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STANDARD PROCEDURES FOR IMPROVED ACCESS TO AREA AND OTHER PUBLIC HEALTH SERVICES BY PEOPLE OF NON-ENGLISH SPEAKING BACKGROUND (PD2005_483)

These Standard Procedures are intended to apply to all Area and other public health services in geographical areas where the resident population includes people of non-English speaking background.

The provision of health services to migrants rests on two policy principles:
- the right of equality of access to health care services regardless of cultural origin or linguistic skills, and
- the responsibility of the health system to respond appropriately to its target population which includes people of non-English speaking background.

It is government policy that the full range of mainstream health services be accessible and appropriate to ethnic communities. Specially targeted programmes are provided where appropriate.

Access of people of non-English speaking background to appropriate health services is reviewed in the Department of Health’s annual report to the Ethnic Affairs Commission of NSW. While significant progress has been made in many areas, problems which have been identified in the most recent Review include:
- Under-representation of people of non-English speaking background in the client groups of health services such as community health and sexual assault services.
- Some clients not being informed of the availability of the Health Care Interpreter Service and their right to request an Interpreter.
- Lack of ethnic consumer representation on many Ethnic Services Committees in hospitals and community health services, as well as on other relevant planning committees.

These Standard Procedures have been developed to assist in overcoming barriers to equitable access to health services by ethnic communities. The current Migrant Health resources which are available to assist in the practical application of the Standards are set out in Section A.

Area Health Services were constituted in metropolitan areas on 1st October 1986. Health services will increasingly be administered on an Area basis.

Accordingly these Procedures provide advice on Area planning and co-ordination in Migrant Health to ensure the implementation at the Area level of the Department’s Migrant Health policy principles.

In particular the Procedures deal with the need for:
- Appropriate Area Migrant Health Committee structures and the development of Area Migrant Health Plans as a part of strategic planning.
- The retention of Ethnic Access Committees based in hospitals and community health services particularly in metropolitan areas.
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- The continued preparation of Ethnic Access Plans by hospitals and community health services.
- The continued appointment of Ethnic Services Co-ordinators in hospitals and community health services serving significant numbers of people of non-English speaking background.

All government agencies are now required to develop an Ethnic Affairs Policy Statement (EAPS) and to report annually to the Ethnic Affairs Commission on progress achieved in its implementation. This is to ensure that members of ethnic minorities have equal access to the full range of government services and that services are culturally and linguistically appropriate. The Department of Health will report on progress achieved in each financial year period and will submit its Annual Report by December 31 to the Ethnic Affairs Commission. Area/District Health Boards will be required to submit their annual reports to the Department each year. Reporting will be based on implementation of these Standard Procedures and the Area Migrant Health Plans. Further details can be obtained from Migrant Health Advisors/Co-ordinators or the Policy Analyst (Migrant Health).

AREA AND OTHER PUBLIC HEALTH SERVICES

A. BACKGROUND INFORMATION

14.1 DEMOGRAPHIC OVERVIEW

According to the 1981 Census, 20.5% of people in New South Wales were born overseas. Of these fifty-five per cent, or approximately 617,000 were born in non-English speaking countries. The numbers increase significantly if the children of migrants are included. The largest immigrant groups from a non-English speaking background are from Southern Europe, from Yugoslavia, Italy and Greece, with smaller groups from Eastern Europe. Newer arrivals, particularly refugees, are also from South East Asia, Central and South America and the Middle East.

Overall more than 70 ethnic groups are represented in the resident population of New South Wales, representing a multiplicity of cultures, languages and dialects.

Ethnic communities are concentrated in the Sydney metropolitan areas, with significant populations in the industrial centres of the Illawarra and Hunter areas. Smaller populations are located in other areas. In the last ten years, the number of migrants in the metropolitan areas has increased substantially.

The following table indicates the distribution of the overseas-born population of non-English speaking background between the regions. This is based on 1981 Census figures adjusted for subsequent changes in regional boundaries. It is expected that the 1986 Census will reveal significant increases in these estimates, particularly in the metropolitan regions.
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<table>
<thead>
<tr>
<th>REGION</th>
<th>POPULATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern Metropolitan</td>
<td>199,703</td>
</tr>
<tr>
<td>Western Metropolitan</td>
<td>234,071</td>
</tr>
<tr>
<td>Northern Metropolitan</td>
<td>87,103</td>
</tr>
<tr>
<td>Illawarra</td>
<td>37,545</td>
</tr>
<tr>
<td>Hunter</td>
<td>21,012</td>
</tr>
<tr>
<td>South West</td>
<td>10,339</td>
</tr>
<tr>
<td>North Coast</td>
<td>7,798</td>
</tr>
<tr>
<td>South Eastern</td>
<td>7,655</td>
</tr>
<tr>
<td>Central West</td>
<td>4,545</td>
</tr>
<tr>
<td>New England</td>
<td>3,808</td>
</tr>
<tr>
<td>Orana/Far West</td>
<td>3,220</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>616,799</strong></td>
</tr>
</tbody>
</table>

Source ABS 1981 Census

**Note:** These figures have been adjusted to take into account the changes in Regional boundaries associated with area organisation of health services.

14.2 PRINCIPLES OF SERVICE DELIVERY

The provision of Migrant Health services rests on two policy principles. These are:

- the right of equality of access to health care services regardless of cultural origin or linguistic skill, and
- the responsibility of the health system to respond appropriately to its target population which includes people of non-English speaking background.

It is government policy that the full range of health services be accessible and appropriate to ethnic communities. This objective is attained through the modification of mainstream services and the provision of programmes such as the Health Care Interpreter service to facilitate access. In addition specially targeted programmes and services, for example in the area of health education, are provided where appropriate.

The following strategies should be adopted to implement the principles stated above. They form the basis of the Standard Procedures.

Inservice training of administrative and professional staff. This aims to increase awareness of the implications of linguistic and cultural differences for effective health service delivery.

Appropriate use of Migrant Health staff, such as the Health Care Interpreter Service, Ethnic Health Workers and Migrant Health Education Officers, as well as other bilingual staff, the Health Translations Service and ethnic services in the community.

Effective structures, such as Area and facility based committees that promote and co-ordinate health service access for ethnic minority groups.
Liaison and consultation with ethnic community groups as well as representation by them on planning and co-ordination structures.

These strategies are in an integral part of the implementation of the Department’s Migrant Health Policy. Statements of policy are contained in the Department’s “Ethnic Affairs Policy Statement” (EAPS) and the document “Health Service and Ethnic Minorities”. These may be obtained from the Migrant Health Advisors/Co-ordinators or the Policy Analyst (Migrant Health).

14.3 CURRENT HEALTH SERVICES FOR PEOPLE OF NON-ENGLISH SPEAKING BACKGROUND

Area Migrant Health Advisors/Co-ordinators:

Area Advisors/Co-ordinators have been appointed in the Southern Metropolitan, Western Metropolitan, Illawarra and Hunter Health Regions. In the latter two regions, they are based in Areas but retain their regional role. In the Northern Metropolitan Region, part-time Area Advisors have been appointed.

Health Care Interpreter Service (HCIS):

The interpreter service is available in the Sydney Metropolitan Regions, Hunter and Illawarra. In these Regions, the HCIS provides a region wide service with bases located in approximately 20 hospitals. The administration of the interpreter service, including the booking system, is the responsibility of a Co-ordinator in one Area in these regions.

There are current 111 full-time and 20 part-time health care interpreters distributed over the 5 Regions. Up to 26 languages are covered.

In addition, there are more than 200 sessional interpreters, available on a contract basis, providing services for smaller communities whose numbers do not warrant full-time interpreters when demand becomes excessive.

The Health Care Interpreters can be booked by telephoning the following numbers:

<table>
<thead>
<tr>
<th>Region</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern Metropolitan Health Region</td>
<td>(02) 516-6999</td>
</tr>
<tr>
<td>Western Metropolitan Health Region</td>
<td>(02) 633-5444</td>
</tr>
<tr>
<td>Northern Metropolitan Health Region</td>
<td>(02) 438-7560</td>
</tr>
<tr>
<td>Illawarra Health Region</td>
<td>(042) 74-4211</td>
</tr>
<tr>
<td>Hunter Health Region</td>
<td>(049) 26-3533</td>
</tr>
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</table>

Ethnic Health Workers:

There are currently approximately 50 Ethnic Health Workers located in Community Health Centres on a full time and part time basis.
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Health Information Translation Service:

This service, located in Head Office, is a cross-regional resource responsible for the provision of printed health information in community languages.

A wide range of health education publications are available dealing with prevention and treatment. These are distributed in response to orders from all Areas/Districts.

Copies of all publications are provided free of charge from the Health Translations Service and free copies of the Catalogue of Translations may also be obtained. The Catalogue which is regularly updated, lists all publications currently available. Its accompanying English Language Manual provides the English texts.

New material is continuously in preparation, and requests for translation may be address to the Co-ordinator of the service, telephone: 217 5924.

14.4 OTHER RELEVANT GOVERNMENT SERVICES INCLUDE:

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commonwealth Telephone Interpreter Service</td>
<td>211-1111</td>
</tr>
<tr>
<td>Department of Immigration and Ethnic Affairs</td>
<td>239-3000</td>
</tr>
<tr>
<td>Ethnic Affairs Commission</td>
<td>237-6500</td>
</tr>
</tbody>
</table>

B. STANDARD PROCEDURES

14.5 APPLICABILITY OF THE STANDARD PROCEDURES

The Standard Procedures are intended to apply to all health services provided in the public sector where the resident population includes people of non-English speaking background. Increasingly these services will be administered by Area Health Boards. It is essential that Areas establish appropriate Co-ordination and Planning mechanisms to enable the implementation of these Procedures.

Areas are required to report annually on progress in relation to the implementation of the Procedures as part of the Department’s EAPS reporting process.

The Procedures that apply to community health services are designed to be compatible with the standards contained in the Community Health Accreditation and Standards Project (CHASP).¹

14.6 AREA CO-ORDINATION AND PLANNING OF MIGRANT HEALTH SERVICES

Area Migrant Health Committees

In areas with significant numbers of people of non-English speaking background, it is appropriate for Area Migrant Health Committees to be established to ensure that the full range of Area Health services are accessible and appropriate to ethnic communities resident in the Area. The Area Committees should advise the Chief Executive on these matters on a regular basis.

¹The Manual of Standards for Community Health 1984, developed by CHASP, is available from the Australian Government Publishing Services, 120 Clarence Street, Sydney, or PO Box 84, Canberra, ACT, 2601.
Terms of reference of such Committees should be drawn up in consultation with the Migrant Health Advisor/Co-ordinator. Members of such Committees would normally include a member of the Area Health Board, Ethnic Services Co-ordinators, Ethnic Consumer representatives, the Chief Executive Officer or delegate, the Migrant Health Advisor/Co-ordinator and a representative of the Health Care Interpreter Service.

In addition, it is important that, where appropriate, Area planning committees include persons with professional or community interest in migrant health to ensure that the interests of people of non-English speaking background are catered for in health service development.

Area Migrant Health Plans

Areas serving catchment areas with significant numbers of people from a non-English speaking background are requested to draw up an Area Migrant Health Plan as a part of strategic planning.

This should be developed in consultation with the Migrant Health Advisor/Co-ordinator. It should contain objectives and strategies which facilitate the implementation of the Department’s Migrant Health Policy and these Standard Procedures in a way that is appropriate to the needs of the Area. The Plan should be presented to the Chief Executive of Area Health Service for formal endorsement.

Areas will be required to report on an annual financial year basis on achievements in relation to objectives in the Area plans and to revise the plans for the following 12 months.

Hospital Ethnic Access Committees

In hospitals serving significant numbers of people from non-English speaking background, Ethnic Access Committees should be retained to co-ordinate and monitor hospital activities in terms of implementation of the Procedures. This is particularly the case in the metropolitan areas.

Membership of these committees would normally include the hospital Executive Officer or delegate, and Nursing, Medical and Administrative representation.

Hospital Ethnic Access Plans

This committee should update its hospital Ethnic Access Plan at the beginning of each financial year to facilitate migrant access to appropriate hospital services.

Guidelines for these Ethnic Access Plans may be obtained from the Migrant Health Advisor/Co-ordinator or the Policy Analyst (Migrant Health). The Plan should contain strategies to achieve the hospital related objectives contained in these Procedures for the following 12 months period.

Hospitals will be required to report to the Area on the implementation of their Ethnic Access Plans on an annual financial year basis as part of the EAPS reporting process.

Hospital based Ethnic Services Co-ordinators

PD2005 406 required that all hospitals serving significant numbers of people from a non-English speaking background appoint an existing Senior Staff member to co-ordinate implementation of the hospital’s Ethnic Access Statement. This arrangement should continue.
Community Health Services - Ethnic Access Committees

Community Health Services serving significant numbers of people of non-English speaking background should continue to maintain a committee to co-ordinate and monitor activities concerned with facilitating access to appropriate community health services. This should be done in consultation with the Migrant Health Advisor/Co-ordinator or the Policy Analyst (Migrant Health).

Membership of the Committee would normally include the Area Co-ordinator or Community Physician, Team Leader (where appropriate), the Senior Community Nurse, Health Education Officer, a Migrant Health Worker (where employed) and other delegated staff as appropriate. Representation from local ethnic communities should be ensured.

Community Health Services - Ethnic Access Plans

The Committee should update its Ethnic Access Plan at the beginning of each financial year. The Plan should set objectives and strategies for the subsequent financial year to ensure that community health services are accessible and appropriate to ethnic communities.

Guidelines for the Ethnic Access Plans may be obtained from the Migrant Health Advisor/Coordinator or Policy Analyst (Migrant Health). The Plans should include information about the population characteristics of the area, assessment of utilisation (under-utilisation) of community health services by various ethnic groups, identification of obstacles to appropriate usage of community health services by ethnic groups and strategies to overcome these obstacles. They should include the strategies outlined in the following sections of the Standard Procedures.

Community Health Services will be required to report to the Area on the implementation of their Ethnic Access Plan on an annual financial year basis as a part of the EAPS reporting process.

Community Health Services - Ethnic Services Co-ordinators

The Ethnic Access Committee should nominate one of its members to act as Ethnic Services Co-ordinator, to be a contact officer for the staff and to represent the Committee at Area Migrant Health Meetings.

STANDARD PROCEDURES FOR WORKING WITH HEALTH CARE INTERPRETERS (PD2006_053)
(For people from culturally and linguistically diverse backgrounds who are not fluent in English and people who are Deaf2).

This policy applies to all NSW Area Health Services and replaces Policy Directive PD2005_281. It should be read in conjunction with the following related Policy Directives:

- NSW Health Departmental Policy Directive PD2005_406, “Patient information and consent to medical treatment”.
- Privacy Manual for Health Information (March 2015).

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2 Use of the capital ‘D’ in Deaf, see glossary on page 21.
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- NSW Health Departmental PD2005_483, “Standard procedures for improved access to Area and other public health services by non English speaking background people.”
- NSW Health Departmental GL2005_032, “Guidelines for the production of multilingual health resources by Area Health Services, NSW Health Department and NGOs funded by NSW Health”

**What this policy says**

It is NSW Government policy that professional health care interpreters be used to facilitate communication between people who are not fluent in English, including people who are Deaf, and the staff of the NSW public health system. The use of professional interpreters allows health professionals to fulfil their duty of care, including obtaining valid consent.

This Policy Directive describes the situations in which interpreters must be used, the responsibilities of health care providers when working with interpreters, what to do if an interpreter is not available and the roles of health care interpreters.

**Who this policy is for**

All providers of health care services in NSW Health facilities and funded services.

1.0 **EXECUTIVE SUMMARY**

- NSW Legislation requires that public sector agencies and services provide equitable access to people from non-English speaking backgrounds and people who are Deaf (*Anti-Discrimination Act 1977*, *Mental Health Act 1990*, and the *Community Relations Commission and Principles of Multiculturalism Act 2000*).

- Health care interpreters are to be used in all health care situations where communication is essential including, admission, consent, assessment, counselling, discharge, explanation of treatment, associated risks and side-effects, health education and medical research and day only surgery (*Privacy Manual for Health Information* (March 2015) and PD2005_406, “Patient information and consent to medical treatment”).

- Generally, health care can only be provided with the consent of the patient. Consent will not be valid unless the patient has understood the information given to them regarding the intervention. (Departmental Policy Directive PD2005_406, “Patient information and consent to medical treatment”).

- Personal health information must be collected directly from the person, unless it is unreasonable or impracticable (*Privacy and Personal Information Protection Act 1998* and the *Health Records and Information Privacy Act 2002*, *Privacy Manual for Health Information* (March 2015).

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• Area Health Services are to ensure that systems and procedures are in place which ensure that patients who are not fluent in English or who are Deaf are given appropriate information and consent to treatment through the use of a health care interpreter.

• Both health care providers and patients/clients have a right to request a health care interpreter.

• Professional accredited health care interpreters provide interpreting services within the NSW public health system. The service is available 24 hours a day, 7 days a week, either face-to-face by telephone or by videoconference, where it is available. All interpreting services are free to public health patients/clients.

• The need for an interpreter should be recorded in a prominent place on the patient’s/ client’s medical record.

• Consent obtained without the use of a professional interpreter (e.g. a relative or a friend) may not be legally valid.

• Health care interpreters can usually provide short written translations which are directly related to individual patient/client care.

• Where possible, requests for interpreters should be made in advance.

• Health care interpreters are professionally trained interpreters and abide by a professional code of ethics, see Appendix 2. Bilingual health care staff are not be used as interpreters.

2.0 INTRODUCTION

From the 2001 Census, almost a quarter of the total NSW population (23%) was born overseas. During 2000-2001, NSW also received 46.1% of all immigrants arriving in Australia and the Department of Immigration and Multicultural Affairs (DIMA) indicates that this trend is unlikely to change significantly in the near future. This means, 1,012,613 people living in NSW were born in a non-English speaking country of which 1,156,767 indicated that they spoke a language other than English at home. If the numbers of people who are profoundly Deaf are included, at the last Census, 232,115 living in NSW indicated they spoke English poorly; and many of this group also lack the capacity read and write English.

The provision of professional health care interpreters aims to overcome the communication and cultural barriers faced by many Australians who are not fluent in English or who are Deaf, when using health services. Communication with the assistance of a professional health care interpreter allows non-English-speaking patient/clients, including people who are Deaf, to use mainstream services effectively and to be able to communicate with the health provider as if they were fluent in English. Through an interpreter, the patient/client is able to ask questions about the health system, the treatment and/or procedure recommended and the risks involved.

2.1 POLICY

NSW Health is committed to the Principles of Multiculturalism. The provision of health services to immigrants and refugees is based on two policy principles, which are enshrined in NSW legislation.
1. Equality of access to health care services for culturally and linguistically diverse populations including people who are Deaf (*The Anti-Discrimination Act 1977*).

2. The responsibility of the health care system to respond appropriately to the specific needs of different groups in the community which include people from culturally diverse backgrounds (*Community Relations Commission and Principles of Multiculturalism Act 2000*, and the *Mental Health Act 1990*).

The Community Relations Commission of NSW, through agency Ethnic Affairs Priority Statements, requires public sector agencies to develop protocols for language services to ensure they are accessible to people from Culturally and Linguistically Diverse (CALD) backgrounds. The Commission also requires that staff are proficient in the application of the protocols, including the process for booking interpreters.

Health personnel must communicate appropriately and effectively, through the use of a health care interpreter, with patients who are not fluent in English or who are Deaf, when collecting personal details, health information and/or obtaining consent to conduct a medical procedure.

### 3.0 STANDARD PROCEDURES

To ensure optimum use of the Health Care Interpreter Services (HCIS), Area Health Services are required to implement the following standard procedures. (For a list of the HCIS contact numbers please see Appendix 3.)

### 3.1 PROMOTING THE AVAILABILITY AND USE OF THE HCIS

3.1.1 Areas need to develop systems and procedures which ensure that patients who are not fluent in English or who are Deaf are given appropriate information and consent to treatment through the use of a health care interpreter.

3.1.2 All patients/clients who are not fluent in English or who are Deaf should be informed about their right to access a professional health care interpreter and offered the services of the HCIS at the first point of contact with the health care service.

3.1.3 All health facilities are to display in all public contact areas:
- multilingual information about the availability of interpreter services
- the relevant contact phone and fax numbers of these services

3.1.4 The treating professional is responsible for arranging the health care interpreter.

3.1.5 An interpreter will be provided when the patient/client, the patient/client advocate or representative requests the use of a professional interpreter, even if the health care professional does not consider one is required.

### 3.2 WHO IS ELIGIBLE TO USE THE HCIS

3.2.1 Health care interpreting services may be provided on-site, by telephone, or by videoconferencing depending on the facility and clinical priority for:
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- patients/clients of the NSW public health sector
- people using other NSW government organisations, where a public health professional is the lead professional, such as in child protection
- non-government organisations primarily funded by NSW Health, i.e. more than 50% of their funding. (The cost of the HCIS service provided to the NGOs is to be born by the Area in which the patient presents for service.)
- Justice Health
- Mental Health Review Tribunal
- staff of health services in relation to non-clinical activities such as disciplinary interviews, as well as clinical care
- the Health Care Complaints Commission
- Official Visitors under the NSW Mental Health Act
- patients/clients attending NSW Health state-wide services

3.2.2 The Health Care Interpreter Service is not usually available for:
- officers of other government instrumentalities, or non-health professionals
- private health care providers and facilities

3.2.3 With an increase in coordinated care and other collaborative health programs, decisions may need to be made from time to time about whether a request for a health care interpreter falls within these guidelines. Where possible, health care providers should discuss such situations with the manager of their local HCIS.

3.2.4 In some situations the HCIS will provide a service and charge for the service on a cost recovery basis. Examples of situations where this may apply include:
- service agreements with particular providers
- some non-government agencies funded by NSW Health
- provision of care to patients/clients covered by workers’ compensation or compulsory third party insurance claims
- some funded programs (e.g. research or health promotional campaigns)
- overseas visitors (those whose countries do not have reciprocal health care agreements with Australia)

3.3 CLINICAL BENEFITS OF USING HEALTH CARE INTERPRETERS

3.3.1 The clinical benefits to health care providers are:
- facilitation of accurate diagnosis
- improvement of patient/client understanding and adherence to medication and treatment plans
- ability to offer health promotion and prevention programs to patients/clients

3.3.2 The benefits to patients/clients who are not fluent in English and those who are Deaf, include:
- the ability to understand the information imparted by the health professional
- the ability to ask questions about their condition, the proposed treatment, or procedure and risks associated with it
- make an informed choice and provide informed consent before treatment

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3.3.3 The use of professional interpreters can bring efficiency benefits to the health system, such as:
- the reduction of readmission rates and length of stay
- savings in health personnel time and the prevention of misunderstandings which could result in litigation
- savings in unnecessary diagnostic tests and procedures
- improving safety and reducing adverse events, e.g., incorrect patient identification, incorrect procedure, postponement of procedures due to incorrect administration of medication

3.3.4 Using a non-professional interpreter may have a number of serious consequences.
- inferior quality of interpreting and inaccuracies due to lack of skills and familiarity with ethics, medical concepts and terminology
- altering, censoring, distortion and suppression of messages, especially when relatives act as interpreters
- inappropriate responsibilities being placed upon family members
- breach of patient/client confidentiality
- invalidity of consent
- invalidity of patient identification, correct procedure, correct site

3.4 WHEN TO USE HEALTH CARE INTERPRETERS

3.4.1 Prior to commencing treatment, health care providers are required to disclose all relevant information regarding treatment, method, risks associated with treatment, any side-effects or adverse outcomes. It is essential to communicate this information to patients/clients who are not fluent in English and patients/clients who are Deaf, through a professional health care interpreter. (see Departmental PD2005_406 “Patient information and consent to medical treatment”.)

3.4.2 It is essential that health care interpreters are present during interviews or discussions with the patient/client, especially with regard to the following situations:
- admission/initial assessments (see Section 3.6)
- consent for operations, procedures, treatment and research, (see section 3.9 and 3.10)
- identifying correct patient, correct procedure and correct site, (see PD2014_036)
- high-risk/life-threatening situations
- counselling
- death of a patient/client and bereavement counselling
- discharge procedures and referrals
- explanation of medication
- day-only surgery
- health education and promotion programs (both individual and group)
- medical instructions
- medical histories, assessments and treatment plans
- Mental Health Review Tribunals and magistrates’ enquiries
- pre-operative and post-operative instructions
- psychiatric assessment and treatment
- psychological assessment
- treatment or counselling for sexual assault, physical and emotional abuse
- speech therapy
- procedures relating to organ/tissue donation

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3.5 THE USE OF TELEPHONE AND VIDEOCONFERENCE INTERPRETING

3.5.1 While telephone interpreting may be used, face-to-face interpreting is more reliable and therefore is the preferred option in the provision of health care. Telephone interpreting does not allow for interpretation of non-verbal forms of communication such as body language and gestures. It may also be easier to misunderstand what is said or not heard clearly over the telephone.

3.5.2 In the event that a health care interpreter cannot be provided on site, telephone interpreting or videoconference interpreting, where it is available, should be considered. The HCIS should be contacted first and if they are not available, the Commonwealth Translation and Interpreting Service (TIS) should be contacted. (For a list of the HCIS contact numbers please see Appendix 3.)

3.5.3 When using a telephone interpreting service with the patient/client present, it is preferable to use a speakerphone or a two-handset phone. These are invaluable communication devices and should be made available in all high traffic areas. Care should be taken to protect the privacy of the patients/clients when using speakerphones. Speakerphones will be installed/used in quiet/secluded areas.

3.5.4 In cases of emergency, when a HCIS, or TIS interpreter are not available, this must be noted in the medical record and the service providers must ensure that the Health Care Interpreter Service is called as soon as possible to ensure that accurate information has been communicated and the medical history taken is accurate.

3.5.5 See item 3.9.5 for information on using a telephone interpreter to obtain consent.

3.6 PROCEDURE AT INITIAL ASSESSMENT

3.6.1 Language spoken at home (or preferred language), country of birth, and need for interpreter assistance must be recorded at admission or intake for all patient/clients.

3.6.2 The treating professional or clerk of the facility should ensure that information relevant to the patient/client’s linguistic, cultural, religious and social needs are recorded in the patient/client’s medical record.

3.6.3 When a need for the HCIS is established, the health care provider or clerk of the facility should place a sticker stating “(language) interpreter needed” on the cover of the medical record and/or on the admission form for attention during subsequent contact and treatment. It is the responsibility of all facilities to ensure that the need for an interpreter is also clearly recorded on the electronic system.

3.6.4 It is the duty of the treating health care provider to provide all relevant information regarding treatment, method, any risks associated with treatment, any side-effects or adverse outcomes prior to commencing treatment. It is essential to communicate this information to patients/clients who are not fluent in English and those who are Deaf through a professional health care interpreter. The treating health care professional should satisfy themselves that the patient has understood the information transmitted through the interpreter to them and answer any questions raised by the patient to ensure that informed consent is obtained.
3.7 PATIENTS/CLIENTS WHO REFUSE THE USE OF HEALTH CARE INTERPRETERS

3.7.1 As the treating professional is responsible for providing best quality health care through the communication of accurate medical information, a professional interpreter should be used when the patient/client is not fluent in English or is Deaf. On occasions when a client/patient declines the use of an interpreter the practitioner should:

- explain that he/she is obliged to ensure that all communication is accurate and impartial; this includes medical information provided by the practitioner to the patient/client as well as information given by the patient/client to the practitioner
- explain that the service is free to the patient/client
- explain that all communication will be confidential and privacy will not be breached if an interpreter is used
- encourage the use of a professional interpreter by exploring reasons with the patient/client for their refusal

3.7.2 Patients/Clients may refuse a health care interpreter because of confidentiality - some CALD communities are small and a patient may be acquainted with the health care interpreter from that community. As a result, requests for a different health care interpreter should be supported. If the Health Care Interpreter Service cannot provide an alternative interpreter, when appropriate, a telephone interpreter from TIS may be used.

3.7.3 While some patients/clients may request that relatives or friends be present to offer support and comfort and to assist in the provision of information this is not a substitute for a health care interpreter.

3.7.4 In the case that a professional interpreter is not used because the patient/client has declined the use of one, the provider must record these details in the patient/client’s medical record, with details of the discussions that have taken place about the use of an interpreter (see 3.7.1) and inform the patient/client that this is being done.

3.8 BOOKING PROCEDURE

3.8.1 The NSW HCIS is available at all NSW public health facilities, free of any charge to public health patients/clients, 7 days a week 24 hours a day. Health care interpreters cater for the communication needs of most communities.

3.8.2 When booking an interpreter, establish the preferred language or dialect for communication purposes (the preferred language may not always be the main language spoken in the country of birth).

3.8.3 For a list of the Health Care Interpreter Service (HCIS) and the Translating and Interpreting Service (TIS) contact numbers see Appendix 3.

3.8.4 When booking an interpreter for a Deaf person see Appendix 4.

3.8.5 Interpreters are in high demand, and may not be available at short notice. Health care providers should book interpreters as much in advance as possible and may need to negotiate the time and date of the appointment. Bookings should preferably be made by phone to the HCIS office.
3.8.6 Where a health care interpreter cannot be provided on site, video or telephone interpreting should be used if appropriate and they are available.

3.8.7 In outpatient or other clinics, to permit optimum and efficient use of the HCIS, patient/clients speaking the same community language should be block booked on the same day so as to be seen in succession.

3.9 CONSENT

3.9.1 It is imperative that a professional interpreter is present to ensure patient/client consent is valid and that the patient/client has understood the information provided when a recommendation for surgery, treatment or research is communicated to a person who is not fluent in English or who is Deaf. Specific procedures are to be followed by health care practitioners and interpreters in obtaining patient/client consent for surgery, clinical treatment or research. (See Section 3.10)

3.9.2 The following material should be read in conjunction with Departmental Policy Directive PD2005_406, “Patient information and consent to medical treatment”.

Departmental Policy Directive PD2005_406, “Patient information and consent to medical treatment” states that:

- As a general rule, no operation, procedure or treatment may be undertaken without the consent of the patient, if the patient is a competent adult. Adequately informing patients and obtaining consent in regard to an operation, procedure or treatment is both a specific legal requirement and an accepted part of good medical practice. The NSW Health Patient Charter also contains a commitment to patients that public health organisations will clearly explain proposed treatment including significant risks and alternatives in a way patients can understand and obtain patient consent before treatment, except in an emergency or where the law says patients must have treatment. Consent to the general nature of a proposed operation, procedure, or treatment must be obtained from a patient. Failure to do this could result in legal action for assault and battery against a practitioner who performs the procedure.

- In addition to meeting the requirements for obtaining a valid consent, the patient must be provided with sufficient and material information for there to be a genuine understanding of the nature of the operation, procedure or treatment. Failure to warn a patient about the material risks inherent in a proposed procedure is a breach of the medical practitioner’s duty of care to the patient and could give rise to legal action for negligence.

3.9.3 The responsibility for ensuring that informed consent has been obtained rests with the attending medical officer.

3.9.4 Consent for treatment may not be valid if it is obtained through a child, other family members, other patient/clients, visitors, or non-accredited staff acting as interpreters.

3.9.5 Telephone or video interpreting for obtaining consent should only be provided when face-to-face interpreters are not available and medical intervention is urgently required. If consent has been obtained over the phone, it is desirable that the patient/client be seen by a professional interpreter as soon as possible after the event to ensure that information provided has been understood and enable further communication to occur if necessary.
3.9.6 New technology such as Tele-Health will increasingly allow interpreting to be provided from a remote site. However, this should not be used as a substitute for obtaining consent by the use of a face-to-face interpreter if this option is available.

3.10 PROCEDURE FOR OBTAINING CONSENT WITH AN INTERPRETER PRESENT

3.10.1 The process of obtaining informed consent from a person who is not fluent in English or who is Deaf via an interpreter is to follow one of the two procedures outlined below.

Procedure one: The treating health care professional provides all necessary information and risks associated with the medical procedure so that the patient/client may give informed consent (these procedures are detailed in Departmental Policy Directive PD2005_406) and the health care interpreter interprets this information. Once the health care provider is satisfied that the patient/client understands the information, the treating practitioner should then read out the consent form and the interpreter should interpret this.

Procedure two: The treating health care professional provides all necessary information and risks associated with the medical procedure so that the patient/client may give informed consent (these procedures are detailed in Departmental Policy Directive PD2005_406) and the health care interpreter interprets this information. Once the health care provider is satisfied that the patient/client understands the information provided, the interpreter may be asked to ‘sight translate’ the content of the consent form to the patient/client. If sight translation is requested, it must take place in the presence of the health care provider in order that the provider can clarify questions which may arise. When sight translation is completed, a note with the interpreter’s signature that states “the form has been sight translated for the patient/client in the presence of a health care provider” must be included in the consent form.

3.10.2 If at any time the interpreter believes the patient/client has not understood the content of the form, the interpreter should advise the practitioner of this so further explanations can be provided by the health care provider.

3.10.3 All consent forms should contain a section for the interpreter to sign indicating they were present and interpreted for consent.

For example:

Health care interpreter present............................................ (signature)

Interpreter’s Name ............................................................. (block letters)

Date.................................

3.10.4 If the consent form does not contain such a section, the interpreter should note on the consent form that they were present.

3.10.5 Interpreters should also write a brief statement in the patient/client medical record indicating that interpreting has been provided for the patient/client in the presence of a health care provider (e.g. “interpreted in the presence of Dr X and patient/client Y”) and then sign and date the entry. An “Interpreter Attended” sticker must also be placed on the record, where a paper record is used, see section 4.1.5 for further details.
3.10.6 Approved bilingual consent forms (i.e. forms in both the patients/clients language and English) may be used if available, but these should not replace the use of a health care interpreter who can enable the patient/client to ask the health care provider questions essential for making an informed decision.

3.10.7 In the event where a patient/client does not sign the consent form, the interpreter should not sign the consent form and must write in the patient/client medical record that the interpreter was present during the interview and witnessed the patient/client decline to sign the consent form. The interpreter must sign and date this entry. Similarly, if the health care provider is not present for the provision of all information relating to consent, including during sight translation of the form, the interpreter should not sign the form, even if the patient/client is willing to do so.

3.11 BRIEFING AND DEBRIEFING THE INTERPRETER

3.11.1 The health care provider will brief and debrief the health care interpreter, especially in difficult and sensitive situations.

3.12 INTERPRETER ACCESS TO MEDICAL RECORDS

3.12.1 The health care interpreter will always be regarded as an integral member of the multidisciplinary health care team and be given access to medical records for the purpose of documenting his/her visit and the patient/client’s future need for language services support. It is the responsibility of the health professional to ensure that this requirement is met. Health care interpreters are bound by the Australian Institute of Interpreters and Translators’ Code of Ethics which require them to maintain confidentiality of patients/clients at all times. (See Appendix 2 for a summary of this code of ethics or the following web-link for the unabridged version, http://www.ausit.org)

3.13 PROCEDURE AT DISCHARGE

3.13.1 A health care interpreter should be booked to attend when information on discharge and medication is given. The patient/client should be informed of available community services, any follow-up appointments, or referrals appropriate to the case.

3.14 HEALTH INFORMATION IN COMMUNITY LANGUAGES

3.14.1 The provision of written information in appropriate community languages should be seen as complementary to the Health Care Interpreter Service. Written patient/client information should not replace the use of a professional interpreter where the patient/client is not fluent in English or is Deaf.

3.14.2 The Health Care Interpreter Service can generally be asked to provide written translation of short documents essential to individual patient/client care, subject to resource availability.

3.14.3 It is at the discretion of each Health Care Interpreter Service to undertake translations of short written material not essential to individual patient/client care. For translation of longer documents or interpretation in languages not generally available through the staff of HCIS, fees may be charged.
3.14.4 The Health Care Interpreter Service and the NSW Health Multicultural Health Communication Service can also provide advice on alternative options for the translation of health information.

3.14.5 NSW Health Department Guidelines, GL2005_032 “Guidelines for the Production of Multilingual Health Resources by Area Health Services, NSW Health Department and NGOs Funded by NSW Health”, is to be used in the development of multilingual resources. Copies of all multilingual resources developed are to be provided to the NSW Multicultural Health Communication Service.

3.14.6 Written translations on a wide range of health issues can be obtained from the NSW Health Multicultural Health Communication Service website, http://www.mhcs.health.nsw.gov.au/ Where internet or intranet access is not possible, the Service can be contacted on telephone number 02 9816 0302.

3.15 BILINGUAL HEALTH CARE PROVIDERS/STAFF

3.15.1 Interpreting is a professional skill. Fluency in a language other than English does not imply the ability to interpret at a professional level. A distinction must be made between staff who are bilingual and staff who are professional interpreters.

3.15.2 Bilingual staff members may use their community language in the provision of direct patient/client care in the normal course of their work. Bilingual staff members should not be used to interpret for other staff members unless they are formally accredited under NATTI as an interpreter. Any such use is contrary to the Policy Directive, Standard Procedure for Working with Health Care Interpreters, and may constitute a breach of the legal duty of care.

3.16 STAFF TRAINING

3.16.1 All health personnel need to be informed of the existence of the HCIS immediately after commencing their employment in a particular facility through orientation programs, written procedures, or in-service training programs. Each Area Health Service is to ensure that all personnel are aware of the Policy Directive, Standard Procedure for Working with Health Care Interpreters, and that all staff are required to adhere to it and be proficient in its application.

3.16.2 Training on working with health care interpreters must be provided to all staff who are in positions of direct contact with patients/clients.

3.16.3 Such training can be provided by the Health Care Interpreter Service or multicultural health staff, or by outside trainers approved by these services.

3.17 QUALITY ASSURANCE AND EVALUATION

3.17.1 Consumer satisfaction surveys should ensure that patient/clients who are not fluent in English or who are Deaf, are proportionally represented. Access to and satisfaction with the HCIS should also be regularly surveyed among CALD patient/clients.

3.17.2 The Multicultural Health Service including health care interpreters will assist with the administration of such surveys subject to resource availability.
3.18 COMPLAINTS PROCEDURES


3.18.2 Patient/clients should be informed of their right to make a complaint if they are not satisfied with a health service or the HCIS.

3.18.3 The HCIS is available for use by the Health Care Complaints Commission, the Health Conciliation Registry and Area Health Services to assist them with the complaints management process.

3.18.4 If a health care provider has a complaint about the behaviour or professionalism of an interpreter, contact should be made in the first instance with the manager of the HCIS from which the interpreter was called and follow Area Health Service and Department of Health complaints procedures.

4.1 DUTIES OF THE HEALTH CARE INTERPRETER

4.1.1 Statutory Requirements
Health care interpreters are required to comply with the Health Records and Information Privacy Act (NSW) 2002.

4.1.2 Code of Ethics
Health care interpreters are at all times required to abide by a code of professional ethics, which includes confidentiality, accuracy and impartiality. (See Appendix 2 for a summary of this code of ethics or the following web-link for the unabridged version, http://www.ausit.org)

4.1.3 Skilled Interpretation
Interpreters provide a professional language support services. Their bilingual and interpreting skills are both tested and accredited. Interpreters are required to complete an approved medical terminology course, operate within the confines of their code of conduct, and participate in on-going professional development programmes. Most interpreters are accredited or recognised by the Commonwealth National Accreditation Authority for Translators and Interpreters (NAATI), or other appropriate bodies.

4.1.4 Language Assessment
Health care interpreters may be asked to assess a patient/client’s comprehension and ability to converse in English. Their assessment should override any other opinion.

4.1.5 Cultural Advice and Information
Interpreting requires a thorough knowledge of cultural differences, value and belief systems expressed through the use of language, as well as an understanding of the cultural contexts within which the health care provider and the patient/client interact. Accordingly, interpreters may be asked to provide specific culturally related information that is relevant to the clinical and social needs of patient care.

However, the health care provider should direct all initial enquiries regarding culture and its impact on clinical care to the patient and their family.
4.1.6 Completion of Records
The health care interpreter is required to sign and date the patient medical record or patient/client community health record and to document his or her attendance at the interview by writing a statement indicating the nature of service she/he provided.

An “Interpreter Attended” sticker must also be placed on the record, where a paper record is used. For example: 23 July 2004, 9.30 am - Interpreted for Dr. X, procedure explained to patient/client and consent form was signed.

Specific entries will ensure accurate records and hospital/centre compliance with this policy.

Interpreters may document information in the medical record relevant to the patient/client’s linguistic, cultural, religious or social needs. Where required, health care interpreters may need to enter this information on computerised systems.

4.1.7 Sight Translation
Interpreters provide sight translations of information written in English or other languages which are essential to the health care of an individual patient/client. Sight translation essential to the health care of an individual patient/client must take place in the presence of a health care provider. The translation of lengthy and technically complex documents may require extra time and resources. (For other translation requirements refer to Section 3.14).

4.1.8 Completion of Questionnaires/forms
Health care providers are required to be present when health care interpreters provide interpreting assistance to complete forms and questionnaires.

4.1.9 Translations
Health care interpreters may be asked to provide written translations of documents essential to individual patient/client care.

4.1.10 Other Duties
Health care interpreters may also be asked to carry out other duties consistent with their role and the needs of the Service, such as administrative tasks, participation in health promoting activities and promoting access and appropriate use of health care interpreters.
5.0 GLOSSARY

5.1.1 Interpreting is the transmission of messages between two spoken languages, between a signed language and a spoken language, or between two signed languages. The interpreter, therefore, enables two or more parties who do not share a common language to communicate verbally or in sign by attending to what one party says or signs and repeating that message in the other party’s language, transferring all components of the message that would be available to the parties as if they shared a common language.

5.1.2 Translation is the written transmission of messages from one language into another.

5.1.3 Deaf - The capital ‘D’ in Deaf reflects membership of and identification with a sociolinguistic minority group. People who are Deaf identify as a CALD group even if they are born and raised in Australia of Australian parents and use a sign language, usually Auslan (Australian Sign Language), as a first or preferred language. For most Deaf people, English is therefore a second or non-preferred language. Communicating via lip-reading and/or written notes is inappropriate for most members of this community.

The need for an interpreter should be considered even if the person has good speech skills and appropriate terminology should be used to refer to Deaf patients/clients - for example, the term ‘signing Deaf’ is preferable to ‘deaf and dumb’ or ‘deaf-mute’, which are considered offensive.

5.1.4 Sight translation is the spoken or signed transmission, sometimes in summary, of a written message in another language. In the health context, this should occur in the presence of a health care provider.

5.1.5 The terms patient, client and consumer are used in the Policy Directive, Standard Procedure for Working with Health Care Interpreters, refer to any person obtaining a health service in the NSW public health system.

5.1.6 CALD - Culturally and Linguistically Diverse

5.1.7 HCIS - Health Care Interpreter Service

5.1.8 TIS - Translation and Interpreting Service

5.1.9 HCI - Health Care Interpreter

5.1.10 AUSIT - The Australian Institute of Interpreters and Translators

5.1.11 NAATI - National Accreditation Authority for Translators and Interpreters
APPENDIX 2

The Australian Institute of Interpreters and Translators Code of Ethics
for Interpreters & Translators
[abridged]

1. Professional conduct
Interpreters and translators shall at all times act in accordance with the standards of conduct and
decorum appropriate to the aims of The Australian Institute of Interpreters and Translators (AUSIT).

Interpreters and translators should:
- always be polite and courteous, unobtrusive, firm and dignified
- explain their role to clients, encouraging them to speak to each other directly
- allow nothing to prejudice or influence their work, and disclose any possible conflict of interest
- decline gifts and tips (except token gifts customary in some cultures), explaining to clients that
  accepting them could compromise their professional integrity
- ensure punctuality at all times (and if lateness is unavoidable, advise clients immediately)
- prepare appropriately for assignments and ensure they are completed
- refrain from unprofessional or dishonourable behaviour and refer any unresolved disputes to the
  AUSIT Executive Committee and accept its decision

2. Confidentiality
Interpreters and translators shall not disclose information acquired during the course of their
assignments.
- interpreters and translators may only disclose information with the permission of their clients
  (or if the law requires disclosure)
- if other interpreters or translators are involved in the same assignment and require briefing, this
  should be done after obtaining the clients’ permission, and all are obliged to maintain
  confidentiality
- no work should be subcontracted to colleagues without clients’ permission.
- translated documents remain the client’s property

3. Competence
Interpreters and translators shall undertake only work which they are competent to perform in the
language areas for which they are “accredited” or “recognised” by NAATI.
- acceptance of an assignment is a declaration of one’s competence and constitutes a contract. If,
during an assignment, it becomes clear that the work is beyond the interpreter’s or translator’s
  competence, they should inform clients immediately and withdraw
- interpreters/translators must clearly specify their NAATI accreditation, level and language
  direction, if necessary explaining its significance to clients
- it is the interpreter’s responsibility to ensure that working conditions facilitate communication
- if an interpreter or translator is asked to provide a second opinion or to review alterations to the
  work of another practitioner, there should be final agreement between all interpreters and
  translators concerned.

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4. **Impartiality**
Interpreters and translators shall observe impartiality in all professional contracts.
- Professional detachment must be maintained at all times. If interpreters or translators feel their objectivity is threatened, they should withdraw from the assignment.
- Practitioners should not recommend to clients anyone or anything in which they have personal or financial interest. If for some reason they have to do so, they must fully disclose such interest, including assignments for relatives or friends, or which affect their employers.
- They should not accept, or should withdraw from, assignments in which impartiality may be risked because of personal beliefs or circumstances.
- Interpreters and translators are not responsible for what clients say or write. They should not voice or write an opinion on anything or anyone concerned with an assignment.
- If approached for service by all parties to a legal dispute, an interpreter or translator shall offer to work for the first party making the request and notify all parties concerned.

5. **Accuracy**
Interpreters and translators shall take all reasonable care to be accurate. They must:
- Relay accurately and completely all that is said by all parties in a meeting, including derogatory or vulgar remarks, non-verbal clues, and anything they know to be untrue.
- Not alter, add to, or omit anything from the assigned work.
- Acknowledge and promptly rectify any interpreting or translation mistakes. If anything is unclear, interpreters must ask for repetition, rephrasing or explanation. If interpreters have lapses of memory which lead to inadequate interpreting, they should inform the client, ask for a pause and signal when they are ready to continue.
- Ensure speech is clearly heard and understood by all present. Where possible (and if agreed to by all parties), interpreters may arrange a short general conversation with clients beforehand to ensure clear understanding by all.
- Provide full evidence of NAATI accreditation or recognition if requested.

6. **Employment**
Interpreters and translators shall be responsible for the quality of their work, whether employed as freelance practitioners or by interpreting and translation agencies or other employers.
- AUSIT members may set their own rates and conditions in freelance assignments.
- They may not accept for personal gain any fees, favours or commissions from anyone when making any recommendations to clients.
- Interpreters and translators are responsible for services to clients performed by assistants or subcontracted employees. Interpretation and translation practitioners employed by colleagues must exercise the same diligence in performing their duties.

7. **Professional development**
Interpreters and translators shall continue to develop their professional knowledge and skills.
- They should constantly review and re-evaluate their work performance.
- They should maintain and enhance their skills by study and experience, and keep up to date with relevant languages and cultures.

8. **Professional solidarity**
Interpreters and translators shall respect and support their fellow professionals. They should:
- Assist and further the interests of colleagues, refraining from comments injurious to the reputation of a colleague.

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58(12/06)
• promote and enhance the integrity of the profession through trust and mutual respect.
  Differences of opinion should be expressed with candour and respect - not by denigration -
  refraining from behaviour considered unprofessional by their peers

The full version of this code of ethics is available at the following link
14. MIGRANT HEALTH

APPENDIX 3

NSW Health Care Interpreter Service, the Translation and Interpreting Service (TIS) telephone numbers

<table>
<thead>
<tr>
<th>Geographical Location</th>
<th>Business Hours</th>
<th>After Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sydney South West (Eastern Zone) and South East Sydney</td>
<td>(02) 9515 9500</td>
<td>(02) 9515 9500</td>
</tr>
<tr>
<td>Sydney South West (Western Zone)</td>
<td>(02) 982 86088</td>
<td>(02) 9616 8111</td>
</tr>
<tr>
<td>Sydney West</td>
<td>(02) 984 03456</td>
<td>(02) 9840 3456</td>
</tr>
<tr>
<td>Northern Sydney</td>
<td>(02) 9926 7560</td>
<td>(02) 9926 6500</td>
</tr>
<tr>
<td>Central Coast</td>
<td>1800 674 994</td>
<td>1800 674 994</td>
</tr>
<tr>
<td>Hunter</td>
<td>(02) 4924 6285</td>
<td>(02) 4921 3000</td>
</tr>
<tr>
<td>All country NSW except Greater Southern</td>
<td>1800 674 994</td>
<td>1800 674 994</td>
</tr>
<tr>
<td>Illawarra</td>
<td>(02) 4274 4211</td>
<td>(02) 4274 4211</td>
</tr>
<tr>
<td>Greater Southern</td>
<td>1800 247 272</td>
<td>1800 247 272</td>
</tr>
</tbody>
</table>

Translating and Interpreting Service (TIS)
- General number | 131 450 | 131 450 |
- Hospital Priority Number | 1300 655030 | 1300 655030 |

Valid as of 21/6/06

58(12/06)
When booking an interpreter for a Deaf person, please ascertain the preferred mode of communication, which include:
- Australian Sign Language (Auslan);
- Signed English (usually used by Deaf children and adolescents only)
- fingerspelling only (usually only used by elderly Deaf people)

For people who are Deafblind:
- hand over hand (Auslan)
- visual frame (Auslan)
- tactile fingerspelling

For Deaf people who lack fluency in Auslan, Signed English or fingerspelling, (due to educational or linguistic disadvantage, intellectual, psychiatric or physical disability, or having recently migrated to Australia), a Deaf relay interpreter may also be required to work in a team with an Auslan interpreter.
GUIDELINES FOR THE PRODUCTION OF MULTILINGUAL HEALTH RESOURCES BY AREA HEALTH SERVICES, NSW HEALTH DEPARTMENT AND NGOs FUNDED BY NSW HEALTH (GL2005_032)

The attached guidelines concerning the development of new multilingual health resources apply to all Area Health Services, the NSW Health Department and Non Government Organisations (NGOs) funded by NSW Health. This Policy Directive should be read in conjunction with PD2006_053: Interpreters - Standard Procedures for Working with Health Care Interpreters.

What this circular says:
It is NSW Government policy that people not fluent in the English language should receive, when possible, information, instructions and health education material in the language of their choice.

This circular describes the steps that health workers should follow to find out about existing multilingual resources, about producing new materials and about sharing them across the NSW Health system.

Who this circular is for:
This circular applies to all providers of health care services within the NSW Health system, central administration and NGOs funded by NSW Health.

Contents:

1. POLICY BACKGROUND

1.1 As a result of a comprehensive review conducted by the NSW Government in 1995/96 a number of positive changes were made to the Ethnic Affairs Commission Act. These changes reinforced the Government’s commitment to ensuring that people from culturally and linguistically diverse communities are included as an integral part of the social, cultural and economic future of NSW. More recently, the Community Relations Commission and Principles of Multiculturalism Bill 2000 enshrined the principles of multiculturalism (formally known as the Principles of Cultural Diversity) as the policy of the State.

1.2 In summary these principles are:

Principle 1
All individuals in New South Wales should have the greatest possible opportunity to contribute to, and participate in, all aspects of public life.

Principle 2
All individuals and public institutions should respect and make provision for the culture, language and religion of others within an Australian legal and institutional framework where English is the common language.

Principle 3
All individuals should have the greatest possible opportunity to make use of and participate in relevant activities and programs provided or administered by the Government of New South Wales.
Principle 4
All public institutions of NSW should recognise the linguistic and cultural assets in the population of New South Wales as a valuable resource and promote this resource to maximise the development of the State.

1.3 Implementation of the Charter within the context of NSW Health continues to rely upon two policy principles:
• The right of equality of access to health care services regardless of cultural origin or linguistic skill; and
• The responsibility of the health system to respond appropriately to its target populations which include people of non-English speaking background. This responsibility includes modification of existing health services to reflect consumer needs and to develop and provide bridging programs and services which can deliver appropriate and effective health care (Health for a Culturally Diverse Society: An Implementation Plan, 1995).

1.4 The implementation of the principles of the Charter requires NSW Health to provide information and health resources in languages other than English. Individuals who are not fluent in English should receive written information such as instructions and health education material, where it is available, in the language of their choice.

1.5 However, written patient information should not replace communication in clinical practice. For accurate communication with a patient/client a professional interpreter should be used.

1.6 In 1997 NSW Health Department established the NSW Multicultural Health Communication Service (Multicultural Communication) to produce, coordinate, collect and disseminate multilingual health resources of statewide applicability in NSW.

1.7 NSW Health Department is committed to the production new multilingual health resources based on identified priorities and statewide significance. Four or five resources are produced annually. Multicultural Communication provides advice to Health Public Affairs on subjects, languages and format.

1.8 Multicultural Communication produces a minimum of 11 multilingual fact sheets annually. Consultation, requests and research determine topics and languages. The content of all fact sheets is approved by the Chief Health Officer and are published on the Multicultural Communication website.

1.9 Sections of NSW Health, Area Health Services and NGOs producing multilingual resources should inform and negotiate with Multicultural Communication for inclusion of the resource on the website. Any multilingual resource placed on the website needs to be of statewide significance and approved by Health Public Affairs.

2. OBLIGATION NSW HEALTH WORKERS

2.1 When developing multilingual resources the level of literacy of the community must be taken into account and alternatives to written information such as signs/symbols and audiovisual formats should be considered.
2.2 NSW health workers have three obligations in relation to multilingual health resources. These include enhancing duty of care by:
   • locating and using available resources
   • producing new material where appropriate resources are not available
   • sharing such resources across Area Health Services.

3. STANDARD PROCEDURES

3.1 To ensure that good practice operates in the development and usage of multilingual resources, all NSW Health employees involved in the production of new multilingual health resources are required to:
   • familiarise themselves with multilingual health resources currently available
   • observe the “Procedures for Producing Multilingual Health Information” set out in Appendix 1

There are two options for developing new material:
   • to develop the content in English for translation into other language/s or
   • to develop the content in the other language/s to be checked by back translation into English.

In either case, only accredited translators should be given the task of translating and checking the information as recommended in the Procedures for Producing Multilingual Health Information. In some new arrival and minority groups there are no accredited translators. In those cases advice should be sought from the NSW Health Care Interpreter Service.

3.2 To build a freely available and readily accessible store of resources for use by all employees of the NSW Health system, a copy of all new multilingual health resources is to be provided to the NSW Multicultural Health Communication Service.

3.3 NSW health workers and health workers employed by NGOs need to inform the Multicultural Health Communication Service about their resources. The Multicultural Health Communication Service will determine the statewide significance of these resources and will arrange for approval by Health Public Affairs to include them on the NSW Website.

4. EXISTING RESOURCES

4.1 Over recent years the NSW Health system has accumulated a significant number of multilingual health resources. Many of these resources are listed on the Multicultural Health Communication Service website and can be downloaded and printed from:
   • NSW HealthWeb (Internet):
14. MIGRANT HEALTH

4.2 For the cost of a local call, a catalogue and individual multilingual health publications are available by fax from “the Health fax-back service: 1300 859 659”.

4.3 Where Intranet or Internet access is not available the NSW Multicultural Health Communication Service can be contacted by telephone (02) 9382 7516 or, Facsimile (02) 9382 7517 to provide advice on local distribution points.
APPENDIX I

Procedures Producing Multilingual Health Resources
The information that follows relates to the preparation of multilingual resources. Detailed guidelines on every step of the translation, checking and production process are available from the website of the NSW Multicultural Health Communication Service. See “Guidelines for health staff producing multilingual information” and “Seven steps-guidelines for checking a translation”.

RESEARCH
To avoid duplication, before developing new multilingual health resources a check should be made as to whether any other resources are available to meet the need.

- Check with the NSW Multicultural Health Communication Service to ascertain if anyone else has worked on, or is currently working on, something similar; or
- Consult with the person responsible for Multicultural Health in the Area about possible new projects.

If other resources are not available, consideration should be given to producing a new resource. However, the following issues should be considered before developing a new resource.

- Is there suitable information already available in English?
- In which format will the resource be produced?
- How much money is available to undertake the work?
- What language/languages should the new publication be available in?
- Who will do the work?
- Is written material the most appropriate way to reach target groups or would another medium would be more effective
  - (e.g. signs/symbols or audiovisual)?
- How will the resource will be distributed?

Content
Where clear, unambiguous English text is already available, it is preferable to use that text rather than attempt to rewrite it or develop something new. If new text is required, it should be written in plain English, avoiding medical or specialist health jargon, wherever possible. The final draft should be approved by the person responsible for Multicultural Health or the NSW Health Care Interpreter Service of the Area in which the new resource is to be provided. Statewide services, NGOs and Head Office sections should consult Multicultural Communication. Representatives of the target community should be involved in pilot testing the resource. This will ensure that the text is in a form that will be culturally appropriate when translated. Advice on how to obtain an interpreter should also be included.

Costing
Costs involved in the production of translated material can be broken down into translation, checking, proofreading, and typesetting. Printing costs will need to be estimated as well. Costs depend on the number of words to be translated and the layout required. It is advisable to negotiate job fees with each translator or agency and to obtain estimates for these costs.

55(4/06)
For Area Health resources and subject to availability of staff, the NSW Health Care Interpreter Service may be able to translate documents of up to 50 words which are essential for individual patient care. For documents over 50 words or languages not available to the NSW Health Care Interpreter Service, fees may apply.

Languages

The languages selected for translation should reflect the need for the resource. This does not always mean that the information should be produced in all of the major languages. Consideration should be given to the relevance of the information to various communities, as well as the English language proficiency of the specific target groups. It is often the smaller, newer communities that have the greatest need for information in their language. However, the literacy level in each target group should also be checked because a written resource is not always the most suitable format.

Translation

Translators accredited by the National Accreditation Authority for Translators and Interpreters (NAATI) at the professional level (former level 3 or above) should, whenever possible, undertake translation and checking. However, professionally accredited translators of the desirable level may not be available for some of the newly arrived groups. In such cases Paraprofessional accreditation may be accepted or equivalent demonstration of competence to undertake translation.

It is possible to contract translators individually, or to engage the NSW Health Care Interpreter Service, South West Sydney Area Health Service Translation Unit, or a translation agency to undertake the work. If translation is to occur in only one language, it is relatively easily managed on an individual basis. However, if many languages are required, it may be advisable to work through the NSW Health Care Interpreter Service or a commercial agency. A list of agencies is available from the NSW Multicultural Health Communication Service. Always check with agencies that they are using accredited translators.

Producing the Resource

Details to be included when producing new resources include:

- who owns the publication
- the date of the publication
- name of agency or individual responsible for translation
- title headings and sub-headings are to be in the other language first (with the title in English following in a smaller font). This will help English-only health staff identify the publication and use it effectively.
- the name of the language should be printed on the front page in English and in the other language as well (e.g. Italian, italiano)

Sharing the Resource

When a new resource is developed, it should be shared with other staff across the State. This process will be facilitated by the NSW Multicultural Health Communication Service through the inclusion of all relevant material on their website. All material, in English and other languages, should be forwarded to the NSW Multicultural Health Communication Service (Locked Mail Bag No 5003, Gladesville, 2111, or fax: (02) 8753 5002 or email mhcs@sesiahs.health.nsw.gov.au for inclusion on the site.
MIGRANT HEALTH EDUCATION OFFICERS (PD2005_483)
(See also Community Education).

Migrant Health Education Officers are employed by Area Health Services. They perform a cross Area role wherever appropriate. Their role includes:

- Provision of advice to health workers and others on migrant health education issues.
- Liaison with Health Education Officers to ensure that all health education projects include material suitable for local ethnic communities.
- Design, development and conduct of health information and education programmes directed to ethnic communities.
- Provision of support to Ethnic Health Workers in the areas of planning, implementation and evaluation of health education and community programmes.
- Staff training in migrant health education issues and cultural awareness.

BILINGUAL STAFF (PD2005_483)

Bilingual professional staff play a vital role in improving access to hospital and community health services and in providing culturally and linguistically appropriate services.

Bilingual staff members should be encouraged to use their community language in the provision of direct client care in the normal course of their work. Bilingual staff members should not be used to interpret for other staff members.

Where practicable hospitals and community health services should arrange to have bilingual staff members linguistically tested. A number of tertiary institutions have testing facilities for this purpose. Advice can also be sought from the Co-ordinators of the Health Care Interpreter Service in each area. Bilingual staff members who fail a language test should not use their community language in the work situation.

Health professionals need to be aware of the areas of expertise and location of bilingual health professionals in their Area and District. In certain situations, where complex assessment and counselling of non-English speaking clients is required, it may be appropriate to encourage ethnic minority clients to attend services staffed with appropriately bilingual health professionals.

HEALTH INFORMATION IN COMMUNITY LANGUAGES (PD2005_483)

The provision of written information in appropriate community languages should be seen as complementing the use of bilingual health workers. Written patient information should not replace the use of a trained interpreter where the patient has difficulty with English.

An adequate supply of relevant multilingual publications should be prominently on display at all public contact points, such as Accident and Emergency, Outpatients, waiting rooms etc.

Specialist clinics should ensure that all available multilingual information is provided to people of non-English speaking backgrounds.
The Health Translations Service publishes and distributes over 300 different publications in up to 17 languages.

All publications currently available are listed in the Catalogue of Translations, which is regularly updated.

Copies of all publications listed may be obtained free of charge by completing an order form specifying file number, languages and quantities required. (A maximum of 100 copies of any text in any language may be ordered.)

Order forms, publications and the Catalogue may be obtained by writing to the Health Translations Services, PO Box K110, Haymarket 2000 or telephoning (02) 217 5927.

The English Language Manual which contains copies of the English text of all publications, may be purchased for $15 from the Service.

REQUESTS FOR TRANSLATION OF NEW MATERIAL (PD2005_483)

If translation is required of written medical records, diet or medication instructions of a patient or client during a consultation attended by a Health Care Interpreter, the interpreter will assist with translation.

Short notices or signs may also be translated by Health Care Interpreters (maximum 50 words).

Material of a general nature which is normally provided to patients/clients in English should be available in appropriate community languages.

Subject to available resources, such material may be translated by the Health Translations Service. All proposed translations should be discussed with the Co-ordinator (217 5924) or Assistant Co-ordinator of Translations.

Translating work is undertaken on contract by professional translators (accredited with the National Accreditation Authority for Translators and Interpreters (NAATI) at Level 3-Translating).

Full details about the Health Translations Service system are available in the document “Health Information in Community Languages - Policy and Procedures, Health Translations Service - 1987”.

Ethnic Services Co-ordinators and Ethnic Access Committees will be kept informed by the HTS of all translation requests received from their hospital or centre but editorial details and any requests for clarification by translators should be negotiated directly between the HTS and the person initiating the request.

MULTILINGUAL SIGNS AND SYMBOLS (PD2005_483)

Important hospital and community health public signs should be shown in universal symbols where appropriate. Universal symbols have been developed by the Standards Association of Australia. Signs should include indication of the availability of the Health Care Interpreter Service. In many cases, however, it is necessary to use multilingual signs.
STAFF DEVELOPMENT (PD2005_483)

Information concerning the health needs of ethnic minorities should be incorporated in all in-service training curricula.

Orientation for all new staff and further in-service training for existing staff should provide education in:

- skills of communication through trained interpreters.
- the location and appropriate use of bilingual health workers, local ethnic community welfare support services and other migrant services provided by government and community agencies.
- socio-cultural information of relevance to service provision.
- the Department’s Migrant Health Policy.

The migrant component of in-service training should be developed in consultation with appropriate Migrant Health staff.

EMPLOYMENT POLICIES (PD2005_483)

Equal Employment Opportunity is New South Wales Government policy.

The Department has issued an Equal Employment Opportunity Management Plan for 1986/87. This includes the following objective:

“To identify relevant duties and staff selection criteria for positions which would benefit from input from people with non-English speaking background and for Aborigines”.

The Department has issued a Policy Statement on Equal Employment Opportunity for Area Health Services. This is available from the EEO Unit in Central Office. Area Health Boards are required in their first year to develop employment practices which reflect a sensitivity to the community being served.

The Policy Statement will be revised in 1987 to incorporate a requirement for identification of positions for which multicultural/multilingual skills are a relevant qualification.

Objectives listed in the Area Migrant Health Plans should include the objective of identification of positions for which multicultural/multilingual skills are a relevant qualification.

EEO Co-ordinators and Migrant Health Advisors should be consulted as part of the process of job identification and for the inclusion in job advertisements of a relevant statement under ‘desirable’ or ‘essential’.

In general, health services serving significant numbers of people with non-English speaking background should seek to appoint staff with relevant community language skills in all public contact positions, whether professional, clerical or administrative.
14. MIGRANT HEALTH

COMMUNITY EDUCATION (PD2005_483)

Health education programmes provided by hospital and community health services should be conducted in appropriate community languages, and should be culturally relevant to ethnic target groups.

Broadly orientated health promotion projects should be adapted to target ethnic communities. Specific health problem areas among ethnic communities may require specially formulated health education programmes.

Health education programmes for the English speaking population might usefully include information about the socio/cultural background of resident ethnic communities as a way of promoting positive community relations.

The Health Education Officer (Ethnic Media) in Central Office, Migrant Health Advisors/Co-ordinators and Migrant Health Education Officers are available for advice concerning health education and the use of the ethnic media and other channels.

Bilingual community educators should be trained and engaged for specific programmes directed to ethnic communities.

If translated material is to be provided as part of a community education programme, multiple copies should be ordered from the Health Translations Service at least 4 weeks in advance. There is no charge for the supply of existing material.

If new material is required to be translated for a community education campaign the programme budget should include the cost of translating and printing, as Health Translations Service’s resources are limited.

The Health Translations Service should be approached at an early stage, at least 4-6 months before the material is to be used, to discuss detail of content, presentation and printing, and to allow time for the translating/printing process.

MODIFICATION OF HOSPITAL AND COMMUNITY HEALTH SERVICES (PD2005_483)

It is important that wherever practical and relevant hospitals and community health services modify their services to meet the health needs of patients from non-English speaking backgrounds. This should include:

- Provision for different dietary preferences, in order to ensure the provision of culturally appropriate and nutritious meals. Ethnic - specific menus should be developed where numbers of particular ethnic clients are large.
- Reasonable flexibility in such matters as regulations concerning hospital patients’ visitors to take account of cultural background, subject to proper consideration of other patients.
- Provision of multilingual pharmaceutical labels where feasible.
- Consideration of cultural and religious differences in dealing with issues such as birth, death and religious practices.
14. MIGRANT HEALTH

- Provision of Thalassaemia screening and referral to Thalassaemia counselling. The Department Policy Statement on Thalassaemia screening may be obtained from the Migrant Health Advisor/Co-ordinator or Policy Analyst (Migrant Health).
- Provision of English classes for long stay patients in a psychiatric unit in conjunction with the Adult Migrant Education Service.
- Provision of female medical staff. Many women of non-English speaking background find it traumatic to be treated by male doctors, particularly for gynaecological conditions. It is important to provide female medical staff in these circumstances, wherever possible.

CHILD CARE (PD2005_483)

Area Health Services should seek to provide for the childcare needs of clients attending group work and education sessions. Migrant Health staff are available for advice on the availability of bilingual child care workers.

LIAISON AND CONSULTATION WITH ETHNIC WELFARE AND COMMUNITY ORGANISATIONS (PD2005_483)

It is important that Area Health Services establish close links with and provide support to ethnic-specific community agencies to ensure that appropriate and responsive services are established. Agencies should be provided with information about available health services, migrant health staff and the Department’s Migrant Health Policy.

DOMESTIC VIOLENCE AND MIGRATION REGULATIONS: RELEVANCE FOR HEALTH WORKERS (Information Bulletin 2005/4)

The NSW Health Policy and Procedures for Identifying and Responding to Domestic Violence (2003) recognises that clients who are from culturally and linguistically diverse (CALD) backgrounds may have particular issues relating to the domestic violence and their immigration status.

The Australian Government introduced the Domestic Violence Provision as part of the Migration Regulations 1994 of the Migration Act 1958, to protect victims of domestic violence who have certain temporary visas as partners or spouses of Australian citizens. Under the legislation, if a relationship has broken down because of domestic violence, a person may remain eligible for permanent residence. This legislation was introduced to protect victims of domestic violence who had to remain in violent and abusive relationships for the mandatory time of two years, or were otherwise forced to return to the country of origin.

In order to access the Domestic Violence Provision, a victim must prove that the relationship was genuine and ongoing and that domestic violence occurred in Australia. A Statutory Declaration, form 1040, provided to the Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) completed by a “competent person” can establish that domestic violence occurred.

According to the Provision, “competent persons” can include registered medical practitioners, psychologists, nurses, and social workers who are employed in the NSW Health system. These health workers can, in their professional capacities, complete the Statutory Declaration form 1040 if requested by a client or patient. The health worker may indicate in the Statutory Declaration that, in their opinion, domestic violence has been suffered by the person and the evidence on which this is based.
The Non-English Speaking Background Domestic Violence Network convened by the Immigrant Women’s Speakout has produced an information leaflet *You are a “competent person”...Under the Migration Regulations* (August 2004), to guide “competent persons” in completing the Statutory Declaration.

The PDF version of *You are a ‘competent person...Under the Migration Regulations* is attached to this Information Bulletin and can also be downloaded from the Immigrant Women’s Speakout website: [http://www.speakout.org.au/CP.pdf](http://www.speakout.org.au/CP.pdf)

The Immigrant Women’s Speakout can be contacted for further information and advice on (02) 9635 8022.

A MESSAGE TO DOCTORS AND NURSES

Under the Migration Regulations you can support a woman, on certain visa classes and who is a victim of domestic violence, in her application to stay in Australia.

Background

Under the Migration Regulations, partners of Australian citizens/residents applying for Permanent residence on “Partner grounds” receive a Temporary 2 year visa, which then becomes Permanent if after 2 years the relationship is found to be still ongoing and genuine.

To protect victims of domestic violence, who found themselves in the vulnerable position of having to choose between returning to their country or remaining in a violent relationship until the 2 years were over, the government introduced the Domestic Violence Provision in 1991.

Why is it important you support the woman experiencing domestic violence?

Migration is a difficult and stressful process. Women leave their families, jobs and culture in order to marry and begin life in a new country. The uprooting and readjustment that women make when marrying and migrating to Australia cannot be underestimated.

When a marriage breaks down because of abuse by the partner, the stress experienced by the woman is two-fold. She has to cope with being a single woman, making employment and other life decisions and caring for other members of the family, in addition to dealing with the abuse and trauma caused by the partner. The process of healing from abuse is long and difficult. In such a situation, the last thing a woman needs is to have her visa cancelled and be forced to return to her native country.

Her home country may not welcome her back due to traditional views on family break-up and divorce. They may view divorce with extreme disapprobation. It is possible that the woman will continue to be abused – this time not by her partner but by her own community. The woman may also face discrimination in employment, and the entire family could be subjected to direct or indirect hostility.

The process of reverse migration would add to the stresses faced by the woman. However, she may be eligible to apply for Permanent Residence under the Domestic Violence Provision and you may be able to support her in this process. This may enable her to rebuild her future in Australia.

What is the Domestic Violence Provision (DVP)?

“The Domestic Violence Provision of Australia’s Migration Program, allows certain people applying for permanent residence in Australia to continue with their application after the breakdown of their spouse or partner relationship if they, or a member of their family unit, have experienced domestic violence committed by their spouse or partner”.

The DVP allows applicants on certain Partner visas, who have experienced domestic violence after arriving in Australia and whose relationship with the sponsoring partner has broken down because of domestic violence, to remain eligible for Permanent Residence if they can demonstrate that the relationship with their sponsoring partner was genuine and broke down because of domestic violence. As such it is an essential safeguard for women who would otherwise be locked in an abusive and violent relationship.

**How is the Domestic Violence Provision accessed?**

For the purpose of making an application under the Domestic Violence Provision, domestic violence is defined in the Migration Regulations to be:

> “Violence against the alleged victim or his or her property that causes the alleged victim, or a member of the alleged victim’s family to fear for, or to be apprehensive about the alleged victim’s personal wellbeing or safety. Violence includes the threat of violence.”

To access the DVP the victim of domestic violence needs to establish:
1. That the relationship was genuine and ongoing (which is done by the Department of Immigration and Multicultural and Indigenous Affairs - DIMIA)
2. That domestic violence occurred in Australia

**How can you help?**

One of the ways to establish that domestic violence occurred in Australia is for the woman to provide DIMIA with a Statutory Declaration by a “Competent Person”.

**Who is a “Competent Person”?**

Competent People include the following:

Registered Medical Practitioners and Psychologists, Registered Nurses, Social Workers and Managers of Domestic Violence Services.

As a GP or registered nurse you may be approached by a woman asking you to provide a statutory declaration.

**How to make your declaration most effective**

- Identify yourself, establish your qualifications and expertise and the basis on which you are a competent person
- Include the name of the person who has experienced the violence and the name of the perpetrator
- Include a statement that in your opinion domestic violence has occurred
- Detail the facts on which you base that opinion

It is very important that your declaration is based on your professional expertise and on factual observation, and to ensure that it is not just the retelling of the victim’s story.
For example you may want to include:

- Specific incidents with dates
- Observations on the victim’s physical state and health history, such as injuries, bruises, lacerations, delay in seeking medical attention and a pattern or history of repeated injuries
- Observations on the victim’s psychological state and history such as: stress, depression, anxiety, drug or alcohol abuse, use of tranquillizers and anti-depressants, chronic headaches and other pains, sleeping and eating disorders, suicide attempts
- Observations on other possible symptoms such as: abdominal pain, complaints of sexual dysfunctions, joint and muscle pains, miscarriages etc
- Your opinion on the impact of the violence on her personal well-being and safety

If in your opinion these symptoms are consistent with domestic violence and the woman’s story, you should state this in the statutory declaration. If the woman is a regular patient you can check her record for a history of symptoms consistent with domestic violence.

**ESSENTIAL: ALWAYS REFER THE PATIENT TO A DOMESTIC VIOLENCE SERVICE**

| Domestic Violence Line       | 1800 656463 |
| Immigrant Women’s Speakout   | (02) 96358022 |

This info-sheet was produced by the NESB DV Network with financial support from the NSW Strategy to Reduce Violence Against Women, Sydney, August 2004. It provides basic information only and is not a substitute for legal advice. If you have a migration issue, consult a registered migration agent.

Additional copies can be downloaded from Immigrant Women’s Speakout website at www.speakout.org.au.
The *NSW Multicultural Mental Health Plan 2008-2012* is the strategic state-wide policy and service delivery framework for improving the mental health of people in NSW from Culturally and Linguistically Diverse (CALD) communities.

This Plan was developed after extensive consultation, and reflects current and emerging trends across our communities. It aligns with relevant initiatives including:

- A New Direction for NSW: The State Plan;
- A New Direction for NSW: The State Health Plan;
- NSW: A new direction for Mental Health 2006; and

The Plan is a seminal document that synthesises epidemiological issues with the mental health challenges within CALD communities. This knowledge underpins a strong reform agenda for multicultural mental health at all levels of care, as well as ensuring responsive consultation with the CALD communities.

The Plan reflects and complements national and state policy directions and planning for multicultural mental health. It recognises that a comprehensive model of service delivery for multicultural mental health includes a range of services such as health promotion and prevention programs, early diagnosis, assessment and treatment services and care planning, to cultural consultancy and training and education.