters in routine healthcare in the Irish setting comprised 11 individuals representing six stakeholders (Table 2). All members had a stake in improving the use of trained interpreters in the Irish healthcare system.

Table 2. HSE working group stakeholder profile and representatives

Stakeholder profile	No. of participants/ representatives
Educationalists	2
Interpreters*	2
Service planners	4
Primary care nurse	1
Researchers	3

* One participant represented the educationalist and interpreter profile and another participant represented the interpreter and migrant profile.

The process for working together was informed by the principles of Participatory Learning and Action research methodology to ensure that stakeholders from different backgrounds could share knowledge and learn from each other's perspectives (Chambers, 1997; O'Reilly-de Brún et al., 2017). A sociology theory – Normalisation Process Theory (NPT) – was used as a conceptual framework to ensure that there was comprehensive examination of issues that are known to affect implementation in healthcare settings (May and Finch, 2009; McEvoy et al., 2014).

The process for the working group involved a combination of teleconferences and face-to-face workshops and meetings. The objectives related to establishing a shared understanding of the aims and objectives, identifying levers and barriers to implementation of trained interpreters and considering concrete actions to overcome the identified barriers.

Most of the work was carried out at four face-to-face workshops (Step 2). A series of questions were explored in an iterative way to draw on stakeholders' knowledge and expertise (see Table 3). This generated a list of 140 levers and barriers

to implementing trained interpreters in the Irish healthcare setting. The working group condensed these into 10 themes reflecting levers and 10 themes reflecting barriers.

Table 3. Workshops – questions asked and outcomes

	Question asked	Outcome
Workshop 1	What are the key issues in implementing the routine use of trained interpreters in Irish healthcare settings?	List of levers and barriers (n = 100+)
Workshop 2	What are the key issues in implementing the routine use of trained interpreters in Irish healthcare settings? *(from the perspective of service planners, hospital managers and administrators)*	Extended list of levers and barriers organised into themes (n = 140+)
Workshop 3	What are the levers and barriers to the implementation of routine use of trained interpreters?	Consensus about the thematic analysis of levers (n = 10) and barriers (n = 10)
Workshop 4	Among the identified barriers, which ones should be addressed first and later? Which actions can we take to address the barrier, who would perform the action and when?	Action plan with allocation of 19 tasks to working group members

The 10 themes reflecting levers are shown in Table 4. They reflect that there are resources available at present which could be activated to challenge the status quo. These included the potential for the use of technology for interpreting by telephone and video, the potential for members of migrant communities to advocate for change and the scope for existing and recent legal provisions to stimulate action in this area. The essentials of existing legal provisions is summarised in Box 3.

Other levers related to training and skill development to work with trained interpreters. When stakeholders experience this best practice it is transformative and becomes a lever for resisting the use of untrained interpreters. Finally, raising awareness about clinical risk among HSE managers was considered an important lever as this resonates with HSE policy about quality and patient safety.

Table 4. Levers to implementing trained interpreters in healthcare consultations in Ireland

Levers
Use of technology (telephone and video) could be a resource for providing interpreting in rural and remote areas.
Use existing legal provisions, e.g. Public Sector Equality and Human Rights Duty, to encourage ongoing involvement from HSE, the Department of Health and related government departments.
Involving migrants, interpreters and primary care staff in training to use interpreters is effective.
If resourced, members of migrant communities could advocate about migrants' rights and entitlements.
Trained interpreters are champions of upholding standards in their field.
Working with trained interpreters is transformative for healthcare personnel.
Patients can feel trust in trained interpreters.
Trained interpreters value working with GPs who are trained to work with them.
Emphasising clinical risk resonates with the importance placed by HSE management on quality and risk.
Sharing good practice on using trained interpreters is effective.

Box 3. Summary of Equal Status Acts relating to provision of linguistic supports for persons with limited or no English in Ireland

The Equal Status Acts (ESA) prohibit discrimination on a number of specific grounds including the race ground – that is, as between any two persons that are of different race, colour, nationality or ethnic or national origins.

The ESA prohibit discrimination in the provision of services, including healthcare services, on the ground of race. A failure to provide linguistic supports for persons with limited or no English could act as a barrier for such persons in accessing healthcare services, and could amount to discrimination on the ground of race.

Source: Information from Irish Human Rights and Equality Commission

The 10 themes reflecting barriers were analysed and ranked in terms of which ones should be addressed first and which should be addressed later. These are shown, in rank order, in Table 5. The 'distance' between barriers was often very small as they were often interconnected. The barriers that should be addressed first relate to the need for resources for a comprehensive interpreting service across sectors. This requires political will for a whole of government response to the issue. This would stimulate the required level of support for system level changes such as the development of educational initiatives to improve the training and certification of interpreters.

The next level of barriers related primarily to the low awareness of clinical risks associated with using untrained interpreters. It was considered important to disrupt the status quo by raising awareness among healthcare staff that there are serious clinical risks involved, by providing training for healthcare staff to work with trained interpreters. This would improve the *demand* for trained interpreting and could, in turn, stimulate motivation for addressing the lack of coordination and provision of interpreting services across the HSE. Other barriers that need action relate to the *supply* of trained interpreters. For this there needs to be improvement in the working conditions of trained interpreters. At present, there is no financial or professional benefit to having a qualification in interpreting.

Finally, there are barriers that relate to low awareness among migrants about their rights and entitlements to have access to professional, trained interpreters, problems that relate to ethnocentrism and racism in the HSE and broader society and the logistical challenges of organising interpreted consultations in busy clinical settings.

Table 5. Barriers to implementing trained interpreters in healthcare consultations in Ireland

Barriers
Lack of resources for a comprehensive interpreting service
Lack of political will for a whole-government response
Lack of training and certification of interpreters
Low awareness of clinical risks associated with not using trained interpreters among healthcare staff
Lack of training for staff to work with trained interpreters
Gaps in knowledge about the benefits of working with trained interpreters
Complex for migrants to emphasise their entitlements and rights to have access to trained interpreters
Poor working conditions of trained interpreters
Lack of coordination of interpreting provision across the HSE
Racism/ethnocentrism
Challenges with organisation of consultations with trained interpreters in clinical settings

The final outcome at the end of 12 months was an action plan with 19 tasks assigned to one or more Working Group members, with a defined time period for follow-up. The majority of actions related to gathering more information in the members' networks about:

- policy and legal context (n = 6 actions)

- research evidence (n = 2 actions)

- international training and practice (n = 10 actions)

- innovative ways of disseminating information to government and policy makers (n = 1 action).

SECTION 4. CONCLUSION AND RECOMMENDATIONS

The National Office for Social Inclusion in the HSE established a Working Group to develop a model to support the implementation of trained interpreters in routine healthcare in the Irish setting. The previous section described the approach and findings of the Working Group during 2017. Based on the identified levers, barriers and action plan, there are three key overarching conclusions, as follows.

1. Actions are required within the HSE (training and delivery issues, health service research) and in undergraduate healthcare educational environments. This Working Group will *concentrate primarily on the context of the health services* at this time.

2. To support the implementation of trained interpreters in the Irish healthcare setting, there needs to be an increase in the demand and supply of trained interpreters. This will require a *series of strategic and sequential interrelated actions.* Some actions could be progressed in parallel. For example, raising awareness among service providers and health sector managers about the need for trained interpreters could progress in parallel with the development of training for front-line staff to work effectively with interpreters. However, at the same time, there is a tension with such an approach given that the overall professional and educational context for interpreters is undeveloped. Essentially, increasing awareness about the need to work with trained interpreters among service providers could increase the demand for a service at a time when the supply of trained interpreters is inadequate. Similarly, it was not considered prudent to progress actions about establishing university-accredited courses for interpreters without first establishing government 'buy-in' to support and resource the use of trained interpreters and, thus, to improve their working conditions compared with untrained interpreters. 'Buy-in' from the Department of Health and HSE management to improve resources for the procurement and coordination of trained interpreting services is also essential.

3. A fundamental and urgent first step for improving the conditions for implementing trained interpreters in the Irish healthcare system is to *raise awareness about the problems with the status quo.* This is important among HSE service providers, GPs and the migrant community but also at more senior management levels such as among the HSE management team and service planners. Developing and disseminating evidence-based infographics and policy briefs emerged as a top priority.

This initiative was spearheaded by the HSE National Office for Social Inclusion but the findings and implications extend beyond Social Inclusion and the HSE. Therefore, HSE-wide responsibility for all arising recommendations and inter-sectoral working to promote a 'whole government' response is required.

RECOMMENDATIONS

The three recommendations for 2018 from the Working Group are as follows.

Focus on awareness-raising about clinical risks associated with the status quo

- Raise awareness and provide information to all relevant stakeholders about the clinical risks associated with untrained and informal interpreters, using a 'cascade' model from the National Office for Social Inclusion focusing on:

  » Inter-sectoral committees and groups concerned with refugees and migrants

  » HSE senior managers and clinical leads

  » Regional HSE offices and their HSE services

  » HSE networks across the community and NGO sector involved in migrant health.

Focus on policy levers

- Explore the implications of the Public Sector Equality and Human Rights Duty (Irish Human Rights and Equality Commission Act 2014) for contractual arrangements with commercial interpreting agencies.

- Liaise with CORU regarding the implications of the Public Sector Equality and Human Rights Duty (Irish Human Rights and Equality Commission Act 2014) for education and accreditation of healthcare professionals in Ireland.

Focus on knowledge gaps

- Develop a model for step-wise changes to the education, accreditation and employment conditions for trained interpreters to increase knowledge about how to improve the supply of trained interpreters in Ireland.

- Review the model for interpreting put in place as a pragmatic response by the Department of Justice and Equality for Syrian refugees to increase knowledge about how effective recent interventions for interpreting have been.

- Analyse the gaps in interpreting service provision in the HSE from an anticipated mapping of services in social inclusion, and use this knowledge to develop an appropriate action plan to increase interpreting service provision.

- Support participatory action research projects that promote migrant community and health sector engagement to enhance knowledge about strategies to support the implementation of trained interpreters in healthcare settings.

The Working Group have agreed to go forward into 2018 to progress these interconnected recommendations in order to improve the access to, and participation in, the Irish health services for migrants who require the services of trained interpreters. They will not lose sight of other findings from their analysis to date and will remain alert to timely actions depending on changes to the broader context around immigration, integration and healthcare development.

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APPENDIX

Box A.1 Summary of public health risks for refugees and migrants

- Trauma and mental health needs relating to conflict in countries of origin.
- Trauma, mental and physical health needs during transit including death.
- Unfavorable social, occupational and economic conditions in host countries with detrimental effects on health.
- Increased rates of complications in pregnancy and childbirth including increased rates of infant mortality.
- Sexual violence, abuse and trafficking of women and children.
- Occupational health hazards for men.

Source: WHO, 2016b; Roura et al., 2015.

Box A1.2. WHO Strategy and Action Plan for Refugee and Migrant Health Strategic Areas

1. Establishing a framework for collaborative action

   To promote and strengthen collaborative action on migrant health issues among international, national and local organizations and institutions.

2. Advocating for the right to health of refugees

   To contribute to policy and practice with factual and precise information on refugee and migrant health issues.

3. Addressing the social determinants of health

   To build upon an adequate policy dialogue on the health of refugees, asylum seekers and migrants across all the involved government states and public.

4. Achieving public health preparedness and ensuring an effective response

   To incorporate the health needs of refugees, asylum seekers and migrants in the outlining and advancement of public health services and policies based on Health 2020.

5. Strengthening health systems and their resilience

   To focus on the capacity to attain an accord on the healthcare system competences required to respond to the health needs of refugees and migrants.

6. Preventing communicable diseases

   To provide the necessary capability to focus on communicable diseases in transit and destination countries.

7. Preventing and reducing the risks posed by non-communicable diseases

   To establish that the needs of refugees and migrants form part of the national strategy for the prevention and control of non-communicable diseases.

8. Ensuring ethical and effective health screening and assessment

   To ensure that screening is risk-specific and evidence-based and provide the real interests of refugees, asylum seekers and migrants and the host population.

9. Improving health information and communication

   To provide the adequacy, standardisation and comparability of records on the health of refugees, asylum seekers and migrants, to facilitate access to health information.

Source: WHO, 2016b