

“The conversation wouldn’t happen without us”: How interpreter involvement affects dementia service delivery for CALD clients in Australia

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Research Article

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Abstract

Background

Successive migration to Australia has produced an ageing population with diverse language needs, making interpreter-mediated communication important in dementia care. This study examined how interpreter involvement was perceived to shape service delivery for culturally and linguistically diverse (CALD) people living with dementia, from the perspectives of certified interpreters, health practitioners, and caregivers.

Methods

This Australian cross-sectional qualitative study analysed 64 interpreter questionnaires, 17 health practitioner questionnaires, and semi-structured interviews with 11 health practitioners and 12 caregivers. For this article, data from all three cohorts were re-analysed as an integrated corpus using inductive reflexive thematic analysis informed by constructivist grounded theory sensibilities, including constant comparison and memo-writing.

Results

Four interrelated themes described participants' perceptions of interpreter involvement as: (1) a condition for clinically workable and ethical consultations; (2) strengthened or constrained by interpreter positioning as either a recognised partner or a "talking machine"; (3) organised through availability-led hierarchies that prioritised family members or bilingual staff as substitutes, thereby reshaping accuracy and whose voice anchored the encounter; and (4) specialised dementia work in which cognitive and sensory changes and the limited cultural and linguistic portability of assessment tools created validity risks.

Conclusions

Participants perceived that interpreter involvement could support communication, direct participation, and the interpretability of assessments when it was timely, appropriately prepared, and aligned with clinical roles. The findings suggest service design priorities for Australia and generate propositions for other migrant-receiving health systems; their effects on clinical outcomes require evaluation.

Background

Dementia care relies on communication: symptoms are described, risks are negotiated, consent is sought, and care plans are coordinated through talk. For CALD people living with dementia, however, communication is frequently compromised by limited English proficiency, dialect differences, and

culturally bound ways of describing cognition, mood, and behaviour [1–5]. Interpreter involvement is therefore not simply a practical accommodation; it is a core mechanism through which equity, safety, and ethical dementia care can be enacted.

These communication challenges reflect a broader consequence of globalisation. International migration and population mobility have increased the linguistic and cultural diversity of health systems, while ageing migrant populations are bringing this diversity into dementia assessment and long-term care. Dementia services in migrant-receiving countries must therefore adapt communication practices, care models, and cognitive-assessment processes that were often designed around dominant-language populations [1, 2, 4]. In this context, professional interpreting is not merely a local accommodation but part of the health-system infrastructure required to respond equitably to cross-border mobility and linguistic diversification.

Australia provides a useful setting in which to examine the intersection of migration, ageing, and dementia care. At 30 June 2025, 8.8 million residents (32.0%) were born overseas [74]. Among Australians aged 30 and over who reported dementia in the 2021 Census, 25% were born in a non-English-speaking country. Among people reporting dementia whose main language spoken at home was not English and who had arrived at least 15 years earlier, 52% reported speaking English “not well” or “not at all” [75]. These estimates describe differently defined populations, and Census reports of dementia have limitations; they are not measures of interpreter demand. They do show why country of birth or length of residence cannot, by itself, establish a person’s language needs. Australia’s successive migration waves have also produced older communities with varied languages and care expectations. The National Dementia Action Plan 2024–2034 recognises language access, culturally appropriate services, and the suitability of assessment tools as priorities [76]. In this context, interpreter needs may recur across diagnosis, treatment, and ongoing aged-care encounters rather than arise only at first contact.

Despite policy support for professional interpreting in Australian health settings (e.g., state procedures and the availability of telephone services) [6–8], interpreter involvement is often uneven in practice. Clinicians and services frequently rely on family members, bilingual staff, or ad hoc tools because they are immediately available, perceived as faster, or easier to arrange, even when professional interpreters are regarded as the safer and more accurate option [9–12]. This substitution can be consequential in dementia care: it may shift the focus of communication away from the person with dementia to an English-speaking relative, filter sensitive information, or create role conflicts in disclosure and decision-making [1, 2, 13].

At the same time, interpreter involvement is not a uniform good. Its effects depend on how interpreters are positioned in the encounter (as a neutral conduit, cultural broker, advocate, or collaborative partner), the modality used (in-person, telephone, or video), and the extent to which clinicians and services support preparation, continuity, and appropriate working conditions [1, 4, 14–16].

Literature review

Interpreter involvement is widely recognised as fundamental to safe and equitable care for people with limited English proficiency, particularly when clinical communication is complex, sensitive, or linked to consent and decision-making. Across health contexts, professional interpreters are associated with improved communication, care quality and patient satisfaction, whereas ineffective communication increases the risk of misunderstanding, misdiagnosis, and inefficient or delayed care [17–22]. In dementia settings, these stakes intensify because assessment and care planning are highly language-dependent and often emotionally charged, requiring careful explanation of diagnosis, prognosis, risk, and support options.

Research in dementia-related assessment contexts highlights strong agreement among stakeholders that professional interpreters support clearer communication and safer practice. For example, work examining interpreter-mediated cognitive assessment has identified the importance of professional interpreters, variable perceptions of interpreter roles, clinicians’ reduced sense of control in assessments, and dementia-specific challenges linked to cognitive testing [23]. These findings sit alongside broader evidence that interpreter-mediated assessments can be feasible via alternative modalities: video-interpreting has been reported as reliable for instruments such as RUDAS and the Geriatric Depression Scale and may reduce costs compared with face-to-face provision [24]. Other research in neuropsychology similarly emphasises that interpreter-mediated assessment is often necessary to avoid biased results when testing occurs in a patient’s non-native language, while also warning that interpreter-mediated assessment introduces clinical and diagnostic dilemmas, including time burden, variable training, and limited validation of instruments for interpreted administration [4, 23, 25–32].

Although professional interpreters are positioned as best practice, interpreter involvement in routine care is often inconsistent. Multiple studies describe how clinicians’ decisions are shaped by the perceived value of communication relative to time constraints, uncertainties about when an interpreter is necessary, and practical barriers in arranging services [10, 33].

In settings with frequent, unscheduled interactions—common in aged care and dementia support—telephone access delays, booking complexity, and inconsistent interpreter availability can make routine interpreter involvement difficult to sustain [11, 34]. These constraints contribute to a familiar hierarchy of substitution: family members, bilingual staff, and ad hoc tools are often used first because they are readily available, while professional interpreters are used later or only after other strategies fail [12, 13, 35].

Substitution practices are not neutral. Family members may be trusted, offer relational comfort, and help with continuity, but they may also filter, omit, or reshape information, hold their own agendas, or shift the encounter into a family–clinician exchange that sidelines the person with dementia [36–40]. Even where patients prefer family for privacy or trust, guidelines commonly caution against relying on family interpreters for complex, sensitive, or consent-related discussions [6, 41]. Bilingual staff can support

simple low-risk communication but are generally not recommended as substitutes for complex decision-making conversations [42]. Meanwhile, translation technologies may assist in limited low-risk situations, but concerns remain about accuracy, clinical risk, and suitability in complex care, particularly when cognitive impairment and sensory issues are present [11, 43].

A persistent tension in the literature concerns whether interpreters should operate as neutral conduits (“word-for-word” transfer) or as active contributors who facilitate understanding by conveying meaning, pragmatics, and culturally specific context. While many clinical expectations privilege neutrality, research shows that interpreters frequently adopt additional roles—conversational facilitator, cultural facilitator, experience facilitator, cultural broker, or patient advocate—often on an “as needed” basis and within perceived professional boundaries [16, 44, 45]. Role ambiguity may also be reinforced by institutional hierarchies that limit interpreters’ ability to adopt particular roles [46], and by clinicians’ limited training in triadic communication [47, 48]. Interprofessional education and structured practices such as briefing and debriefing have therefore been recommended to align expectations, clarify roles, and improve communication quality [4, 49–52].

Continuity of interpreter provision is often presented as good practice for ongoing care because it reduces repeated rapport-building and supports trust [14, 53]. However, continuity can also increase emotional load and stress for interpreters in some contexts [54]. In dementia care—where familiarity, reduced anxiety, and stable routines can support participation—continuity and relational competence may be particularly important, yet are difficult to achieve under constrained interpreter supply and scheduling systems [34]. Overall, the literature shows that interpreter involvement can improve communication, safety, and person-centredness, but its benefits are frequently undermined by availability-led systems, substitution practices, contested role expectations, and dementia-specific assessment challenges. What remains underdeveloped is integrated evidence that brings together interpreters’, practitioners’, and caregivers’ perspectives to explain how interpreter involvement reshapes dementia service delivery in real-world settings. Addressing this gap is essential for designing service models that do not merely provide interpreters, but make interpreter involvement reliable, collaborative, dementia-informed, and oriented toward preserving the voice and agency of CALD people living with dementia.

Although empirically situated in Australia, this study addresses the globalisation-related question of how migrant-receiving health systems respond to linguistic diversity generated by international population mobility. It examines the organisational and relational mechanisms through which interpreter involvement enables or constrains equitable dementia care and considers their relevance to other linguistically diverse health systems.

Methods

Study design and methodological orientation

This paper reports findings addressing the research question: “How does interpreter involvement affect service delivery in dementia settings?” It formed part of a broader cross-sectional qualitative project conducted in Australia between July 2024 and March 2025 that examined language-related barriers experienced by culturally and linguistically diverse (CALD) people living with dementia and their caregivers when accessing interpreter-mediated health services.

A cross-sectional qualitative design was used, informed by a constructivist grounded theory (CGT) sensibility [55] alongside inductive reflexive thematic analysis (RTA) [56, 57]. CGT principles—particularly constant comparison, attention to context and process, and memo-writing—supported analytic development, while RTA provided a systematic framework for generating themes grounded in participants’ accounts.

For this article, all data relevant to the research question were re-analysed as one integrated corpus comprising interpreters, health practitioners, and caregivers. Participant role and data source were retained during analysis so that cross-cohort convergence and divergence could be examined rather than erased. This enabled identification of patterns that cut across role positions and illuminated how interpreter involvement shapes dementia service delivery as a co-produced practice within clinical encounters and service systems.

In this article, migration provides the Australian population and service context for language-discordant care. The analysis compares the accounts of the three participant cohorts; it does not compare migrant with non-migrant patients or estimate effects of migration status, time since arrival, or visa pathway on dementia care.

Participants and recruitment

Three cohorts were included to capture multiple perspectives on interpreter involvement in dementia care: NAATI-certified interpreters with experience relevant to health settings (including dementia-related work), health practitioners involved in (interpreter-mediated) dementia-related care across disciplines, and caregivers of CALD people living with dementia, comprising informal family caregivers and a smaller number of formal care workers. Recruitment was conducted through national and sector organisations and professional networks relevant to dementia care and interpreting (e.g., Dementia Australia, NAATI, AUSIT, FECCA) using volunteer and purposive sampling, with organisations asked to circulate study information through their channels to reach eligible participants.

In total, 81 interpreter questionnaires and 28 practitioner questionnaires were received. After excluding incomplete responses (17 interpreter and 11 practitioner questionnaires), 64 interpreter and 17 practitioner questionnaires were retained for analysis. Semi-structured interviews were also conducted with 12 caregivers (4 formal and 8 informal) and 11 health practitioners, and these interview data were included in the integrated analysis.

Data collection

Data were collected using a mixed qualitative approach across cohorts. Interpreters completed an online questionnaire that included demographic items and open-ended questions about interpreter involvement in dementia contexts, challenges in interpreter-mediated encounters, and perceived effects on service delivery. Health-practitioner data comprised 17 retained questionnaires and 11 semi-structured interviews. The questionnaires captured demographics, interpreter-related experiences, and exposure to relevant training, while the interviews explored interpreter use in dementia care, perceived impacts on assessment and care processes, and service-level constraints shaping interpreter involvement. Caregivers took part in semi-structured interviews focusing on their experiences accessing dementia-related health services, navigating different interpreting options (professional interpreters, family members, bilingual staff, and ad hoc solutions), and how these forms of interpreting influenced communication, decision-making, and the participation of the person living with dementia.

Interview guides were semi-structured to support consistency while allowing participants to prioritise the issues most salient to them. Interviews were conducted primarily online via Microsoft Teams, with some conducted in person when participants experienced technological barriers. Interviews lasted between 23 and 90 minutes. With participants' informed consent, all interviews were audio-recorded and transcribed for analysis.

Ethics approval and consent to participate

The broader research project, including the present study, received ethical approval from the RMIT College Human Ethics Advisory Network (CHEAN) on 12 September 2023 (project number 26203). All participants received information about the study and provided informed consent before participating. Participant confidentiality was protected through de-identification. Quotations were attributed using role-based identifiers for interpreters (I), health practitioners (HP), and caregivers (CG), and personally identifying information was removed.

Data analysis

Analysis followed an inductive reflexive thematic analysis process, supported by constructivist grounded theory sensibilities. First, the researcher became familiar with the data by reading and re-reading all extracts across cohorts as a single integrated dataset. Initial coding then focused on the effects and mechanisms of interpreter involvement, including the feasibility of communication, assessment interpretability, participation and voice, relational impacts, and system constraints shaping interpreter use. As analysis progressed, constant comparison was used to examine codes and emerging ideas across cohorts, enabling the identification of cross-cutting patterns as well as divergences in how interpreters, practitioners, and caregivers made meaning of interpreter involvement.

Codes were subsequently clustered into candidate themes, which were iteratively reviewed against the dataset, refined for coherence, and defined to capture both the mechanisms through which interpreter

involvement shaped dementia service delivery and the conditions that amplified or constrained its impact. Analytic memos were maintained throughout. Memo-writing was also used to trace relationships among conditions, actions/interactions and consequences and to refine the emerging process of conditional integration. Bracketing was used as a reflexive strategy [58] to monitor how prior assumptions—such as the expectation that professional interpreters are always the preferred pathway—might influence interpretation. These reflexive notes helped preserve participant-defined benefits and risks across both professional and family interpreting pathways, rather than treating departures from policy or professional norms as analytic noise. Relevant literature was consulted after theme development to contextualise the inductively generated findings and was not used as an a priori coding framework.

Results

Analysis of questionnaire items and interview extracts generated four interrelated themes describing how interpreter involvement was perceived to shape dementia service delivery. Rather than representing separate cohort accounts, the themes capture cross-cohort mechanisms operating across interpreter-mediated encounters: making communication clinically workable, positioning interpreters within care teams, organising access through availability-led hierarchies, and managing dementia-specific communication and assessment demands. Table 1 summarises these mechanisms, their enabling and constraining conditions, and their relationship to relevant literature.

Table 1. Integrated mechanisms through which interpreter involvement shaped dementia service delivery

Integrated theme	Principal mechanism	Enabling conditions	Constraining conditions and consequences	Related literature
1. Interpreter involvement as a condition for workable dementia care	Enables reliable communication, supports difficult conversations, and affects whether the person with dementia is directly addressed	Complete transfer, emotional sensitivity, professional independence, and direct communication with the client	Partial transfer or family-only mediation may filter information, burden relatives, or displace the client's voice	[17–23, 36–41]
2. Interpreter as “talking machine” or team member	Professional recognition influences whether linguistic, cultural, and interactional knowledge enters care	Team inclusion, shared role expectations, briefing and debriefing, and joint training	Instrumental positioning and role ambiguity can remove clinically relevant context or create concerns about overstepping	[15, 16, 44–52]
3. Availability-led hierarchies	Logistics and service organisation influence who carries communication in practice	Embedded booking pathways, sufficient time, appropriate modality, quiet environments, and a sustainable workforce	Booking difficulty, shortages, time pressure, and non-attendance encourage substitution by family, bilingual staff, or ad hoc tools	[10–13, 33–43, 69, 70]
4. Dementia-specific interpreter work	Cognitive and sensory changes and the limited portability of assessments make dementia interpreting specialist work	Dementia knowledge, continuity, assessment protocols, and culturally and linguistically appropriate tools and modality	Unclear speech, cueing, culturally unfamiliar test items, and interpreter turnover create risks for assessment interpretability and trust	[4, 23–32, 53, 54, 64–67]

Theme 1: “The conversation wouldn’t happen without us” – Interpreter involvement as the condition for workable dementia care

Across cohorts, interpreter involvement was framed as more than a practical accommodation. Participants described it as a condition through which otherwise fragmented communication could become clinically usable, ethically manageable, and more directly oriented towards the person living with dementia. The three subthemes show how this occurred through completeness of communication, support for sensitive conversations, and the redistribution of voice within the encounter.

Subtheme 1.1: Making communication possible, reliable, and complete

Across cohorts, professional interpreting was described as converting an otherwise incomplete or unreliable exchange into communication that could be used for assessment and care. Interpreters captured this enabling function in direct terms: “The conversation wouldn’t happen without us” (I38/Arabic), with another describing the interpreter as a “communication bridge between client and service provider” (I25/Mandarin). Practitioners placed the same mechanism in clinical terms. For HP2, interpreters were “indispensable” because without them practitioners could not “communicate reliably with the individual” or obtain communication that was “accurate, thorough and detailed” (HP2/Gerontologist).

Caregivers assessed this reliability through what was carried across the interaction. CG11 contrasted experiences of partial interpretation with a professional interpreter who “didn’t miss anything that she [mother] or the doctor said” and “was able to translate everything” (informal caregiver with Chinese background). These accounts converge with wider evidence associating professional interpreting with greater comprehension, communication quality, and patient satisfaction [17–22], while showing how those benefits become particularly consequential in language-dependent dementia encounters [23]. The mechanism was therefore not interpreter presence alone, but sufficiently complete and reliable transfer to make the consultation clinically workable.

Subtheme 1.2: Enabling ethical, person-centred dementia communication beyond family mediation

The contribution described by participants was also ethical and relational. Practitioners explained that relying on relatives can require them to deliver bad news or interpret “personal invasive questions”, while making it impossible to speak privately and directly with the patient (HP2/Gerontologist). A professional interpreter could reduce this burden by creating a communicative relationship that did not depend entirely on family mediation, an issue also identified in guidance and research concerning family interpreting in sensitive or consent-related encounters [6, 36–41].

Caregivers extended this account beyond privacy to the emotional conduct of difficult conversations. CG5 described a skilled interpreter as someone who could help a person understand the importance of a situation and “help to deescalate the stress and the anxiety” (informal caregiver with Lebanese background). In a dementia-specific example, CG10 recalled that an interpreter “read the situation really well” and used an appropriate and gentle tone when communicating her grandmother’s diagnosis and prognosis (informal caregiver with Taiwanese background). Interpreters’ own description of the role as an “interpreting machine with a human heart” (I59/Japanese) similarly conveyed the tension between accurate transfer and humane delivery. This relational work is consistent with literature showing that emotion and empathy are jointly managed in interpreter-mediated consultations [51, 52]. It was perceived to make distressing dementia conversations more understandable and ethically manageable, without transferring inappropriate communicative responsibility to relatives.

Subtheme 1.3: Who gets spoken to — Interpreter involvement and the patient’s voice

Interpreter involvement also affected whose account anchored the consultation. I39 observed that when an English-speaking adult child held power of attorney, “most communication occurs between the professionals and the power of attorney rather than directly with the patient” (Mandarin interpreter). The concern was therefore not simply whether information was translated, but whether the CALD person with dementia remained an addressed participant or became the subject of a family–clinician exchange. This reflects literature showing that informal interpreting can alter participation, filter information, and shift authority within clinical encounters [1, 13, 36–40].

Caregiver accounts complicated any assumption that professional interpreting would automatically be preferred. CG6 described family members as the primary bridge and considered an impartial interpreter from the Australian Government's Translating and Interpreting Service (TIS National) “the second best option” when relatives were unavailable (informal caregiver with Indian background). Thus, interpreters and practitioners foregrounded the risk of the patient's voice being displaced, whereas some caregivers evaluated interpreter choice through trust, familiarity, and family responsibility. Interpreter involvement could support direct participation, but only when services addressed the person with dementia through the interpreter while negotiating, rather than dismissing, the family's desired involvement.

Theme 2: “Talking machine” or team member? – How recognition and role conditions shape interpreter impact

Interpreter presence did not by itself determine its contribution to service delivery. Participants' accounts indicated that interpreter knowledge became more clinically available when interpreters were recognised, given a clear role, and included in collaborative practices. The theme therefore moves from professional inclusion, through contested definitions of neutrality, to the briefing, debriefing, and shared learning needed to turn presence into meaningful participation.

Subtheme 2.1: Precarious inclusion and its consequences for service quality

Interpreters described a continuum between being present as a language channel and participating as a recognised professional. At one end, inclusion meant that the assessing team requested feedback on “the level of understanding, language use, proficiency... or coherence” of a client's responses (I76/Italian). Such requests allowed interpreters' linguistic and interactional observations to enter clinical sense-making, which was particularly relevant when language difference and cognitive change were difficult to disentangle.

At the other end, interpreters could be indispensable to the conversation yet excluded from professional participation. I21 said that interpreters were acknowledged as important but treated as a “talking machine”, not as members of the team (Mandarin-Cantonese interpreter); another reported being separated from decision-making and treatment planning. These accounts resonate with research showing that institutional hierarchy and limited professional recognition can constrain interpreters' roles in medical teams [44–46]. They also distinguish physical presence from epistemic participation: inclusion affected whether interpreters' knowledge could inform care, whereas instrumental positioning

confined their contribution to mechanical transfer and potentially removed clinically relevant context from the encounter.

Subtheme 2.2: Contested role boundaries – “adds nothing” versus culturally meaningful transfer

Across cohorts, interpreter quality was not defined uniformly. Practitioners generally associated fidelity with low interpreter visibility: one summarised the ideal as “Interprets word for word and adds nothing” (HP2/Gerontologist), while another prioritised objectivity and non-interference. Interpreters likewise invoked impartiality and professional codes, but did not necessarily understand accuracy as lexical substitution alone. I61 described alerting practitioners when cultural differences could affect assessment and accurately conveying interactional features such as pauses and hesitation (Vietnamese interpreter). This tension parallels longstanding debates between conduit-based and culturally responsive conceptions of healthcare interpreting [15, 16, 44–46].

Caregivers evaluated the same issue primarily through its consequences. CG8 recalled an occasion when the interpreter misunderstood the clinician, so that “the information was all wrong” (informal caregiver with Malay background), while CG12 described partial transfer leaving a GP without the context needed to understand a family's account. Taken together, the findings suggest that role clarity requires more than asking interpreters to remain neutral. Teams need shared expectations that distinguish accurate transfer and transparent cultural clarification from the provision of independent advice. Without them, neutrality may operate either as a safeguard against interference or as a reason for excluding culturally and clinically relevant meaning.

Subtheme 2.3: Conditions that enable high-quality collaboration (briefing, debriefing, joint training)

Participants identified structured preparation as the practical bridge between role expectations and collaborative work. Interpreters repeatedly requested briefing and debriefing, with I60 calling for both “before and after every job” so that the interpreter could understand the client's situation and explain their own role (Spanish interpreter). These practices could establish what needed verbatim transfer, identify sensory or cognitive concerns in advance, and provide a transparent space to flag cultural-linguistic issues after an assessment. They therefore addressed both the uncertainty described by practitioners and the contextual responsibilities described by interpreters.

Participants also located collaboration beyond individual appointments. I67 requested joint training so interpreters and practitioners could understand one another's roles and “how to support each other during interview” (Burmese interpreter), echoing recommendations for interprofessional education and structured preparation in interpreter-mediated care [4, 47–52]. Caregiver accounts showed why organisational normalisation was also necessary. Despite multiple hospital encounters, CG6 could not recall being asked whether their grandparents needed an interpreter; only aged-care assessors proactively preferred a formal interpreter to family mediation (informal caregiver with Indian background). High-quality collaboration therefore depended on services making interpreter involvement

routine and prepared, rather than expecting individual clinicians, families, or interpreters to negotiate it anew in each encounter.

Theme 3: Availability-led hierarchies — How systems organise interpreter involvement (and why substitution reshapes care)

Across cohorts, the person who carried communication was often selected through service logistics rather than clinical preference alone. Professional interpreters were widely valued, but booking systems, workforce conditions, the unscheduled rhythm of dementia care, and family preferences produced an availability-led hierarchy in which more immediate substitutes were often used first. The following subthemes show how this hierarchy was produced, how substitution changed the encounter, and why modality and environment affected the usefulness of interpreting once it was arranged.

Subtheme 3.1: Professional interpreters as ideal—yet structurally “last”

Practitioners described a consistent paradox: the option they regarded as most accurate was often the last one operationally available. Caregivers were used first because they were already present, followed by bilingual staff, whereas professional interpreters required booking and coordination. HP17 made the trade-off explicit: “Interpreter is the last because first, we need to book them, second we need to find the time”, even though an interpreter could retain the original meaning while a family member “might put their own mind into the process” (occupational therapist). HP17’s account illustrates a perceived trade-off between accuracy and immediate access within this practitioner’s workflow.

Interpreters connected the same hierarchy to labour-market conditions. I35 reported declining availability because of “poor remuneration and poor terms and conditions”, with bilingual workers consequently used in interpreter roles (Sinhalese interpreter). Caregivers then encountered the hierarchy through service unreliability. When an interpreter was late or absent from her grandfather’s appointment, CG11 said the family proceeded without one and that these experiences affected their opinion of professional interpreters (informal caregiver with Chinese background). These findings are consistent with evidence that time, booking difficulty, workforce conditions, and perceived convenience contribute to underuse of professional interpreters [10, 33–35, 69, 70]. Together, they show a reinforcing process: constrained supply and cumbersome access placed interpreters last, while unreliable provision weakened the trust needed for families and clinicians to seek them again.

Subtheme 3.2: Substitution practices reshape participation and accuracy (family, bilingual staff, ad hoc tools)

Substitution did not merely replace one language channel with another; it changed participation, fidelity, and whose interpretation of events carried authority. Interpreters observed that clinicians sometimes preferred to converse with family members even when a professional interpreter was present (I28/Thai). Practitioners explained how this occurred in everyday aged care, where staff needed to speak with residents throughout the day but interpreters had to be scheduled. An administrative officer therefore

described Google Translate or staff who spoke the resident's language as “the easiest resource” for unscheduled communication.

Caregivers did not, however, understand family or bilingual mediation only as inferior substitution. CG7 preferred to interpret personally because of her “personal stake” in her grandparents' health and their wish to limit how many people knew sensitive information (informal caregiver with Vietnamese background). CG12 placed bilingual staff first because they appeared to combine greater accuracy than family with knowledge of “how you speak”, rather than only “the correct words” (informal caregiver with Malay background). This tension reflects literature showing both the risks of filtering, omission, and role conflict in informal interpreting and the trust, continuity, and comfort that family involvement can provide [6, 12, 13, 36–43]. Substitution was thus not uniformly experienced as harmful, but it reorganised the consultation. Its service-delivery consequences depended on whether convenience and relational trust could be retained without sacrificing accuracy, confidentiality, or the direct participation of the person with dementia.

Subtheme 3.3: Modality and environment shape whether interpreter involvement helps or hinders

Once interpreting was arranged, its usefulness depended on the fit between modality, environment, and dementia-related communication needs. Interpreters repeatedly requested quiet premises without distraction and sufficient time, summarised by I62 as a need for a “Longer appointment and briefing” (Dari interpreter). These conditions were especially important where clients had hearing loss, reduced attention, or difficulty producing coherent responses.

Caregivers' concerns about remote interpreting focused less on distance itself than on the conditions in which it occurred. CG10 recalled hearing dogs barking while an interpreter worked from home; the noise distracted the family and led her to prefer either in-person interpreting or a remote interpreter located in a quiet office (informal caregiver with Taiwanese background). This account should not be read as showing that one modality is inherently superior: video interpreting can support reliable cognitive assessment under appropriate conditions [24], while telephone interpreting may expand access where in-person supply is limited, although concerns about suitability and quality remain [34, 70]. Rather, participants described modality as condition-dependent. Adequate sound, privacy, time, visual access where needed, and low distraction influenced whether remote or in-person interpreting supported rather than added to the communicative burden [11, 24, 34, 70].

Theme 4: Dementia-specific interpreter work — Assessment validity, cultural interpretability, and “fit” in complex encounters

Participants described dementia interpreting as specialist work undertaken at the intersection of language, cognition, hearing, culture, and assessment design. In this setting, accuracy could not be reduced to fluent transfer between languages: interpreters had to preserve fragmented communication, avoid altering the difficulty of cognitive tasks, and work with clients and families whose trust could be

disrupted by repeated changes of interpreter. The three subthemes trace these communication, validity, and continuity requirements.

Subtheme 4.1: Dementia communication complexity changes what “accuracy” requires

Interpreters described working at the edge of intelligibility rather than with fully formed messages. I21 reported difficulty conveying speech that was “slurry, unclear” or did not make sense (Mandarin-Cantonese interpreter), while others referred to unanswered questions, apparently nonsensical speech, and hearing difficulties during telephone interpreting. Accuracy in these encounters required preserving features such as fragmentation, repetition, and non-response rather than silently repairing them, because those features could themselves be relevant to practitioners' understanding of the interaction.

Practitioners described dementia as simultaneously complicating communication and increasing the need for first-language support. HP8 observed that some residents returned increasingly to their first language and that interpreters could help them “understand more in their own language” (registered nurse). Caregivers, meanwhile, described the work transferred back to families when medical meaning remained incomplete. CG12 sometimes had to “go home and google” and piece together what a GP had said, and wanted interpreters to transfer the more medically complex information to the grandparents directly (informal caregiver with Malay background). These patterns accord with literature showing that language discordance in dementia is compounded by language reversion, sensory impairment, and changes in coherence and pragmatic communication [1–5, 23, 28]. Dementia-specific accuracy therefore meant rendering uncertain communication faithfully while making clinical explanations sufficiently accessible, rather than producing artificially fluent speech in either direction.

Subtheme 4.2: Assessment validity across languages: tests, concepts, and the risk of misinterpretation

Assessment intensified the tension between accurate transfer and the cultural and linguistic portability of the material being transferred. Interpreters questioned tests that had not been designed for other languages, with I9 stating that “the tests don't work in other languages” (French interpreter) and I23 observing that many had not been conceived with another language in mind (Spanish interpreter). I61 illustrated the problem through an unfamiliar English term for boat equipment: simplifying or explaining the term could make it culturally intelligible, but the practitioner believed that doing so would alter a test of general knowledge (Vietnamese interpreter). The resulting difficulty was not simply finding an equivalent word; it was deciding whether the original item measured cognition, language knowledge, or culturally specific familiarity.

Practitioners approached validity from the complementary concern that interpreters should not change task difficulty. HP2 praised an interpreter who understood that she could not help clients by “giving clues or helping jog their memory”, allowing the client to respond without assistance (gerontologist). Caregivers located preparedness at a broader level. CG3 considered knowledge of dementia necessary for interpreters to understand “what they are dealing with” (formal caregiver with Filipino background),

while others questioned whether such training was consistent across the workforce. These concerns mirror neuropsychological literature on cueing, limited test validation, cultural-linguistic mismatch, and the need to document uncertainty in interpreted assessment [4, 23–32, 64–67]. The accounts do not establish that interpreted tests were invalid or that interpreter involvement made them valid. Instead, they identify a potential assessment-validity safeguarding role: trained interpreters could help practitioners recognise language, cultural, sensory, or tool-related sources of uncertainty while preserving the standardised demands of the task.

Subtheme 4.3: Continuity and trust as part of “fit” for dementia interpreting

Continuity functioned as part of interpreter “fit” because familiarity could reduce the relational work required at each dementia appointment. CG10 had a different interpreter at every visit and reported that requests for a previous interpreter were repeatedly declined because that person was unavailable (informal caregiver with Taiwanese background). Another caregiver described discontinuing interpreter use temporarily when a grandparent was uncomfortable with an unfamiliar interpreter and concerned about privacy. These accounts showed that formal availability did not ensure uptake: families also needed to trust the particular person entering a sensitive and repeated care relationship.

Practitioners experienced the same discontinuity as a clinical cost. When the requested interpreter was unavailable, HP25 had to “build up that rapport and relationship with the patient again”, which took time (occupational therapist). This aligns with practice literature presenting continuity as a support for rapport and trust [14, 53], although continuity also needs to be balanced with interpreter availability and the emotional burden that repeated involvement can create [54]. In dementia care, continuity was therefore not a minor preference: it influenced comfort, privacy, efficient rapport-building, and willingness to continue using professional interpretation.

Across the four themes, interpreter involvement was conditionally integrated: its perceived effects depended on alignment among availability, professional recognition, trust, preparation, modality, and role clarity. Where these conditions aligned, participants described more clinically usable communication, stronger patient participation, and more interpretable assessments. Where they did not, substitution, role ambiguity, and reduced patient voice prevailed. Conditional integration therefore captures the cross-cutting process through which interpreter presence became—or failed to become—meaningful participation in dementia service delivery.

Discussion

The findings indicate that interpreter involvement in dementia settings is not merely a technical language solution but part of the clinical infrastructure of person-centred care. Dementia consultations depend on nuanced discussion of symptoms, capacity, risk, consent, prognosis, and service coordination; these tasks become more fragile when language discordance intersects with cognitive-communication change. This accords with evidence that interpreter-mediated encounters can improve communication and safety, whereas ineffective communication increases misunderstanding and clinical error [17, 28].

The cross-cohort analysis adds an account of mechanisms: interpreters were described as enabling clinically usable interaction, shaping who was addressed, and buffering emotionally difficult moments. Interpreter involvement was therefore described as a condition for “workable” dementia care, with the potential to make fragmented or family-mediated exchanges more clinically usable and ethically manageable.

The Australian migration context

Australia’s migration history makes language access a recurring issue for dementia services. National data show that difficulty speaking English can persist among people reporting dementia who speak another language at home, including some who have lived in Australia for at least 15 years [75]. Participants’ accounts show how such language needs may interact with dementia and service routines: HP8 described increased reliance on a first language as dementia progressed; CG6 could not recall proactive interpreter offers across hospital visits; and CG12 described reconstructing medical information after an incomplete consultation. HP17 explained how booking time could place professional interpreting behind family mediation in day-to-day practice. These accounts identify possible pathways through which unmet language needs can transfer communication work to families and affect whose account reaches the clinician. They do not establish that migration itself caused an individual care outcome.

Australian dementia care spans general practice, hospitals, specialist assessments, and aged care, where access to interpreting is organised through different services and procedures [6–8, 76]. An individual may therefore encounter reliable language support in one setting and depend on relatives or bilingual staff in another, as participants described. Recording preferred language and dialect at referral, planning interpreter access before a memory assessment, allocating sufficient time for interpreted discussions, and seeking continuity where the person wants it are practical responses suggested by the findings. Families can continue to provide relational support while a qualified interpreter conveys complex or sensitive clinical content. These proposals align with the National Dementia Action Plan’s emphasis on interpreter access and culturally appropriate care [76]; this study did not evaluate their effectiveness.

A key analytical insight is that interpreter involvement is best understood as a relational and systemic arrangement, not a simple matter of “interpreter present or absent.” Participants described that when interpreter involvement is treated as optional or exceptional, dementia care is reorganised around substitutes—family members, bilingual staff, or ad hoc tools—whose availability is immediate but whose use shifts the encounter’s ethical and epistemic centre. This availability-led hierarchy echoes prior work showing that professional interpreters are often underused due to logistical constraints, time pressures, and beliefs that ad hoc options are good enough [10, 11, 13, 35]. In the dementia context, however, substitution may be especially consequential because cognitive-communication changes can already limit the person’s communicative agency. When the system defaults to family or a power of attorney, it can inadvertently institutionalise speaking about the person rather than with them—an effect that

resonates with concerns that migrant dementia diagnosis and care are inseparable from broader patterns of service underrepresentation and clinician–interpreter–patient relational dynamics [1]. The present findings suggest that displacement of the patient’s voice is not only an interpersonal problem; it may also be produced through predictable service routines and the friction of booking systems and time-limited appointments. In this sense, placing the interpreter last may operate as a structural mechanism through which inequity is reproduced, even when stakeholders value professional interpreting in principle.

At the same time, the data complicate any simplistic narrative that professional interpreters are always the preferred pathway. Caregivers’ strong accounts of privacy, trust, and relational comfort—sometimes favouring family interpreting—challenge a purely policy-driven model that equates professional with best in all circumstances. This tension is widely recognised in the literature: while guidelines caution against family interpreting for complex or sensitive interactions [6, 41], family involvement can also provide continuity, reassurance, and contextual knowledge, and some patients prefer family due to confidentiality concerns with strangers [25, 39, 59–62]. Rather than framing caregiver preferences as non-compliance, these findings invite a more realistic ethical stance: in dementia care, the question is not only whether professional interpreters are used, but whether language support arrangements protect the person’s agency, preserve informational integrity, and align with family dynamics without transferring inappropriate responsibility for diagnosis, prognosis, or invasive questioning onto relatives. This matters because caregivers often enable access, appointment-making, and continuity when cognitive decline affects recall and service navigation [3, 63]. The findings support service models that facilitate caregiver involvement while ensuring that professional interpreter access is reliable enough to avoid forcing families into ethically fraught roles.

Another important insight concerns contested definitions of good interpreting, particularly in dementia assessments. Practitioners’ emphasis on neutrality—interpreting “word for word” and “adding nothing”—reflects a common clinical expectation that fidelity equals non-interference [15]. Yet interpreters and caregivers described quality through a broader lens: completeness, preservation of interactional cues, culturally meaningful transfer, and relational competence (tone, gentleness, de-escalation). These competing standards echo long-standing debates about interpreter roles beyond the conduit model, including conversational facilitation, cultural brokering, and patient advocacy when needed [16, 44, 45]. Dementia sharpens this dilemma because meaning is carried not only in lexical content but also in how responses are produced—pauses, hesitations, coherence, pragmatic appropriateness—and these features may be misread as cognitive deficit if not conveyed accurately. Guidance in interpreter-mediated neuropsychology similarly warns that interpreted assessment raises ethical and diagnostic dilemmas, including interpreter unfamiliarity with assessment procedures, the limited validation of tools for interpreted administration, and the need to document uncertainties about validity [28, 30, 32, 64–67]. The present findings suggest that role expectations may become a hidden determinant of assessment interpretability: practitioners may fear interpreters helping, while interpreters may fear that strict word-for-word transfer strips out culturally and interactionally relevant meaning. These findings support moving beyond abstract “neutrality” toward explicit shared protocols: what must be rendered verbatim,

what contextual information can be transparently flagged, and how to protect assessment integrity without erasing cultural-linguistic realities [4, 49].

The findings also point to a persistent translational gap between policy and practice. Australian health procedures emphasise engaging interpreters when communication is essential and for valid consent, and place responsibility on health services to inform clients about interpreter rights and arrange interpreters for future appointments [6]. Yet caregivers described routine clinical pathways where interpreter need was not even raised, and practitioners described interpreter access as cumbersome, time-consuming, and misaligned with the day-to-day rhythm of dementia care—especially in aged-care contexts requiring frequent brief interactions [33]. From a systems perspective, reliable interpreter involvement is unlikely to be sustained by individual goodwill alone. The findings support embedding it in organisational routines with low-friction booking, predictable availability, and resourcing that recognises interpreted consultations take longer. Without this, substitution becomes the default not because it is preferred ethically, but because it is structurally convenient.

Workforce conditions and power relations further shape interpreter impact. Interpreters' accounts of being treated as a "talking machine" versus being asked for feedback on coherence and language use suggest that interpreter contribution is contingent on professional recognition and institutional hierarchy. Prior research highlights that hierarchy can constrain interpreters' ability to challenge provider behaviour or clarify misunderstandings [46], and that interpreters may need training and supportive conditions to convey empathic communication without becoming emotionally overwhelmed [68]. The present findings suggest that in dementia care, interpreter observations about language proficiency, coherence, or culturally patterned responses may be clinically relevant when teams create legitimate space for them through briefing/debriefing and role clarity. Importantly, interpreters also linked declining availability to poor remuneration and conditions—echoing wider concerns that interpreter supply, professional status, and working conditions affect service access and continuity [69, 70].

Finally, the discussion must foreground the lived experience dimension: CALD seniors and their carers navigate dementia care within layered contexts of stigma, privacy, and cultural meanings of illness, alongside the practical burden of interpreting choices. Caregivers' preference for fewer outsiders in sensitive conversations is not simply resistance to professional services; it reflects a calculus of dignity, confidentiality, and emotional safety. At the same time, caregivers described how inconsistent interpreting and partial transfer created downstream labour—reconstructing medical meaning at home, searching online, and piecing together what was said. This may represent a hidden inequity, because unsuccessful interpreter-mediated communication can shift time, stress, and risk onto families. The findings therefore support interventions at multiple levels: normalising interpreter offers at entry points [71], educating communities about rights and confidentiality [12, 72], investing in clinician training for triadic communication [47, 48], and developing dementia-specific interpreter preparation [4, 73]. It also requires a nuanced approach to continuity: stability can support trust and reduce repeated rapport-building [14, 53], yet services must also recognise interpreter wellbeing and avoid designing continuity in ways that intensify emotional burden without support [54].

Relevance for other migrant receiving countries

The findings may be transferable as service-delivery questions rather than as an estimate of effect. Other countries experiencing migration can also encounter language discordance, family mediation, and culturally difficult cognitive testing, but migration histories, eligibility rules, interpreter funding, language distributions, and workforce capacity differ [1, 4, 69]. An availability-led hierarchy may therefore arise through different mechanisms in different settings: booking delays, lack of reimbursement, limited dialect coverage, or weak continuity. Services should first identify where interpreting is offered along the dementia pathway, who is responsible for arranging it, and when family members are asked to substitute.

England provides one example of how these findings could inform existing practice. UK migrant-health guidance recommends documenting preferred spoken language and dialect, sharing interpreter needs across referrals, offering professional interpreters where language is a barrier, and allowing for briefing and debriefing [77]. A dementia pathway could build these steps into primary-care referral, memory-clinic assessment, and follow-up visits, with sufficient appointment time. In the United States, the National CLAS Standards recommend timely language assistance at no cost, competent language-service personnel, and the use of community and demographic information to improve services [78]. A memory clinic could use that framework to monitor whether requested interpreters attend, whether language preferences are recorded, and which communities have gaps in provision. These are proposed applications to existing systems, not interventions tested in this study.

Across settings, cognitive assessment requires additional safeguards: practitioners and interpreters should agree in advance how to preserve the difficulty of test items, render pauses or incomplete responses, flag culturally unfamiliar concepts transparently, and document any departures from standard administration [4, 23, 65–67]. Future multisite work could evaluate whether language-preference recording, reliable booking, appropriate modality, briefing, and continuity improve comprehension and participation as reported by people living with dementia, while also examining caregiver burden and service resources. The appropriate mix will depend on local language needs, interpreter supply, and the preferences of the person and family. International relevance is therefore a proposition for adaptation and evaluation, not evidence that the same model has already improved outcomes elsewhere.

Overall, participants portrayed interpreter involvement as an important but condition-dependent part of dementia service delivery. They associated unreliable access and limited professional recognition with reliance on substitutes and fewer opportunities to hear directly from the person with dementia. They perceived that preparation, appropriate modality, and continuity where feasible could improve the conditions for communication and assessment. The study does not establish causal effects on participation, diagnostic accuracy, or equity; instead, it identifies service processes for further investigation in Australia and other migrant-receiving settings.

Strengths & limitations

A key strength of this study is its integrated cross-cohort design, analysing interpreters, health practitioners, and caregivers as a single corpus to identify patterns that cut across role positions and expose how interpreter involvement is co-produced within systems and encounters. This approach strengthens interpretive depth by capturing convergence (e.g., interpreters as essential to workable dementia care) alongside divergence (e.g., “adds nothing” neutrality versus culturally meaningful transfer and relational competence). The use of inductive reflexive thematic analysis supported nuanced theme development grounded in participants’ meaning-making, while a constructivist grounded theory sensibility (constant comparison and memoing) enhanced analytic rigour and attention to process. Reflexive strategies (including bracketing) further strengthened credibility by explicitly accounting for assumptions—particularly the expectation that professional interpreting is always preferred—while retaining caregiver accounts that challenged this view.

Several features limit what the findings can establish. Cross-sectional, self-reported accounts capture perceived effects rather than observed consultation behaviour, test validity, or clinical outcomes, and may be affected by recall and social desirability. People living with dementia did not participate, so their own language preferences, understanding, and sense of involvement could not be examined directly. Recruitment through organisations and networks may have favoured people already connected to services and under-represented those facing the greatest barriers. The 64 interpreter and 17 practitioner questionnaires and the 23 interviews offered different opportunities for probing. Although role and source identifiers were retained, the integrated analysis may obscure differences by profession, care setting, language, or interpreter modality. Analysis by one researcher produced a situated interpretation, as expected in reflexive thematic analysis, rather than a consensus-coded or prevalence estimate.

CALD is a broad category and does not equate to migrant status or a particular level of English proficiency. This analysis did not compare migrant with non-migrant patients or examine differences by migration pathway, years since arrival, visa status, or individual language community. It therefore cannot isolate an effect of migration from dementia-related communication change, service organisation, or family preferences; estimate the frequency of the reported problems; or show that the proposed changes would improve outcomes. Sex- and gender-related differences were not examined because the study was not designed for subgroup comparison. Proposed applications in other countries require testing within local policies, funding arrangements, language needs, and interpreter workforces.

Conclusion

The integrated accounts of interpreters, health practitioners, and caregivers suggest that interpreter involvement can make dementia consultations more workable when services provide timely access, preparation, appropriate modality, clear roles, and continuity where desired. Participants also described how booking delays and reliance on family members or bilingual staff could affect communication, participation, and caregiver workload. These are perceived mechanisms, not measured changes in diagnostic accuracy or patient outcomes.

For Australia, the findings point to recording preferred language at entry and referral, offering qualified interpreters for complex and sensitive encounters, allocating sufficient time, and using dementia-specific assessment protocols. Other migrant-receiving countries could adapt and test these approaches within their own service arrangements and with direct input from people living with dementia. The study identifies priorities for evaluation; it cannot determine the effectiveness of these changes or the independent effect of migration.

Declarations

Ethics approval and consent to participate

The broader research project encompassing this qualitative study received ethical approval from the RMIT College Human Ethics Advisory Network (CHEAN) on 12 September 2023 (project number 26203). All participants provided informed consent before taking part in the study. Confidentiality was protected through the de-identification of participant data. Quotations were labelled using role-based identifiers—interpreter, health practitioner, or caregiver—and all personally identifying information was removed.

Consent for publication

All participants consented to the publication of de-identified study findings and quotations.

Availability of data and materials

The datasets generated and analysed during this study are not publicly available because the combination of small, specialised participant samples and detailed demographic and professional characteristics may create a risk of re-identification. De-identified data may be available from the corresponding author upon reasonable request, subject to applicable RMIT University ethical approvals and privacy requirements.

Competing interests

The author declares that he has no competing interests.

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Authors' contributions

MZ was solely responsible for the conceptualisation and design of the study; development of the data-collection instruments; participant recruitment; data collection and management; formal analysis;

interpretation of the findings; and drafting, reviewing, and editing of the manuscript. The author read and approved the final manuscript and accepts full responsibility for the accuracy and integrity of the work.

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