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More than words can say; Why health and social care policy makers should reconsider their position on informal interpreters

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Abstract

In the UK, individuals with limited English-language proficiency (LEP) self-report poorer health and face challenges accessing health and social care support. Health and social care policies in English speaking countries provide practitioners with guidance that ensures access to public service interpreters for individuals who require them. The guidance simultaneously discourages the use of informal language brokers, including family and friends, suggesting that they are not educated or objective enough to conduct this role, and that they present unmanageable risks. This poses a challenge, as research exploring patient and service user choices, finds that individuals consistently prefer an informal language broker. The paper explores the contradiction between a legislative shift towards empowerment and choice within social work and the policies that restrict these rights in relation to interpretation. Exploring these challenges with a focus on policy and practice, leads to the suggestion that individuals should be empowered to choose who provides their language support. In contrast, existing policies increase the power imbalance between professionals and users of services, significantly affecting the life chances of those with LEP.

Key Words

Language minority, interpret, equality, empowerment, social work

Introduction

This paper will present arguments that challenge the preference in health and social care policy and practice for formal interpreting, and provide a counter narrative that promotes the recruitment of family and friends to the language broker role. This in no way means to devalue the important work conducted by professional interpreters, but to explore how the insistence on using these practitioners undermines statutory duties to respect the rights of citizens. In the UK, the term 'public service interpreter' (PSI) is used to refer to interpreters who have completed a graduate qualification in this subject and have registered with the

National Register of Public Service Interpreters (NRPSI), agreeing to their Code of Professional Conduct (National Register of Public Service Interpreters 2016 [online]). Throughout this article, 'formal' interpreting and 'professional' interpreting are used interchangeably to refer to public service interpreters, and the terms "language broker" and 'family and friends' to refer to the informal process of supporting language exchanges.

There is limited research about the use of interpreters in global health and social care settings, and that which does exist tends to focus exclusively on the views of professionals rather than considering the experiences of those requiring their services (Lucas 2016). This article draws on policy examples from England and the wider United Kingdom, however there are parallels with other English-speaking nations and the research literature is international in scope and impact.

In England, no national data is collated concerning the number of people using public services who need interpreters, the quantity and scope of minority language provisions or the number of bilingual practitioners using their language skills as part of their role (Lucas 2016). Despite this gap in the evidence base, some data is available via the UK Census (Office of National Statistics 2015). The Census revealed that 65% of individuals with self-reported LEP identified as having 'good health' compared to 88% of the English-proficient population (Office of National Statistics 2015) suggesting a correlation between LEP and poor health. Despite identifying a correlation, the Census data does not imply causation, and does not explore the composition of the UK's LEP population. Existing research (Merrell et al 2006; Durbin et al 2017; Pollock 2018) indicates that second language acquisition is intersectional in nature; in these projects the researchers identified that older minority ethnic women were less likely to speak English than older males or younger women from the same ethnic background. In addition, Pollock (2018) and Durbin et al (2017) reported the importance of socio-economic status as a contributing factor influencing second language acquisition with the latter describing individuals with LEP as 'commonly older and female with less education and more physical health comorbidities' (2017:495). It therefore appears that it is not necessarily the lack of English language that increases poor health, but a combination of associated factors such as socio-economic status, education, age and gender.

Alongside poorer self-reported health, Lucas (2016) identifies that these individuals are more likely to defer treatment, miss appointments, leave without advice and struggle to access

health and social care systems. These disadvantages are not limited to health care, as Chand (2005) and more recently Westlake and Jones (2018) report that within the field of child protection social work, families where parents had LEP were more likely to have concerns reported about them escalated even when no more risk was present, indicating that lack of shared language with professionals was deemed a risk in and of itself. Lucas (2016) frames this as language discrimination, reflective of the stigma associated with LEP and the invisible privilege of the English language. Preceding the Equality Act (2010) and The Care Act (2014), Forbat (2004) however, perceives this to be institutional racism. This author proposes that rather than conceptualising inequalities in service provision as numerous individual acts, services should be held accountable for creating and maintaining barriers to access. Services should take responsibility for their role in 'creating and sustaining abusive relationships' (2004:313) with people from minority groups through development and implementation of abusive policy, leading to abusive practice. Cross-Sudworth (2009) for example, outlines the increased risk of domestic abuse that minority ethnic women may face and explicitly associates this with religious practices. The article then bases its practical guidance for midwives working with minority ethnic families on this perceived correlation between religion and domestic abuse. Guidance such as that given by Cross-Sudworth over-simplifies these issues and perpetuates racist understandings of familial relationships. The current article follows Forbat's (2004) lead in challenging policies and practices based on racist assumptions in contemporary health and social care.

In order to counter the challenges presented to individuals with LEP in England, health and social care law and policy provide guidance for practitioners to ensure access to formal interpreters for those who require them. The Equality Act (2010) applies in England, Scotland and Wales and was implemented in order to provide protection from discrimination for individuals possessing 'protected characteristics'. These nine characteristics include 'race', religion or belief, sexuality and gender. The Act also outlines the Public Sector Equality Duty, which obligates public sector organisations to 'remove or minimise disadvantages suffered by people due to their protected characteristics' (Equality and Human Rights Commission 2019[online]). One way this has been interpreted into the practice environment is by recruiting the services of formal interpreters to support individuals with LEP, although this practice is not included in the law itself. The Mental Capacity Act (2005) applies to England

and Wales and ensures that the rights of individuals whose decision-making ability is questioned are upheld by the implementation of five statutory principles. Relevant here are the principles of 'all practicable help' and 'unwise decisions', which require professionals to provide any support necessary in order to enable individuals to make decisions for themselves and respect decisions made by individuals even when they deem their choices unwise. The Act itself includes no reference to interpreters but principle ten of the guidance asserts that 'it is often more appropriate to use a professional interpreter rather than to use family members' (Mental Capacity Act Code of Practice 2016:53).

In England, adult social care is guided by The Care Act (2014), which is underpinned by the 'well-being principle' establishing the individual as best placed to make decisions about their care. The corresponding guidance acknowledges the requirement to comply with The Equality Act when assessing individuals for support and identifies the services of formal interpreters as appropriate to fulfil this duty, asserting that 'it is not normally appropriate to use a family member or carer as an interpreter'. Social care law doesn't legislate against individuals nominating their own informal interpreter, however Manthorpe et al (2012), in their exploration of minority ethnic older people's well-being, report that some local authorities had attempted to implement a ban on this practice. Although this research precedes the Care Act, it suggests that the interpretation of law into local policy is also problematic.

Alongside equality and social care legislation, health policies also provide guidance to professionals working alongside individuals with LEP. In 2015 NHS England released the policy statement 'Principles for High Quality Interpreting and Translation Services' which outlined the expectation that interpreting services should be free, pre-bookable and provided in a timely manner. Principle four of the statement describes a 'personalised approach' to the provision of services, advising practitioners that 'the use of family, friends or unqualified interpreters is strongly discouraged in national and international guidance and would not be considered good practice' (NHS England 2015:5). The document continues to advise professionals that family and friends should only be relied upon in emergency situations. In 2018 NHS England again addressed use of interpreters in its 'Guidance for commissioners: Interpreting and Translation Services in Primary Care'. Based on the previous policy statement this paper explains the complex process involved for individuals who choose a

family member or friend to interpret for them during health appointments. The process requires the individual to provide written consent, ascertained by a formal interpreter without the identified person present, stating that they want the named family or friend to provide their language brokering. This is then documented in the individual's health records. Considering the oppression individuals with LEP are already experiencing, this process appears unnecessarily challenging.

These policies conflict with the right of individuals to make unwise decisions (Mental Capacity Act 2004) and define their own needs (Care Act 2014). The failure to follow uphold these rights can be seen by the way these policies heavily influence an individual's choices through their complex processes.

The policies described above do not explicitly deny people's right to choose their own interpreter, however they do strongly discourage this practice and consistently discredit the ability of family and friends to provide valuable support to their loved ones. The arguments for this strong commitment to formal interpreting include the questionable presumption that they can provide confidentiality and objectivity. In addition, concerns about safeguarding are referenced as rationale; again, this is refutable, and where concerns are evidenced, local authorities have a statutory duty to investigate further. These issues are connected by underpinning preoccupation with risk and power; where formal interpreters are employed, power is maintained by the professionals.

These concerns are further complicated by the involvement of private companies, who are now commissioned to broker interpreters to many public services. The opportunity to exploit existing local authority fears around blame, and to exaggerate risks contribute to the existing challenges for ethical and rights-based practice. In a recent article, a Capita marketing manager describes it as 'crucial' for health and social care services to recruit only 'qualified and suitably experienced' professionals (Davies 2016:3) despite no requirement for their interpreters to be registered with NRPSI. This is identified in a recent statement that outlines the lower qualification and experience requirements of the private organisation (NRPSI 21 August 2019 [online]).

Given the poorer health and social care outcomes associated with LEP, it is essential that the practice of utilising family and friends is reconsidered. This could ensure that rights enshrined in law are upheld. This relates not only to the conflict between these policies and the Mental

Capacity Act and The Care Act but also to the European Convention on Human Rights (ECHR) Article 2: the right to life. The ECHR is enshrined in UK law via the Human Rights Act 1998, and, amongst other things, it requires public authorities to consider an individual's right to life 'when making decisions that might put you in danger or that affect your life expectancy' (Equality and Human Rights Commission 2018 [online]). The evidence outlined above suggests that the life expectancy of those with LEP and associated disadvantages may be reduced by the challenges having LEP present when accessing support from health and social care.

Theoretical Influences on Current Policy and Practice

Despite interpreting practices dating back as far as migration itself (Mikkelsen 2012), community interpreting, defined as 'interpreting in an institutional setting of a given society in which public service providers and individual clients do not speak the same language' (Pochhacker 1999:127) was only established as a profession in 1995. There is little consensus in the interpreting studies field in relation to its theoretical underpinning or methodologies for researching practice. Attempting to clarify the contested role, Niska (2000) mapped the different understandings into a pyramid, with a 'conduit' role forming the large base of the hierarchy and the majority of the work; here interpreters provide a basic like for like exchange. Moving up the pyramid, the 'clarifier' role includes checking understanding where no like for like exchange is available and finding appropriate replacements. The 'culture broker' makes up a smaller part of the role and includes an expectation of filtering information to ensure its cultural suitability for the interpretee. Finally, at the top of the pyramid, forming the smallest part of the position, is the 'advocate' position, where interpreters feel obligated move outside of their interpreting task due to ethical challenges that arise requiring them to advocate for the interpretee. More recently Colley and Guéry (2015) have discussed the identity challenges this complex role raises for public service interpreters.

Much of the legislation and policy discussed above encourages the use of formal qualified interpreters, utilising the rationale that family and friends are not able to provide a professional service to their loved ones. This is a position supported by interpreting studies research that advocates the professionalisation of the discipline to reduce poor quality language support (Davies 2016, Mikkelsen 2012). The NRPSI require specific qualifications

and 400 hours of experience in order to be included in the register (NRPSI 2016) and agreement to follow the Code of Conduct is essential, therefore the aim here is not to discredit the valuable work of this profession.

The underlying inference here however, is that professionals are better at interpreting both because of their qualifications and experience, but also because of the requirement to be objective, corresponding with the conduit model described above, for example, point 3.12 of the Code states ‘Practitioners shall at all times act impartially...’ (NRPSI 2016:4).

Niska’s (2000) pyramid acknowledges that interpreting requires explicit subjective elements, including deciding to step outside of the role to advocate for an individual when they believe it to be necessary, which family or friends would arguably be much better placed to do. There is a substantial evidence base emerging that supports this understanding of professional interpreting (Temple & Edwards 2002, Ho 2008, Bramberg and Sandman 2012, Colley and Guéry 2015; Pollock 2018) thus undermining policy maker’s rationale for encouraging the provision of formal interpreters in health and social care interactions.

In response to these challenges, some researchers have proposed gender and ethnicity matching policies, which have been integrated into the NHS (2018) guidance. These are inappropriate and insufficient (Westake and Jones 2018, Temple and Edwards 2002) and undermine the intersectional nature of LEP; particularly in relation to socio-economic aspects of individual identity (Gunaratnam 2007). Research by Pollock (2018) lends support to the inadequacy of such practices, reporting users of services being described as ‘stupid’ and ‘illiterate’ by gender and ethnicity matched professional interpreters, in reference to stereotypes about the rural region they were born, in their country of origin. Indeed, friends or relations of the individual with LEP may actually be *better* placed to provide individualised language brokering, due to their understanding of the individual’s lived experiences, as Temple and Edwards refer to language as ‘tied to local realities’ (2002:3).

Practical challenges to the rejection of informal interpreters

Alongside the theoretical opposition to policy favouring professional interpreters, many of the practice-based objections to informal language brokering can be challenged. Davies (2016) identifies two main risks in relation to informal or unqualified interpreter use;

knowledge deficit risks and safeguarding and confidentiality risks. Knowledge deficit risks focus on the expectation that interpreters will have knowledge of the necessary terminology to explain complex diagnoses and interventions to those with LEP due to their qualifications and training, whereas friends and relations do not reliably possess such information. Davies (2016) draws attention here to the serious implications of misinterpreting diagnoses or medical instructions. In contrast, Flores et al (2003) reported no significant difference in frequency of errors in hospital settings between professional and informal language brokers, with the latter actually making *fewer* fluency errors. Extending this position, Ho (2008) in their USA based paper suggest that lack of subject specific knowledge can be seen as a positive factor, rather than a risk, as this means informal interpreters can clarify understanding. Additionally, Ho (2008) proposes that as relations and friends are more likely to understand the extent of the patient's knowledge base, they are better placed to tailor information to their needs, meaning they receive more individualised language support. This perspective is further supported as registered interpreters are not permitted to meet with interpretees prior to their interpreting duties commencing, so are less able to develop a relationship (NRPSI 2016).

Both NHS and social care policy, alongside Davis (2016) identify safeguarding and confidentiality concerns to rationalise the preference for formal interpreters. The suggestion here is that practitioners would not be able to safeguard LEP individuals against abuse or undue influence from family, if the individual raising cause for concern was nominated as the interpreter. Similarly, they would not be able to ensure the confidentiality of LEP patients or users of services if family or friends were involved in their language brokering during consultations where sensitive information was to be shared. Although safeguarding and confidentiality concerns are to be taken seriously, research from both the fields of interpreting studies and social work indicate that these issues are also present when using professional interpreters (Lucas 2016, Westlake and Jones 2018, Chand 2005, Bramberg and Sandman 2012). Bramberg and Sandman explored social work practitioner's experiences of using interpreters and identified that social workers felt that formal interpreters presented risks to confidentiality.

In relation to safeguarding, Ho (2008) acknowledges that informal interpreting may include an element of coercion or influence on LEP individuals, but also recognises this as individual

choice. Drawing on a rights perspective Ho presents LEP individuals as able to navigate their own complex relationships, and to make choices about the value they place on freedom of expression versus familial harmony. In England this right is upheld by the Mental Capacity Act (2005) principle of 'unwise decisions', which protects the rights of individuals to make choices that may appear to others as ill advised.

This is not to undermine the seriousness of safeguarding adults who are at risk of abuse. In England, The Care Act (2014) establishes the statutory duty for social workers to conduct safeguarding inquiries about those perceived to be at risk, where they have a need for care and support, and are unable to protect themselves from harm as a result. Although the individual at risk may, if they have the capacity to do so, choose not to engage with these inquiries, social workers may still, complete them if there is a risk to third parties. This duty must be exercised should practitioners judge it to be required, irrespective of whether an informal language broker or professional interpreter performs the interpretation.

The NRPSI Code of Conduct point 3.11 recognises the importance of confidentiality and has a disciplinary procedure through which complaints can be raised. Nevertheless, research indicates that the existence of this Code has not reassured individuals who require language brokers and there is still concern that professional interpreters will breach confidentiality. When interviewing older Pakistani women with LEP, Pollock (2018) found that their preference for family interpreters was in part a mechanism to protect their privacy. The women were from a town with a large Pakistani population and believed that professional interpreters were likely to be employed from within their community. They felt that this was a threat to their privacy, whereas a family member would be trusted to maintain confidentiality.

The arguments here are not to suggest that an informal interpreter is suitable for all interpreter mediated health and social care encounters, but that individuals have the legal right to make that choice, whether professionals agree or not, and that where there are concerns, existing statutory duties enable inquiries to take place.

Ethical challenges to the rejection of informal interpreters

In England and Wales, most health and social care professions are regulated, although social care workers are a notable exception; social work is a registered profession with a protected title, regulated by Social Work England (see Association of Social Work Boards for American state dependent regulations, Australian Association of Social Workers for voluntary registration and McCurdy et al 2018 for a discussion of the current Australian practice requirements). Nursing in the UK is regulated by the Nursing and Midwifery Council, and the General Medical Council provide this function for doctors across the UK. Each regulatory body has its own code of conduct and ethics, requirements for re-registration and continuing professional development.

In comparison, it is not compulsory for professionally qualified public service interpreters to register with the NRPSI, nor are public bodies legally required to recruit registered interpreters to provide language brokering services. Further, the introduction of competition into the public service interpreting field has led NRPSI to outline the less stringent registration requirements of private providers such as CAPITA, including lower qualification and experience thresholds (NRPSI 2019 [online]). Drugan (2017) identifies the lack of compulsory ethics training and support, supervision or continuing professional development activity as a concern, particularly given the policy preference for their use. The implications being that professional interpreters can be ill-equipped for the difficult and complex circumstances they are expected to navigate whilst mediating interactions. It is a concern then, given these issues, that the CAPITA website boasts of working with many NHS trusts (CAPITA Translation and Interpreting 2018 [online]).

In this context, Edwards et al (2006) discuss the level of trust expected from individuals when utilising a professional interpreter. As previously discussed, those individuals with LEP are more likely to be in poor health, older, female, and from lower socio-economic backgrounds than the general population (Merrell 2006; Office of National Statistics 2015; Lucas 2016; Durbin et al 2017; Pollock 2018). When communicating with health and social care services, in the context of this disadvantageous position, individuals are then expected to trust an interpreter, recruited by the organisation, with their welfare. The interpretee holds little power in this exchange, as they are unable to check the accuracy of the information they receive. Here Tipton (2010) appropriately describes this process as a 'leap of faith' on behalf

of the individual, leaving them feeling vulnerable and at risk of being further oppressed, incongruous with the underpinning principle of well-being outlined in the Care Act 2014.

Edwards et al (2006) present two separate forms of trust; personal trust, born from stable commitments and long-term relationships, and abstract trust, based on the presumed competence of the individual to be trusted. They suggest that where professionals see LEP individual's choice of relations or friends to provide interpreting support as uninformed decisions, they are actually expressing a preference for personal trust over abstract trust. Trust is also recognised as an issue for social workers, who acknowledge the difficulty in gaining trust and relationship building with the families they supported when a formal interpreter was required (Bramberg and Sandman 2012), referring to the loss of important non-verbal elements of communication that build trust when using professional language brokers (Lucas 2016).

Trust can be seen as a key element of cultural safety (Ho 2008), which Ho refers to as important to the identity of individuals with LEP. This international research supports the understanding that informal interpreters offer more than just language brokering, they help to address the power imbalance in the relationship between professional and recipient. The intersectional nature of second language acquisition (Merrell 2007) means that users of services are often experiencing multiple disadvantages, and therefore the presence of a chosen relation or friend could contribute to rebalancing this inequality. Pollock (2018) reported that individuals felt protected by the presence of a family member who, in the face of previous poor health and social care experiences, they felt could ensure that professionals were responsive to their needs, as well as fulfilling the interpreting role. She found that individuals with LEP often chose a more privileged relation or friend to perform this combined interpreter/chaperone role, meaning they felt more able to challenge perceived injustices in treatment (Pollock 2018).

The current legislative context of adult social care in England is framed by The Care Act (2014) and its underpinning principle of 'well-being'. Section 1 of this Act outlines the need to include people in decisions about their own well-being, recognising 'the importance of beginning with the assumption that the individual is best-placed to judge the individual's well-being'. The duty to consider people's rights, wishes and feelings should surely extend to include an individual's right to choose who supports their communication. Health and social

care professions, and particularly social work, are grounded on values of honesty, empathy, trust and integrity (Banks 2012) but policies that promote professional interpreters to the detriment of family and friends do not fit this narrative. In contrast, these policies are premised on the discriminatory assumption that families cannot be trusted with the task of supporting one another, that they are not knowledgeable enough and that they have something to hide or pose a risk to their loved ones. In addition, the denial of familial support may be contributing to the failure of health and social care services to provide effective services to individuals with LEP, hence the poorer health outcomes they face. Although policies in some other English-speaking nations recognise the importance of relational support during health and social care interactions (National Institute on Aging 2017 [online]), in the UK this is only condoned once the individual has given their permission via their doctor, or if there are serious mental health concerns. It appears that although family and friends may be able to accompany individuals with LEP to their appointments, there is a restriction on the support they are allowed to offer, meaning the power remains with the professionals.

Discussion

The theoretical, practice based and ethical challenges to current policy that restrict an individual's right to choose their friends or family to interpret for them require addressing. The increase in people living into older age means an increased health and social care need across populations (Government Office for Science 2016), but the poorer health outcomes for individuals with LEP means the issue is more pertinent for this group.

A number of recommendations have previously been made to address the challenges that arise from the use of interpreters in health and social care interactions. Westlake and Jones (2018) propose four recommendations for health and care practitioners when engaging with formal interpreters; clarifying misunderstandings, involving service users in 'small talk' to promote relationships building, ensuring that reflective statements are interpreted and using an individual's native language only, even when they have some English language skills. In addition, Drugan (2017) suggests providing specific training for social workers on how best to work alongside professional interpreters, presenting data that indicate improvements in interpreter-professional relationships as a result of such training. This was also suggested by Alexander et al (2004) in research conducted on behalf of the Joseph Rountree Foundation,

although has received little attention since this time. These recommendations are all viable however they all focus on improving support based on the current policy assumption that family and friends are not able to undertake the role when, if considered, each suggestion could equally be used to facilitate informal interpreters to provide such support. The provision of training and support to family and friends, where appropriate, could build on their existing ability, as evidence already suggests that they make fewer errors (Ho 2008), are preferred by individuals with LEP (Pollock 2018) and feel a sense of achievement by providing support to their loved ones (Green et al 2005). The strengths of this approach could counter the superior interpreting skills possessed by professional interpreters. Additional training could enhance these skills further whilst simultaneously providing much needed relief to the stretched interpreting workforce (Manthorpe et al 2012).

The position that objectivity is both achievable and desirable is contested and our ability to interpret our experiences is dependent on utilising existing systems of representation or discourses learned via interaction with our environments and those around us (Burr 2003, Hall 2013). Therefore, from this perspective, whoever interprets interactions must call on their own subjective understanding of the world in order to make sense of what is to be interpreted. Lending from qualitative research methods (Riessman 2008, McLaughlin 2012), we can see that approaches that acknowledge the triologic nature of interpreted interactions can facilitate a more holistic understanding of the individual. For health and social care interactions, this can mean a more thorough understanding of the presenting issues. Riessman (2008:46) explains that investigators 'can include themselves and translators as active participants in knowledge production'. From this perspective, the interpreter plays an active role in co-constructing the information that is generated in consultations. Here then, it must be considered whether a family member or friend, chosen by the individual themselves, is more appropriate to participate in this co-construction. Where they may not have high levels of medical or social care knowledge, these informal interpreters have more in-depth knowledge of the individual's lived experiences. The addition of familial support may also address racist assumptions about dangerousness and risk inferred onto this population as outlined in the introduction of this article (Forbat 2004 and Cross-Sudworth 2009).

When offered the choice, people with LEP choose a close family member or friend to interpret for them over a professional interpreter (Temple & Edwards 2002, Edwards et al 2006, Pollock

2018). Often the chosen person had attended multiple appointments with the individual, and in many instances either lived with them or in the same geographical area and already provided informal care (Pollock 2018), they therefore had a better understanding of how health and care needs affected their daily lives. A triad including this nominated person is likely to generate a more useful and individualised co-constructed narrative than recruiting a professional who may never have met the individual before. They are more likely to have developed shared understandings of the person's health and care needs, along with shared cultural identity (Jenkins 2013) and systems of representation (Hall 2012). This approach fits with health and social care theories, for example ecological theories that encourage practitioners to consider the relationships and connections that users of services have with other key figures in their lives (Gitterman and Germain 2008). The Care Act 2014 recognises the importance of understanding the person in the context of their family, and this principle now needs to be extended to interpreter mediated exchanges.

Health and social care research involving people with LEP has proposed to address this theoretical challenge by employing ethnicity and gender matching between interpreter and participant. For example, Papadopoulos and Lees (2002) advocated ethnicity matching, suggesting same-ethnicity researchers would have a better cultural understanding of participants. Guneratnam (2003) is highly critical of this approach, as it fails to acknowledge the power relations inherent in participant-researcher interactions and doesn't address the intersectional nature of LEP. Being employed in a professional role can indicate increased socio-economic position, good health and the status that comes with these privileges. In addition, such approaches remain focussed on improving interactions using professionals rather than considering family or friends for this role, maintaining the imbalance of power in the professional-service user relationship. It is therefore important that this technique is not transferred from research into health and social care practice.

There are of course instances where it may not be appropriate for a relation or friend to provide language support despite their theoretical suitability. The duty to safeguarding adults has been enshrined in law in England with the introduction of The Care Act 2014 (HMSO 2014), which includes duties to conduct inquiries where individuals with care and support needs are thought to be unable to protect themselves from actual or suspected abuse. Clearly there is opportunity for coercion to go unnoticed where there is a language barrier. However,

it is crucial that the lack of shared language with professionals is not, by itself, assumed to indicate a heightened risk (Westlake and Jones 2018, Chand 2005), and that assumptions of abuse or coercion are not racially motivated. Section 42 of the Care Act imposes statutory duties on local authorities to make safeguarding inquiries where an individual has care and support needs and is, as a result, unable to protect themselves from harm. In order to establish whether action is needed an inquiry can be conducted even if an individual with capacity does not wish to engage in the process. Although the 'making safeguarding personal' agenda promotes the individual's centrality in the safeguarding process (Gollins 2016), this does not override the statutory duty to act, therefore existing legislation can protect those with LEP, irrespective of their choice of interpreter.

New interprofessional approaches within health and social care services are embracing this interpretation of the wellbeing principle (see Pollock et al 2018 for discussion of family group conferences and Partners 4 Change 2017 for discussion of Three Conversations model) and ensuring the individual's voice is heard. It appears incongruous with this move towards a more social model of practice, for interpreting policy to disregard user's preferences, and patronising to imply that these preferences are 'uninformed and inappropriate' (Edwards 2006), reflecting a more medical approach, with the professional assuming 'expert' status. Slasberg and Beresford (2017) have already suggested that the move to strengths-based approaches is a strategic position, in line with neo-liberalism, to reduce spending rather than a value-based initiative to empower users of services. The failure to address this imbalance of power even where there is a legal right to choice, adds to this evaluation of current practice. Alternatively, adopting a strengths-based approach, guided by individuals' own understanding of their needs and how to meet them, including promoting people's rights to choose who supports their communication needs, is more in line with the current legal framework.

As previously stated, a key principle of the Mental Capacity Act (2005) is an individual's right to make unwise decisions. This means that even in cases where there are safeguarding concerns, adults with capacity to choose their own interpreter should be empowered to do so, with practitioners respecting individual's choice to value familial harmony over their individual well-being. In turn, local authorities could utilise their statutory duty to conduct inquiries, as described above, should they see cause for concern. As Ho (2008) suggests, a

person-centred approach to interpreting should be adopted, where decisions around who is best placed to provide language support, are negotiated in discussion with the individual and their family. By discussing the challenges openly with those involved, practitioners are using their professional values to ensure open and honest interactions, which in turn supports the development of personal trust, as described by Edwards (2008).

In England, social care services are not legally obliged to recruit interpreters that are registered with the NRPSI (Lucas 2016), and NHS Trusts are frequently opting to use private organisations who have adopted less stringent criteria for practice than public service interpreters have traditionally been required to meet (NRPSI 2019 [online]). There is however, growing pressure from policy not to rely on informal alternatives. In addition, there is increasing emphasis on the risk aspects of utilising such informal systems, especially from those set to benefit from the professionalisation of this role. Multinational organisations such as CAPITA now provide brokering services (Davies 2016) who charge a fee to supply interpreters to health and social care providers. This is a concern identified by NRPSI (2019) as the marketisation of such a service must not be at the cost of an individual's choice, well-being or health. This issue is not restricted to interpreting, but to racial discrimination and inequality more broadly. Wroe (2019) describes contracting of multi-nationals such as CAPITA as responsible for 'creating a hostile environment for migrant and non-migrant individuals and families alike' (Wroe 2019). The involvement of such organisations in working towards racist targets compounds the intersectional disadvantage associates with LEP and is a practice that must be challenged. This is particularly relevant given Forbat's (2004) exploration of institutional racism.

Recommendations

There is a dearth of research internationally relating to informal interpreters (Drugan 2017, Mikkelson 2012), however the limited available evidence suggests that family and friends commit fewer fluency errors than professional interpreters when interpreting information in health and care settings. Furthermore, there is no legal reason preventing them from performing this role, and theoretical arguments based on a preference for objectivity are flawed. Rather, the use of formal interpreters maintains a power imbalance between the individual with LEP, who is likely to be experiencing intersectional oppression, and two

privileged professionals; the power in these interactions lies with the professionals. Where family members are able to accompany individuals to appointments, their role is restricted. In their research, Green et al (2005) identify that health practitioners encouraged formal interpreters to persuade patients of one particular course of treatment over another, therefore evidencing their ability to exert their power. NRPSI registered interpreters are required to adhere to their Code of Conduct (NRPSI 2016) however there are a growing number of private organisations competing for health and social care contracts, who are not required to adhere to this code. In addition, Colley and Guéry (2014) identified occasions where NRPSI registered interpreters felt unable to adhere to the Code's requirements. This is an increasing concern, as the commissioning out of interpreting services to multi-national organisations known to militate against professional ethics (Wroe 2019). Even where regulatory bodies ensure registered professionals adhere to a code of conduct, individuals with LEP do not always experience their care in this way (Pollock 2018).

It is acknowledged that using informal interpreters is not always appropriate, but in light of the evidence presented here, it is proposed that rather than dismissing and discrediting family and friends as incapable of performing an interpreting role, there should be a move towards engagement and training with willing relatives and friends. In England the introduction of strengths-based approaches to working with individuals, and the privileging of people's own perspectives on how best to meet their needs via the Care Act 2014 is well placed to support this position, as does the increase in rights-based approaches to practice.

Drugan (2017) provided training to social workers, educating them on how to work with professional interpreters to better support individuals with LEP, and found that these triadic interactions improved as a result. This training could also be provided to family and friends who wish to take on interpreting roles for their family alongside the social workers who work with them, in order to support their existing knowledge and skills. In turn this could also improve trust between professionals, users of services and their families, which facilitates better outcomes for those requiring support. Again, this is not to suggest that informal language brokerage will always be suitable, but as Ho (2008) suggests, a decision could be made on a case by case basis, with informal interpreters and practitioners drawing up a mutually agreeable contract outlining their expectations of the role.

Moreover, the abundance of policy that undermines the ability of family and friends to provide language support needs to be addressed. It is clear that professional interpreters have a high level of skill relation to multiple language interactions and often have substantial knowledge of medical terminology, however, relations of individuals with LEP also have valuable skills and knowledge about their loved ones and the impact of their health and social care needs on their daily lives. For those that are willing to undertake this role, it should be a viable option.

Conclusion

Language support in health and social care is currently provided to individuals with LEP by formal interpreters employed by the organisations they encounter, these organisations are increasingly encouraged to commission this role out to multi-national corporations (Davies 2017). There are theoretical, practical and ethical challenges to this method that undermine the positivistic understanding of interpreting as an objective task and acknowledge its constructed nature. Research evidence indicates that individuals with LEP prefer their relatives and friends to provide language support and feel that they are protected from both poor practice and confidentiality breaches by utilising their loved ones in this role. The values of respect and empowerment that are promoted in professions such as social work via The Care Act 2014 in England, and other legislation and policy internationally also guide us to support service user choice and control over how their needs are met. Therefore, it is argued that providing training and engagement activities to willing family and friends, underpinned by policy that accepts this new position should be considered. It is not suggested that this should replace existing mechanisms for interpreting as there is undoubtedly an important role for qualified interpreters, but the privileging of formal language support should not be at the cost of user choice. There needs to be an emphasis on user and carer experiences when researching interpreting in the health and social care field, to support a change in the current policy and practice direction.

Drugan (2017) has already noted the success of providing training to professionals working with formal interpreters, therefore following this model with family and friends and evaluating the experience, would establish an evidence base to support more inclusive future policy in this field.

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