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 under-qualified parties. It is not 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 as a result of governmental commission and omission in South Africa would be reproduced in the area of language services in health care. Larger political changes and black languages becoming official create a climate more favourable to redressing service inadequacies.

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 fulfilled 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 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 (%)

<table>
<thead>
<tr>
<th>Category</th>
<th>C23 Male (Oct)</th>
<th>Male Forensic (Nov)</th>
<th>Female</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional nurse</td>
<td>34</td>
<td>81</td>
<td>47</td>
<td>53</td>
</tr>
<tr>
<td>Staff nurse (SN)</td>
<td>29</td>
<td>10</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>General assistant (GA)</td>
<td>7</td>
<td>4</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Student nurse</td>
<td>-</td>
<td>9</td>
<td>-</td>
<td>14</td>
</tr>
<tr>
<td>Interpreter</td>
<td>-</td>
<td>31</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Family</td>
<td>15</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>15</td>
<td>5</td>
<td>2</td>
<td>27</td>
</tr>
</tbody>
</table>

* * 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 14 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, 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 interpreters are screened for linguistic competence and provided with training for the
Hepatitis B infection in black children from residential care facilities in KwaZulu-Natal

Implications for adoption and foster care


Objectives. A study was undertaken to assess the prevalence of hepatitis B infection in selected residential child care facilities in Natal.

Design. All residents at three facilities in the Durban and Pietermaritzburg areas of KwaZulu-Natal were tested for markers of hepatitis B infection as part of a broader health status assessment.

Results. One hundred and ninety-five children between the ages of 3 and 194 months (78 ± 47) were studied. Overall 66.2% of children had evidence of past exposure to hepatitis B virus. Of these 14.9% were positive for hepatitis B surface antigen, 13.3% for hepatitis B e antigen, 47.7% for hepatitis B surface antibody and 59.5% for hepatitis B core antibody. Relative rates of infection increased with age from 18.2%, 20% and 27.8% in the 1st, 2nd and 3rd years of life respectively to 72.2% and 88.2% in the 4th and 5th years of life. Relative rates of infection increased with duration of stay from 40% by the end of the 1st year to 100% by the end of the 5th year.

Conclusions. This study has demonstrated a very high rate of infection with hepatitis B virus and a high prevalence of hepatitis B surface antigenaemia in residential care facilities. It has also shown that the infection is horizontally transmitted within these facilities, that infection increases with duration of stay, that there is a dramatic increase in infection rates after the 3rd year of life, that the highest carrier rates are occurring in children between the ages of 2 and 4 years, and that the vast majority of carriers are highly infectious.

REFERENCES


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