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Counting the cost of language services in psychiatry

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Objective. To document interpreter utilisation at a major South African mental hospital over a 2-month period in 1993.

Design. A survey was conducted by requesting clinicians to complete a questionnaire each time they required an interpreter.

Setting. Seven admission wards at a Western Cape mental hospital and an emergency psychiatric service at a general hospital.

Participants. Twenty-nine clinical staff members.

Main outcome measures. Number of patients requiring an interpreter; who provides interpreting services; interpreter availability; and duration of interview.

Results. One hundred and forty-eight predominantly Xhosa-speaking patients (20 - 30% of admissions) required interpreting. Interpreter services were available immediately in 69% of cases. Nursing staff provide 67% of the interpreter service, while cleaning staff provide 10%. There were 93.5 documented hours of interpreting. One person employed as an interpreter in 2 wards had longer interviews on average than the other staff members. The opportunity cost of using nurses and cleaners as interpreters amounts to R1 504 for the period of the study.

Conclusions. Psychiatrically educated staff are clearly preferred as interpreters. A significant proportion of patients are being assessed through the use of family members, cleaners and other inappropriate people. The financial burden to the hospitals of not providing an interpreter service is small, but the impact on working conditions and service to patients is considerable.

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Most Western Cape health services (especially psychiatric) attend to language service needs in an *ad hoc* fashion. Nurses, family members, clerks and cleaners are enlisted to interpret.[1,2] This is surprising given the centrality of language in clinical practice. A local review on interpreting in largely medical settings highlighted the paucity of research on the variable impact of the interpreter's qualifications or background on an interview.[2] There is, however, clear evidence that family members should be avoided, particularly in psychiatric settings. In spite of this, it is thought that in practice much interpreting falls to family members and other under-qualified parties. It is not surprising that the legacy of under-provisioning of facilities and the maldistribution of resources in health care as a whole[3-5] as a result of governmental commission and omission in South Africa would be reproduced in the area of language services in health care[6,7] Larger political changes and black languages becoming official create a climate more favourable to redressing service inadequacies.

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Subjects and methods

The study took place in 10 admission wards at Valkenberg Hospital (VH), a large psychiatric facility, and the 24-hour emergency psychiatric service (C23) based at Groote Schuur Hospital (GSH) that triages patients for local psychiatric hospitals.

No interpreter was employed at either VH or C23 until 1 month into the study when someone was employed to work half-days in the male admissions unit at VH. In this article the term 'interpreter' refers to persons who fulfil this function on request without necessarily being employed for this purpose.

The study was conducted on all weekdays (excluding night calls) in October and November 1993, a total of 43 working days.

Interpreter utilisation was measured in terms of number of patients requiring an interpreter; who was providing this; interpreter availability; and duration of interview. The languages and gender of the participants and contexts of service were also considered.

Data were gathered through requesting clinical staff to complete a questionnaire each time they either used someone as an interpreter or would have had this service been available. This yielded returns from consultant psychiatrists, psychiatric registrars, social workers, psychologists, psychology interns and occupational therapists. The results are drawn from 4 units, comprising 8 of the 10 wards in which data were gathered, i.e. C23, male admissions, forensic admissions and female admissions, but will not be reported in full here. There will be a particular focus on the demands placed on nursing staff in providing interpreter services, with some discussion of the implications for mental health care at this hospital.

Results

Overview

Twenty-nine clinical staff members had used interpreter services during the time of the study, and they returned 299 completed questionnaires. One hundred and forty-eight patients required interpreting, which constituted 20 - 30% of admissions. Most were Xhosa-speakers, but a smattering of Afrikaans, Zulu, Sotho and Tswana speakers also required interpreters.

Interpreting was required most for psychiatric assessment interviews (81.6%), with ward rounds, family interviews, psychometrics and groups accounting for the rest. There was someone to interpret immediately in 69% of instances,

while 21% of the time there was a delay. In 27 cases (9%) this delay extended more than 1 day. The variability across unit in availability of interpreters was clearly a function of the provision of Xhosa-speaking professional nursing staff.

Who is providing the service?

Table I shows that the bulk of the responsibility is falling to the nursing staff (67%), with clinicians expressing a definite preference for professional nurses (PNs) (53%). Cleaning staff are interpreting almost 10% of the time. Instances of security staff interpreting, patients interpreting for their spouses in their own conjoint interviews, strangers to the patient being asked to interpret, psychotic patients interpreting, and Xhosa-speakers being expected to interview in Sotho or Tswana still occur.

Table I. Amount of interpreting (%)

Category	C23	Male (Oct)	Male (Nov)	Forensic	Female	Totals
Professional nurse (PN)	34	81	47	53	50	53
Staff nurse (SN)*	29	10	5	15	11	14
General assistant (GA)	7	4	6	5	18	9
Student nurse	-	-	9	-	14	5
Interpreter	-	-	31	-	-	5
Family	15	-	-	-	-	3
Other	15	5	2	27	7	11

* Nursing assistant in C23.

Duration and frequency of utilisation

For the purposes of this analysis the data have been grouped into the two main centres, C23 at GSH and the Valkenberg wards. At C23 total utilisation was 17.5 documented hours, with 10% of questionnaires missing data on the duration of the interview and only 3 documented instances of no interpreter whatsoever being available.

At VH there was a total of 76 hours of interpreted interviews in the 8-week period. The male admission wards (MAWs) had a total utilisation of 32.2 hours — missing data suggested a further 4 hours on average. There was a total of 21.8 hours in the female admission wards (FAWs). The greatest impact of unavailability was felt here, with delays in 40% of cases and 14 interviews not taking place at all. This partly reflects the fact that an 'open' pre-discharge ward did not have a Xhosa-speaking staff member for 1 entire month of the study. The 2 forensic wards used interpreters for 18.9 hours (this may be under-estimated by approximately 5 hours). In spite of the comparatively low number of interviews in the unit, the total duration of use is similar to the other units because of significantly longer interviews — 50 minutes on average compared with 18 minutes in MAWs and 24 minutes in FAWs.

The October and November statistics for the male wards were separated to isolate the impact of the interpreter's presence in these wards. The interpreter's average length of interview was over 30 minutes, compared with the PN and SN durations of 18 and 14 minutes respectively. The interpreter also had interviews as long as 60 and 90 minutes, whereas interviews with nursing staff rarely exceeded 30 minutes and were never longer than 45 minutes.

An examination of inpatient folders suggested that questionnaires were not completed for approximately 30% of interviews with study patients.

Cost analysis

Extrapolating from recently published figures,[8] it is possible to approximate the opportunity cost to the hospital of staff interpreting. The direct cost of the time spent by PNs, SNs and GAs amounts to R934. The approximately 12 hours of interviewing not noted on questionnaires adds R119. Allowing for the 30% of interviews not documented through questionnaires inflates the figure to R1 504.

Discussion

In overview, the results suggest that individual units would not be able to support full-time interpreters. Personnel with psychiatric insight and education are clearly preferred as interpreters. A significant proportion of patients are being psychiatrically assessed through the use of family members, cleaners and other inappropriate people.

The cost analysis has shown that there is a small monetary amount involved, but the cost in terms of lost clinical productivity is more significant. The interpreter employed during the study was employed at R5 per hour (the GA's hourly rate), while the average hourly cost of using clinical staff is R10. In spite of this, the practice of employing an interpreter at a GA's hourly rate should be questioned. It severely under-represents the responsibility of the position and the level of skill required, and would surely discourage appropriately qualified applicants.

An even more compelling argument for employing interpreters is the implications of not providing adequate language services. While indirect costs are more difficult to specify, data from this study provide some indications. Clinicians noted interviews that had to be repeated, important collateral information that could not be obtained, and diagnostic uncertainty on questions as fundamental as whether or not the patient was psychotic. These difficulties often arose in the context of using someone as an interpreter who was either not competent in Xhosa and English or Afrikaans, or who had no psychiatric training. Even more disabling was the instance of a ward without any Xhosa-speaking staff member for 1 month. The resultant delays in the commencement of treatment, management and ultimately discharge of patients, sometimes for weeks, are a significant financial and clinical burden on the hospital service. Patient management begun under conditions of poor clinician-patient communication and diagnostic uncertainty also results in poor compliance and an increased likelihood of relapse and readmission. This places an additional burden on health services and the community as a whole.

This study has highlighted the importance of psychiatric training for people who function as interpreters. This should, however, be seen as a minimum requirement. In other centres around the world[9-11] interpreters are screened for linguistic competence and provided with training for the

specialised task of interpreting. There is an urgent need to address this lacuna in both medical and psychiatric services around this country.

The absence of an interpreter service also creates a considerable organisational burden. It is a constant bone of contention among hospital employees that nurses are taken away from their duties in order to interpret. Nurses often resent the imposition of an 'unofficial' task for which they are untrained, unappreciated and unrewarded. The fact that there are unwritten agreements with regard to the distribution of Xhosa-speaking nursing staff in wards known to have a high proportion of Xhosa patients adds to the sense of an exploitative system in which nurses ironically have no voice. The results of the study also indicate that clinicians resent wasted time tracking down a willing nurse or cleaner; they keep interviews as short as possible, often have to repeat interviews, and are uncomfortable with imposing upon nursing colleagues. Most importantly, being a Xhosa-speaking patient of a psychiatric hospital entails the constant risk of being denied access to professional, confidential assessment by a qualified person. The cost of the lack of adequate language services in our psychiatric and medical facilities is clearly considerable. The results of this study suggest that redressing this deficit need not be a materially insurmountable problem.

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