Consultation with non-English speaking communities: rapid bilingual appraisal

Anna M Whelan

Abstract

Government services, including health departments, are insisting that consumers or users of health services be consulted. Linguistic diversity in communities can pose challenges to planners and policymakers in this communication and consultation agenda. This article presents rapid bilingual appraisal as a useful technique for health services to meet the requirements set by equity and access guidelines and legislation. This method was used in an area health service as part of an independent feasibility study. Health services should recognise the need for such consultation and allocate appropriate resources and time to conduct such consultations, and for skilled bilingual facilitators and qualified interpreters to be employed and developed as part of the team.

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What is known about the topic?

Health services are consulting patients and consumers to a greater extent. This has resulted in the need for effective techniques to tap the views of non-English speaking communities.

What does this paper add?

This article describes rapid bilingual appraisal, using trained bilingual facilitators and interpreters to enable focus groups with non-English speaking participants to provide rapid assessment of participant views for planning. The technique is most effective when bilingual facilitators and interpreters have developed effective relationships with the community.

What are the implications for practitioners?

This article suggests the need for health services to invest in skill development of relevant facilitators and interpreters.

A STUDY WAS CONDUCTED to investigate the feasibility of a cooperative model for an accident and emergency (A&E) service in an area health service in New South Wales (NSW) (Braithwaite & Associates 1999). The aim of the 1998–99 study was to report on the feasibility of the application of the cooperative concept to the medical and health sectors, as an alternative to closure or privatisation. Methods included literature review, analysis of census and local government data, inpatient and emergency department statistics, and key informant interviews with local health service providers and managers, general practitioners, resident action groups, local trade unions and others in the area.

The team was keen to consult residents living near the hospital who had used the local emergency service within the 3 month study time frame. Census data and discussions with health staff indicated that a high proportion of residents were from non-English speaking backgrounds. The most frequently spoken language in the area after English was Macedonian. Given this high concentration of residents in the immediate catchments, the research team considered it important to explore the views of the neighbouring community through a Macedonian focus group.

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The case for community consultation

Citizen or community involvement in health policy formation and planning has been on the agenda for nearly two decades (Wilenski 1988; Dwyer 1989; Yeatman 1990; Dugdale 1991). Yeatman over a decade ago saw this involvement as a two-way

relationship with a more demanding public, leading to government services becoming "dependent on the active participation of citizens in order to have their demands reflected in the service" (Yeatman 1990, p. 51). Debates have since raged about the theory, policy, practice and potential benefits of participatory administration and management (Putland, Baum & MacDougall 1997).

For health service planners and managers, the case for consultation was first made in a useful document from the Office of Social Policy (1993) as contributing to "good government, good management and good business". Byrne & Davis (1998, p. 41) detailed the ways in which consultation processes assist organisations: through identifying stakeholders; defining the agenda; improving information flow; exchanging views; improving the quality of decision making; improving legitimacy and compliance through ownership; and avoiding challenges.

More specifically, benefits have been listed for health services (IAHS 1997) as:

- higher quality services and projects
- higher profile for health services in the community
- view of health as approachable professionals keen to be in touch with ordinary people
- better informed needs identification and planning
- broader support for health service activities
- fulfillment of health department criteria for consultation with stakeholders
- enhancement of quality assurance activities and approach
- greater accountability for public funds
- potential for development of better quality projects
- wider source of ideas about needs and issues
- greater credibility when lobbying government.

For consumers, benefits were listed as providing:

- opportunity to have a say about issues and needs in the community
- greater sense of influence over the health services they use
- opportunity to have positive input to local health activities
- sense of self-esteem from working alongside health professionals
- greater credibility when lobbying for change to health and community services.

Much has been written since then on consumer participation in health (Draper 1997; Commonwealth Department of Health and Aged Care 2000, NRCCPH 2004). However, as with many matters of public policy, a major concern is with implementation, specifically, how do health services consult with communities in their catchments? While this is an issue for all states in Australia, this study was conducted within New South Wales, hence the participation agenda for this state is reviewed.

Participation agenda and diverse communities — NSW Health

In New South Wales, the Department of Health announced a Government Action Plan for health services (NSW Health 2001a). Part of the broad agenda was said to be to increase the involvement of people who use health services, their families or carers, organisations with an interest in the health system, and residents of NSW in decisions made in the health system (NSW Health 2001b). One strategy has been to form the Health Participation Council. The role of this group is to oversee the implementation of the *Partners in Health* report; undertake reviews of consumer and community participation in health services or programs; identify best practice in consumer and community consultation; and review policies and give advice based on consumer and community views.

New South Wales, as other states of Australia, is home to substantial numbers of residents and health consumers who are not proficient in English. In NSW, 18.8% of the population speak a language other than English at home. This is over 1 million people, and the proportion rises with each census (Community Profile 2001). In some suburbs, the majority of residents do not speak English (Community Profile 2001). The formal response to this demographic shift in NSW began with a focus on language and communication through the introduction of the Health Care Interpreter Service in 1977, the employment of ethno-specific health

workers in the 1980s and the routine translation of health information into several major languages. The response of the public system to linguistic and cultural diversity has since been institutionalised by state law, regulations and policies.

Given the nature of diversity in Australia, the issue of broad consultation becomes more important, and several good publications have been produced to assist service providers and planners (NHS 1993; Commonwealth DHSH, 1995; NSW Health, 1997; NSW Health 1998). Making explicit the diversity in an area health population is considered part of being a "culturally competent organisation" and of showing "diversity leadership" (Dreachslin 1996; Whelan & Matthews 2002). However, despite goodwill and interest in diversity, setting up a consultation process with non-English speaking communities has been described as challenging (Whelan & Matthews 2002), and it frequently drops off the agenda.

Consultation techniques can include public hearings, inquiries, public meetings and taskforces, submissions, polls and surveys, interviews and focus groups (Whelan 1999). All have their benefits and drawbacks (NSW Health 1998). However when a rapid assessment is required, there is a technique that can provide the equivalent of a "rapid rural appraisal" (Chambers 1981) in communities that do not communicate predominantly in English, by using skilled bilingual staff to conduct focus groups.

How useful are focus groups when English is not spoken?

Focus group interviews or discussions are a frequently used interactive technique to elicit experiential views to tap into human tendencies. "Attitudes and perceptions relating to concepts, products, services, or programs are developed in part by interaction with other people" (Kreuger 1994, p. 10). As stated by Kitzinger (1995, p. 229): "The idea behind the focus group is that group processes can help people to explore and clarify their views in ways that would be less accessible in a one to one interview ... When group dynamics work well the participants work alongside the researcher, taking the research in new and often unexpected directions". This method relies on skilled facilitation to draw out the interactions among participants, which is the key feature giving the method a high level of face validity (Kreuger 1994). Tuong Thi Phan and Fitzgerald (1996) developed a useful guide for conducting focus groups in health research.

While an undeniably useful technique for certain purposes, conducting focus groups in the context of cultural and linguistic diversity raises several concerns. In health services, Yelland and Gifford (1995) pointed to concerns about focus group methods in cross-cultural research. Dreachslin (1998) analysed such concerns including racial identity development theory, models of communication style differences, ethnographic studies of cultural archetypes or ethnic markers, and the author's experiences in facilitating focus groups. However, the main issue is that the crucial dynamic interaction between the facilitator and the group is problematic if the language, let alone the culture, is not shared (Esposito 2001). While focus groups are frequently used in health services research and planning, the issue for this study was how does the English speaking manager or health planner who is seeking the views of the community 'participate' in a focus group in another language?

The standard option is using an external bilingual facilitator, taping the focus group and transcribing tapes in full, so the study team can analyse it or the bilingual facilitator can report back impressions to the team after the focus group. However, that option fails to capture the flow of interactions in the group and does not allow the rest of the English-speaking team to share the meanings in real time, nor to alter direction or probe further, as they would if they were conducting the focus group themselves. In other words, the English-speaking team is not involved in the conduct of the focus group and has to wait for the feedback after translation, and to trust that the facilitator has captured the directions and nuances that are of most use.

Given the limitations to the standard option, an innovative technique termed 'rapid bilingual appraisal' was designed based on previous work and advice from staff from the Multicultural Health

Service, the Health Care Interpreter Service and the ethno-specific workers for the community. The aim of this rapid bilingual appraisal was to gain opinions in a timely fashion to influence the planning agenda. This technique is less suitable for research purposes when the aim is to gain a rich, in-depth understanding or for discourse analysis where semantics and exact word usage are crucial (Esposito 2001).

The rapid bilingual appraisal process

The process involved engaging a Macedonian ethnic health worker who had been trained to conduct focus groups and was an experienced and skilled facilitator. With over 20 year's experience, she had developed a trusting relationship with the community. Her input was sought into the design of the focus group discussion and on any cultural issues that should be considered. The aims of the study were explained, a theme list was generated, and issues were refined with the team. The role of the bilingual facilitator was clarified as being there to elicit responses from a focus group of Macedonian women. The selection of the group was crucial and the experience of the ethnic health worker was invaluable in selecting appropriate women who were able to interact constructively. All were women who had used the emergency services of the hospital in the past year, either for themselves or for members of their family. A range of ages was selected to reflect young women who had children and older women who often had either partners or parents who required health services.

A list of trigger questions from the theme list was developed and the rationale, scope and appropriateness were discussed with the ethnic health worker beforehand; modifications and additions were made. Views were to be elicited on how the A&E services had been used in the past 5 years; usage patterns in the past year; satisfaction with the service and staff; suggestions for improvements; and whether other A&E services had been used. Two Macedonian professionally qualified health care interpreters were also briefed about the aims of the study, with their role clearly delineated as providing the voices for the participants.

The focus group was conducted at the hospital site being studied. A light lunch was provided for participants, and transportation was provided if they lived too far to walk to the hospital or were older or less able. A total of 21 women attended, which was more than planned, as some women brought relatives who were visiting them. It was decided that it would be inappropriate to exclude them and risk alienating members of the group before we started. Ethical considerations were explained and participants gave verbal consent. The discussion was audiotaped.

During the focus group, one interpreter sat close to one of the English speaking team (AW) doing 'whisper translation', the other sat with another team member and mainly took notes on key points. The interpreters were also provided with the trigger questions and space in which to write comments. While the ethnic health worker controlled the flow of the discussion, the English-speaking team member was able to break in at times with an additional question, or to probe or seek clarification, because of the immediacy of the whisper interpretation. This allowed for a much more dynamic focus group without having to stop participants and get the facilitator to translate word for word.

Participants related to each other not just to the facilitator and team; they expressed sympathy, shared anecdotes and solutions, and teased and joked. Some found that their views were modified or tempered through the course of the group over the one and a half hours. The participants clearly spelled out the benefits of the current A&E services, and cited examples of how they used the service frequently, often because of the Macedonian-speaking nurse and receptionist who were able to communicate directly with them. They expressed concern that these bilingual staff had been moved to another hospital further away and over the proposal to fully close the service. They asked the area health service to keep it open because of their concern, as expressed by one woman, that "Even if nothing happens now, it will happen in future and [the other hospital] is too far". Some had thought the service was already closed and had started using another local hospital. Others said that the local A&E had become increasingly understaffed, particularly in terms of doctors, and the waits were too long.

On completion of the focus group, the interpreters gave a verbal report immediately to the team.

This allowed the study team to immediately get a picture of the views of this particular community. Later they wrote up their impressions, using the audiotapes, and completed answering the trigger questions on the sheet a few days later. The interpreters used the tape recording to assist in filling out their form, but they did not complete full transcriptions because of time and budget constraints. This process took them less than 2 hours to complete and provided the team with the information required, plus some key quotes that exemplified the range of responses.

Benefits of rapid bilingual appraisal

Numerous benefits of the rapid bilingual appraisal approach emerged. The bilingual facilitator could focus on gaining the richest views of participants on the topic while keeping the interaction dynamic and responsive. The interpreters, on the other hand, were able to perform a valuable role, giving immediate voice to the participants as well as more detail from their notes on later reflection. The English-speaking study team members were able to participate directly with the group, sharing stories and laughter, allowing a relationship to be built that is often lacking in more formal interpreting methods. This method was particularly suitable for the focus group setting in the absence of a one-to-one relationship, where a relationship of trust needed to be quickly established.

A wealth of rich data could have been analysed, but the aim was to collect a rapid assessment of views that could be fed immediately into the planning process. Neither group interaction nor the negotiations that went on between participants were analysed, despite the value to qualitative research methods (Catteral & Maclaran 1997). However, information was available quickly and included in the broader feasibility study, which was examining a cooperative model for A&E services.

Discussion and implications

Rapid bilingual appraisal is useful for health services to meet equity, access and participation requirements, as well as in seeking the views of the community about how well services are meeting their perceived needs. It is even more useful for health services to start a dialogue with users who don't speak English, rather than just hearing the views of 'gatekeepers' who may have other agendas than reflecting the diversity of views of their community. As with all consultation processes, how the community views are then incorporated into health planning and resource decisions is difficult, but not peculiar to non-English-speaking communities. In terms of establishing and maintaining trust, clarifying this with participants beforehand is fundamental.

In the current environment of increasing diversity this rapid bilingual appraisal technique, combined with good workforce development, will assist health planners and managers to consult and develop services appropriate to the needs of their population.The key for health services is to recognise the need for consultation in languages other then English and to allocate appropriate resources and time to conduct such consultations. Where the issue is important and there are time considerations, the use of a skilled bilingual facilitator and interpreter for the English-speaking team is a minimum to allow real-time involvement in gaining views. The process is made much easier when skilled bilingual facilitators and interpreters are already employed and have been developed as part of the team. This study benefited from the fact that the Health Service had previously invested in bilingual staff, developing skills and expertise in both group facilitation and language proficiency. Long-term relationships had been developed within the communities that allowed for trust and excellent two-way communication. The roles of both interpreters and ethnic health workers had been clarified over time, and a good working relationship established between them. Many health services employ such staff, some on a sessional basis, others as permanent part-time or full-time employees. Their relationships and links with their communities are valuable resources for health services, which should be tapped into.

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Competing interests

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