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NARRATIVE REVIEW

Lost in Translation

How language, family interpreting and cultural silence shape the healthcare experiences of culturally and linguistically diverse young people

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When a parent does not speak English confidently, who explains the diagnosis? In many Australian families, the answer is a child. Young people from migrant and refugee backgrounds are frequently asked to interpret at GP visits, in hospital wards and at the pharmacy counter, turning complex and sometimes frightening medical language into words their parents can understand. This report asks what that role means for young people, why it persists when free professional interpreting is available, and how growing up "in the middle" shapes the way culturally and linguistically diverse (CALD) young people later manage their own health.

This report synthesises 20 academic and government sources, with a focus on Australian evidence. It is organised around three themes: the child in the middle, which examines child language brokering and its emotional costs; systems that default to family, which examines why professional interpreters are under-used; and silence, stigma and seeking care alone, which examines how cultural taboos around mental and sexual health affect young people's own help-seeking.

AT A GLANCE

- 20 academic and grey-literature sources
- For young people, families, clinicians, schools and policymakers

THEMES

- The Child in the Middle
- Systems That Default to Family
- Silence, Stigma and Seeking Care Alone

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BACKGROUND

Why Language Is a Health Issue

Language is not only a communication tool; it shapes whether a person can understand symptoms, follow treatment and make informed decisions. For CALD young people, language barriers often affect them twice: first as the family member who bridges the gap for others, and later as a patient navigating care that may not reflect their culture or their need for privacy.

A multilingual country

Australia is one of the most linguistically diverse countries in the world. At the 2021 Census, almost 30% of people were born overseas and 22% (5.6 million people) used a language other than English at home (Australian Bureau of Statistics [ABS], 2022). A smaller but significant group, 3.4% of the population, reported speaking English "not well or not at all" (ABS, 2022). Behind each of these households is a set of everyday health tasks, such as booking appointments, reading medicine labels and understanding test results, that someone has to manage.

RESEARCH

At the 2021 Census, 5.6 million people (22%) used a language other than English at home.

ABS, 2022

Health literacy is already low

Even in English, many Australians find health information hard to use. The Australian Commission on Safety and Quality in Health Care (2014) reported that almost 60% of adult Australians have low individual health literacy. For people reading in a second language, these challenges compound, which makes accurate interpreting and plain-language information especially important.

TERM

Health literacy

The ability to find, understand, judge and use health information to make decisions about your health and care.

Free interpreting exists but is under-used

Australia has a national, government-funded interpreting system. Through TIS National's Free Interpreting Service, eligible GPs, nurse practitioners and medical specialists in private practice can access professional interpreters at no cost for Medicare-eligible patients, by phone at any hour (Department of Home Affairs, n.d.). Victorian health guidance is clear that family and friends should not replace accredited interpreters, and that children under 18 should never be asked to do so (Department of Health, Victoria, 2021). Yet, as Theme 2 shows, practice often looks very different.

TERM

TIS National

The Australian Government's Translating and Interpreting Service, which provides professional phone and on-site interpreters in more than 150 languages.

Taboo topics meet language gaps

Mental health and sexual and reproductive health are areas where cultural stigma and silence are common across many communities (Lirios et al., 2024; Luu et al., 2024). When the topic is already hard to talk about, and a family member is the only bridge to the doctor, young people may stay quiet about their own needs altogether.

DIAGRAM

The Brokering-to-Silence Pathway

This report proposes a simple model to describe how childhood language brokering and service gaps can carry forward into a young person's own health behaviour. It is not a fixed sequence that every young person experiences; rather, it shows how small, repeated pressures can add up. Breaking any link in the chain, for example by providing a professional interpreter at stage 2 or a confidential, culturally safe service at stage 5, can change the outcome.

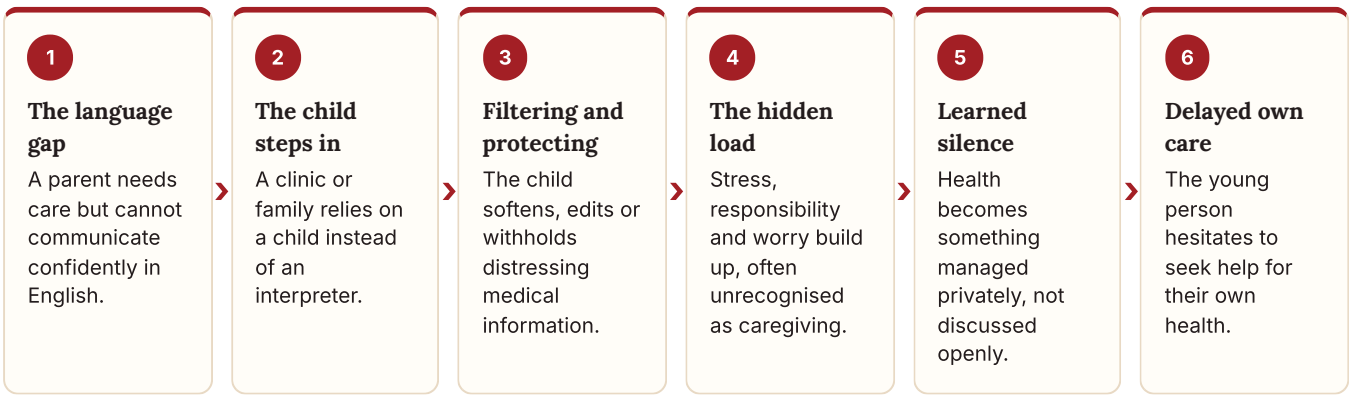


Figure – conceptual model developed from the literature reviewed in this report.

THEME 1

The Child in the Middle

Child language brokering is a normal part of life in many migrant families and can build skills, closeness and confidence. However, in medical settings the stakes are higher, and the evidence suggests that the emotional experience of brokering matters a great deal for young people's wellbeing.

Finding 1.1 – How brokering feels matters more than how often it happens

EMOTIONAL LOAD

The largest synthesis of this research to date, a meta-analysis of 65 studies including almost 18,000 participants, found that brokering frequency had only small links with youth outcomes, such as slightly weaker family relationships and socioemotional wellbeing (Shen et al., 2022). Much stronger patterns emerged for how young people felt about brokering: those who felt positive about the role tended to be better adjusted, while those who felt burdened or anxious tended to fare worse. The authors stress that the effects are modest and mostly correlational, so brokering itself should not be framed as harmful.

A study of 604 Mexican American families in Texas adds detail. Brokering stress, rather than brokering frequency, was linked to depressive symptoms, anxiety and behaviour problems, and the link with depressive symptoms was stronger for girls than for boys (Shen et al., 2020). Stress from brokering for mothers was especially tied to depressive symptoms in families already facing other pressures, such as financial hardship or parental depression. The authors recommend using professional interpreters for especially demanding tasks, such as medical translation.

TERM

Child language brokering

When a child or young person interprets and translates for family members who do not speak the local language, often in formal settings like clinics, schools or government offices.

RESEARCH

Across 65 studies, positive or negative feelings about brokering predicted adjustment more strongly than brokering frequency.

Shen et al., 2022

Finding 1.2 – Young brokers edit medical news to protect their parents

HIDDEN CARE

An Australian qualitative study of 14 adults who began brokering between ages 7 and 16 found that health tasks were a major part of their role, including attending medical appointments and explaining medical information (Narchal & Hembrow, 2024). Participants described "sugar-coating" or filtering distressing news, and some deliberately withheld information so that a parent would accept treatment. One participant described having to convey a parent's cancer diagnosis without knowing the medical words in their family's language.

RESEARCH

"[My] mental health had really suffered" — an Australian adult reflecting on childhood brokering.

Narchal & Hembrow, 2024

Participants also described managing their own emotions so their parents would not see how serious a situation was, and some reported anxiety and lasting emotional strain. Strikingly, most did not see this work as caregiving at all. The authors call it "hidden care", kept out of view by cultural obligation and family loyalty, and raise concerns about whether informed consent is possible when family members interpret (Narchal & Hembrow, 2024).

COMPOSITE CASE

Composite case: Mai, 14

Mai's father has been unwell for months. At the specialist appointment, the doctor speaks to Mai, not her father, and uses words like "malignant" and "biopsy". Mai is not sure what they mean in Vietnamese. She tells her father the doctor wants to "do more tests to be safe". That night she searches the words online alone. She misses school the next week to attend the follow-up. (Composite example based on themes in the literature; not a real person.)

Finding 1.3 – Policy says "never", but children are still asked

POLICY GAP

Victorian health guidance states that children under 18 should never be asked to act in place of an accredited interpreter, and that family members should not be used in critical situations or where family violence may be present (Department of Health, Victoria, 2021). The research on Australian brokers, however, shows that children have been placed in exactly these situations, including serious diagnoses and treatment decisions (Narchal & Hembrow, 2024). Clinicians in an Australian hospital study openly described using family members as interpreters because it was faster and more convenient (White et al., 2018).

This gap between policy and practice means that the burden falls on young people to fill a role the health system is meant to provide. It also means young people may be exposed to information about a parent's health that is distressing, private or inappropriate for their age.

RESEARCH

Children under 18 "should never be asked to act in the place of an accredited interpreter."

Department of Health, Victoria, 2021

PROPOSED SOLUTIONS

For clinics and hospitals

- **Ask, don't assume**
  Record every patient's preferred language and interpreter need at booking, and flag it on every visit.
- **No child interpreters**
  Make "no under-18 interpreters" a visible clinic policy, with posters explaining free interpreting to families.
- **Speak to the patient**
  Train clinicians to address the parent directly, even when a young person is present.

For schools and youth services

- **Recognise hidden care**
  Treat regular medical brokering as a form of young caring and offer support through wellbeing staff.
- **Flexible attendance**
  Avoid penalising students who miss school to support family health appointments, while linking families to interpreters.

For families and young people

- **Know your rights**
  Share in-language information that families can request a free professional interpreter at GP and hospital visits.

THEME 2

Systems That Default to Family

Young people end up interpreting partly because the health system makes it easy to rely on them. Australian evidence shows that professional interpreters are used far less often than they could be, despite strong evidence that they improve the safety and quality of care.

Finding 2.1 – Professional interpreters are rarely used in general practice

UNDER-USE

A national study using data from Australian general practice found that 16.2% of patients spoke a language other than English at home, and about 5% of all GP consultations were conducted at least partly in another language (Bayram et al., 2016). In these consultations, the language was mostly spoken by a multilingual GP (82.3%) or a family member or friend (17.7%). A professional interpreter was involved in only 1% of these consultations.

RESEARCH

Professional interpreters were used in just 1% of GP consultations held in another language.

Bayram et al., 2016

A large Australian trial in 31 general practices in areas of high refugee settlement found that only 48% of practices used TIS at the start of the study (Saito et al., 2021). After a whole-of-practice support program, interpreter use increased, but family members and friends still frequently interpreted, and the extra time needed to arrange interpreters remained a major barrier.

Who interpreted	Share of non-English GP consultations
Multilingual GP	82.3%
Family member or friend	17.7%
Professional interpreter	1.0%

Source: Bayram et al. (2016). Categories can overlap within one consultation.

Finding 2.2 – Hospitals lean on family for speed and convenience

SYSTEM BARRIERS

In an audit of patients who used interpreting services at two Monash Health hospitals in Melbourne, family members interpreted for at least 49% of patients at some point during their stay (White et al., 2018). In focus groups, 32 clinicians explained why: booking systems were cumbersome, interpreters added time to consultations, and less common languages could take days to arrange. Some clinicians ordered extra tests rather than wait, or saved up information for one long interpreted session.

Clinicians in the same study acknowledged that family members could interpret inaccurately or leave information out (White et al., 2018). The barriers described are about workflow and time, not about whether interpreters work, which suggests they can be fixed through better systems.

RESEARCH

"The extra time required to arrange and use interpreting services remained a major barrier."

Saito et al., 2021

Finding 2.3 – Untrained interpreters make more clinically significant errors

PATIENT SAFETY

A systematic review found that professional interpreters were associated with better communication, better use of services, better clinical outcomes and higher patient satisfaction than ad hoc interpreters, bringing care for patients with limited English closer to that of English-speaking patients (Karliner et al., 2007). In a study of 57 recorded paediatric emergency encounters in the United States, 22% of errors made by ad hoc interpreters, such as family members, had potential clinical consequences, compared with 12% for professional interpreters (Flores et al., 2012).

For a young person interpreting for a parent, these numbers mean that even a loving, capable child is being asked to do a job where mistakes are more likely and can matter. The responsibility for those errors should not rest on a young person's shoulders.

TERM

Ad hoc interpreter

An untrained person, such as a relative, friend or staff member, who interprets in a health setting without professional qualifications or a code of ethics.

PROPOSED SOLUTIONS

Make the right choice the easy choice

- **One-click booking**
  Simplify interpreter booking in hospital systems and GP software so it takes seconds, not minutes.
- **Longer appointments**
  Fund extended consultation time when an interpreter is used, so clinicians are not penalised for doing the right thing.
- **Phone first**
  Promote on-demand phone interpreting through TIS National as the default when on-site interpreters are not available.

Build skills and accountability

- **Train all staff**
  Include reception and nursing staff in training on when and how to use interpreters.
- **Audit and report**
  Track how often family and children interpret, and report it as a patient safety indicator.

THEME 3

Silence, Stigma and Seeking Care Alone

Growing up as the family's link to the health system does not always make it easier for young people to seek care for themselves. Cultural silence around mental, sexual and reproductive health, combined with fears about privacy, can mean that CALD young people delay, avoid or navigate care entirely on their own.

Finding 3.1 – Silence at home limits sexual and reproductive health knowledge

TABOO TOPICS

A systematic review of sexual and reproductive health literacy among CALD young people aged 16–24 in Australia found that knowledge varied by topic but was generally low, and that family and culture strongly shaped attitudes and beliefs (Lirios et al., 2024). The review identified "silence" as the main barrier to sexual health literacy, and found that access to information was limited. An earlier scoping review of 120 papers concluded that young people from culturally diverse backgrounds are largely overlooked and underserved by sexual and reproductive health services in countries like Australia (Botfield et al., 2015).

Research with Assyrian and Karen refugee women in Australia illustrates how cultural expectations can shape access. An imperative of premarital chastity limited unmarried women's access to contraception, cervical screening and sex education, and same-sex relationships were described as taboo and unrecognised (Ussher et al., 2012). For LGBTQIA+ young people from these communities, this silence can be doubly isolating.

RESEARCH

Silence within family and culture was the main barrier to sexual health literacy for CALD youth.

Lirios et al., 2024

Finding 3.2 – Fear of being seen by "the community doctor" keeps young people away

CONFIDENTIALITY

In interviews with 27 migrant and refugee young people in Sydney, most said they would not talk about sexual health with their family GP (Botfield et al., 2018). Their main concerns were being judged and having private information passed on to parents or relatives. A GP who shared their language and culture could reduce language barriers but was also seen as "too close" to the family to be trusted. Some young people preferred speaking about sexual health in English with a GP outside their community.

This is the reverse of the brokering problem: as children, these young people may have been present for their parents' private health information, but as patients they fear that their own privacy will not be

RESEARCH

"I know GPs are confined by like confidentiality, [but] I still feel uncomfortable."

Botfield et al., 2018

protected. Clear, repeated assurances about confidentiality are therefore central to engaging them.

Finding 3.3 – Mental health stigma and cultural fit shape help-seeking

MENTAL HEALTH ACCESS

A review of Australian literature on CALD young people's mental health found stigma and cultural shame to be recurring themes, with young people fearing family shame or social exclusion if they disclosed a concern (Luu et al., 2024). Limited mental health literacy, language barriers and doubts about practitioners' cultural competence were also common. A scoping review of 15 Australian studies identified similar barriers, including cultural concepts of mental health, trust, stigma, cost and services that were complex or not culturally responsive (Poon et al., 2025). It found that respecting young people's preferences about whether parents are involved was key to engagement.

Service providers working with refugee-background young people in Melbourne similarly highlighted trust, cultural concepts of illness, family engagement and working well with interpreters as central to access (Colucci et al., 2015). In a qualitative study at a Melbourne youth aftercare service, CALD young people who had experienced suicidal thoughts described cultural taboos that made it hard to talk with family, and a sense of not being taken seriously by clinicians (Rajaram et al., 2025).

RESEARCH

CALD young people described cultural taboos and not feeling taken seriously in clinical settings.

Rajaram et al., 2025

TERM

Culturally responsive care

Health care that respects a person's culture, language, beliefs and family context, and adapts how it is delivered rather than expecting the person to adapt.

PROPOSED SOLUTIONS

Protect young people's privacy

- **Say it out loud**
  Clinicians should explain confidentiality clearly at every youth consultation, especially in community-based practices.
- **Choice of clinician**
  Offer young people the option to see a clinician outside their language or cultural community if they prefer.

Break the silence, safely

- **Bilingual health education**
  Co-design in-language resources on mental and sexual health with young people and community leaders.
- **Peer-led programs**
  Support youth-led groups where CALD young people can learn about health in culturally safe spaces.

Make services fit young people

- **Flexible family involvement**
  Let young people decide how, and whether, parents are involved in their care.

- **Inclusive by default**
  Ensure services visibly welcome LGBTQIA+ young people from all cultural backgrounds.

SUMMARY

Key Findings of Report

1 **Brokering is common and its emotional weight matters**

Young people in migrant families often interpret for parents in health settings. Research shows that the stress and feelings attached to brokering are more closely linked to wellbeing than how often it happens. Girls may be particularly affected by brokering stress.

2 **Young brokers carry hidden care**

Australian brokers describe editing or softening medical information to protect their parents. This work is rarely recognised as caregiving, yet it can leave lasting emotional strain and raises serious questions about informed consent.

3 **Policy and practice do not match**

Victorian guidance states that children should never replace accredited interpreters. However, hospital and GP research shows family members are still routinely used, largely because it is faster and more convenient for clinicians.

4 **Professional interpreters are safer and free**

Professional interpreters improve communication, outcomes and satisfaction, and make fewer clinically significant errors than untrained family members. TIS National's Free Interpreting Service is available to eligible private practitioners at no cost.

5 **Silence and stigma shape young people's own care**

Cultural silence around sexual, reproductive and mental health limits CALD young people's health literacy. Stigma, shame and limited culturally responsive services contribute to low service use.

6 **Privacy is the key to trust**

CALD young people fear that doctors connected to their family or community will not protect their confidentiality. Clear confidentiality assurances, choice of clinician and youth control over family involvement can help them seek care earlier.

WHERE TO GET HELP

TIS National
free professional phone interpreting, 24 hours a day; ask for an interpreter for a health or government service
131 450

headspace
mental health support for people aged 12–25, including online eheadspace
1800 650 890 / headspace.org.au

QLife
LGBTI peer support and referral, 3pm to midnight daily
1800 184 527

1800RESPECT
24/7 support for people affected by sexual assault, domestic or family violence
1800 737 732

Kids Helpline
free, confidential 24/7 counselling for young people aged 5–25
1800 55 1800

Lifeline
24/7 crisis support
13 11 14

1800 My Options
Victorian information on contraception, pregnancy options and sexual health, weekdays 9am–5pm
1800 696 784

In an emergency, call 000.

In an emergency, call 000. This report is health education, not medical advice.

METHOD

Research Method

This report is a narrative literature review of peer-reviewed research and grey literature, including government policy documents and national statistics. Sources were identified through searches of PubMed, Google Scholar and publisher databases, together with Australian government and health service websites, using terms related to child language brokering, interpreter use, health literacy, culturally and linguistically diverse young people, and mental, sexual and reproductive health. The review focused on English-language sources relevant to young people aged approximately 10–24, prioritising Australian and Victorian evidence and supplementing it with international systematic reviews, meta-analyses and key studies. Findings were synthesised thematically.

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