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Arafat, N.M. (2016) Language, culture and mental health: a study exploring the role of the transcultural mental health worker in Sheffield, UK. International Journal of Culture and Mental Health, 9 (1). pp. 71-95. ISSN 1754-2863

https://doi.org/10.1080/17542863.2015.1112419

Language, Culture and Mental Health: A study exploring the role of the Transcultural Mental Health Worker in Sheffield, UK

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ABSTRACT

This paper aims to explore the role of the transcultural mental health worker as an alternative to the use of interpreters in an attempt to identify the communication barriers and improve the mental health care for black & minority ethnic patients in the Sheffield area, UK. A qualitative approach was conducted using a questionnaire, focus groups and semi structured interviews with 92 health and social care participants taking part. All participants apart from 7 found working with transcultural mental health workers either more effective than or as effective as interpreters due to their holistic approach in understanding the various mental health aspects and cultural boundaries. The study highlights the importance of addressing the cultural issues since the different cultural meanings can sometimes cause more difficulties of understanding between health and social care professionals and black & minority ethnic patients than language. It also highlighted the complexities involved in interpreting in mental health settings and the need to tailor practical training sessions and educational programmes for interpreters in this field.

Keywords: Language, Culture, Mental Health, Communication, Transcultural Mental Health Worker

1. INTRODUCTION

As the number of immigrants and refugees to different parts of the world is growing (United Nations Department of Economic and Social Affairs, 2013, Office for National Statistics, 2011), the need to address the issue of language barriers and communication has increased and the understanding of other people's experiences becomes a challenge in places such as the UK (Haroon, 2008). Researchers acknowledge the fact that language and culture play a significant role in patient-clinician interactions because the different uses of languages and their cultural meanings vary between health and social care professionals (HSCPs) and Black & Minority Ethnic (BME) patients who have limited proficiency skills in the English language (Putsch, 1985; Saldana, 2001; Tribe and Ravel, 2003; Beatriz and Hale, 2007). Researchers have also acknowledged that interpretation requires a high level of understanding and proficiency to achieve a communicative relationship between HSCPs and BME patients which goes beyond the translation of simple sentences (Putsch, 1985; Lee, 1977; Tribe and Morrissey, 2004). BME patients who have limited proficiency in the English language are not able to express their feelings in the English language in the same way as they do in their first language (Imberti, 2007). Newmark (2003) identified the concept of meaning and explained that in translation, words of quality and/or words denoting emotional states cause certain difficulties for translators primarily because they have no equivalents in most languages and they tend to change their meanings over the course of time. As a result of these difficulties, the Civil Rights office in the United States developed an interpreter programme in medical

settings, whilst in the United Kingdom, the National Institute for Health (2003: 23) declared that language should not be a barrier for treatment in mental health settings.

Initially, translation and interpretation looked at word for word equivalence in order to ensure exact rendering of source text in the target language. However, the possibility for accurate interpretation in such cases can cause further difficulties for interpreters as they are required to instantly understand and decide on what clients mean in order to select and deliver the right word which corresponds to the same meaning in the source language. Accordingly, Nida (1974:12) focused his theory of translation on the response of the receptor and formed his dynamic equivalence theory stating that '*translating consists of reproducing in the receptor language, the closest natural equivalent of the source language message, first in terms of meaning, secondly in terms of style'.* In recent years, translation of mental health resources shifted from word for word and dynamic equivalence to a more functional approach and socio-cultural concept where according to Nord (2006:133) '*Every translation is intended to achieve a particular communicative purpose in the target audience, and if we analyse who the target audience will be … we might be able to deliver a product that suits their needs and expectation'.* As such, Baker (2006a) clarified that messages conveyed in these interactions regulate our knowledge by explaining language use in all forms of communications and provides the basis for advancing translation theories. The provision of interpreting services has thus improved communication related to language barriers, yet other problems have been reported (Tribe and Morrissey, 2004). Common problems related to interpreting are omission, addition, condensation, substitution, normalisation and alteration which may lead to misdiagnoses and inappropriate intervention (Putsch, 1985; Lee, 1997; Westermeyer and Janca, 1997; Rennie, 1998). Another problem is related to interpreters' competency in both target and source languages because the ability to speak the language does not necessarily imply having the skills to convey the exact sameness of meaning (Putsch, 1985; Westermeyer and Janca, 1997; Rennie, 1998). According to Lago (2011), this is due to the fact that patients may attach specific meanings to the words they use which might be misapprehended by the interpreter or translated differently. Therefore, to facilitate the production of the message in the receptor language, Nida & Taber (1974) pointed out that one should make a great effort to adhere to the semantic and syntactic structure of the sentence as well as recognising that languages are rich with vocabulary which might restrict the production of an appropriate equivalent meaning. The equivalence issue when translating medical terminology or cultural concepts which are untranslatable or do not exist in the target language is another problem facing untrained or novice interpreters (Hudelson, 2006). Moreover, HSCPs often lack awareness of symbolic cultural meanings which shapes the understanding of conveyed messages and tends to stereotype BME patients as either non-responsive to treatment or unsuitable for therapy (Kareem and Littlewood,1992). While the use of untrained or novice interpreters as a third party impairs the ability to communicate effectively with BME patients whose first language is not English, several research studies (Kareem and Littlewood, 1992; Lee, 1997; Ngo-Metzger et al, 2003; Tribe and Ravel, 2003) indicate that BME patients are more likely to engage with transcultural mental health professionals who are able to communicate in the minorities' languages and can address their cultural needs. Therefore, an exploration of the transcultural workers' role is needed to gain further insight about their expertise in dealing with these problematic issues. Ting-Toomey (1991) coined the term 'transcultural' to mean the ability to transform the knowledge learned and gained in cultural encounters

into effective performance and communication with others. Accordingly, for the purpose of this study, a 'Transcultural Mental Health Worker' is a professional who has combined knowledge, skill and experience in mental health settings in addition to having the expertise to communicate effectively with a specific BME group.

Sheffield city located in South Yorkshire, UK, includes a diverse range of BME people from different ethnic backgrounds but the largest groups are of South Asian ethnic origin which includes Indian, Pakistani and Bangladeshi origin, Somalis and Ethiopians, Black Africans and Caribbean, Eastern European, Chinese, Iranians, Kurds and Yemenis. Repeated consultations with these ethnic groups have shown a need to provide services that are culturally sensitive in order to improve access to mental health services (Sheffield First Partnership, 2010). Therefore, the aim of this study is appropriate and relevant to the local needs of clients and professionals. The study hypothesises that in-house 'Transcultural Mental Health Workers' (TMHW) provide better linguistic and culturally appropriate services compared with buying-in services (interpreters). This study explores what in-house TMHW can offer that 'buying in-services' (Interpreters) cannot. Also, this study reviews the current linguistic and cultural challenges facing HSCPs and affecting their interactions with BME patients when working with interpreters.

2. METHODS

2.1 Setting

Mental health services in Sheffield are provided through four sectors of community mental health teams (CMHT) located in the East, West, South West and North of Sheffield. These include psychiatrists, community mental health nurses (CMHN), social workers, occupational health therapists, psychologists, and approved mental health professionals. In addition, a city wide transcultural team which consists of qualified social workers reflecting the diverse ethnic and cultural backgrounds of the BME communities of Sheffield work as part of the Sheffield Health and Social Care Foundation Trust. The team has the skills and experience in mental health issues as well as the expertise in language that is related to specific BME groups. The interpreting service is also provided as part of Sheffield Health and Social Care NHS Foundation Trust through Sheffield Community Access and Interpreting Service (SCAIS).

2.2 Sample

The sample consisted of 92 participants. The researcher selected 17 to 25 participants from each CMHT. All community mental health teams who have experience working with both interpreters and TMHW were considered potential participants and were contacted via email. Table (1) shows a breakdown of the total number and job title of participants.

2.3 Instruments

A constructivist inquiry approach was utilised to review the current linguistic and cultural challenges facing HSCPs when working with BME patients. The goal of this approach is to rely as much as possible on participant's subjective experiences to enable the researcher to construct meaning of the subject under study (Egon and Guba, 1989). It is recognised that this process is dependent on the

subjective interpretation of the researcher him or herself, and how their background knowledge and experience might shape how the data is analysed.

Job Title	Number of Participants
Psychiatrists	13
Psychologists	5
Social workers	24
Community mental health nurses	24
Occupational therapists	4
Employments and educational workers	3
Art therapists	3
Community recovery worker	2
Care management and reviewing manager	1
Lead professional social worker	1
Psychotherapist	1
GP	1
Senior practitioners	2
IAPT workers	3
Community development workers	3
Transcultural mental health workers	2

Table 1: number of participants from the four community mental health teams and their job titles who took part in the study

In this study, the researcher tried quite hard to step back from the double role involvements as TMHW, interpreter and the role of researcher which was quite challenging and which may have influenced the positive generation of information and feedback from participants. Measures, including objectivity, acting in transparency, identifying conflict of interest, refining and clarifying any possible confusion of roles as well as strict adherence to research methodology were all discussed and addressed with academic supervisors to eliminate any possible confusion of roles.

The findings took into account the inputs of all participants involved in this research. This included using a questionnaire survey, and semi-structured individual and focus group interviews. The questionnaire was designed to explore the HSCPs' views about the main language and cultural factors affecting their interaction with BME patients and how the process of interpretation can impact on these communications. Follow up discussions regarding the role of TMHWs in relation to mental health as an alternative approach to interpreters were explored with HSCPs.

2.2.1 Semi Structured Emailed Questionnaire

The content of the questionnaire was selected in light of the literature review and was influenced by some of the empirical translation studies which concentrated on interpreters' and bilingual workers' background experiences, linguistic abilities and cultural understandings. It was comprised of closed and

open questions. The closed questions asked respondents to choose from multiple choice questions regarding the main language and cultural issues facing them in their work remit, their views about interpreters' and transcultural workers' background experiences, linguistic abilities and cultural understanding, and finally, the recommendations to address these issues. Consistent with Reja (2003), open ended questions allowed respondents to comment on their experiences and to clarify additional points not included in the closed questions. These were other issues experienced when working with interpreters, the possible expertise the TMHW might bring to the service, reasons why working with TMHW might be more effective than working with interpreters, and other recommendations to address the issue of language and cultural barriers (see Appendix 1 for a copy of the questionnaire). The questionnaire was distributed via email introducing the study and containing an online link to access and submit the completed questionnaire using Google Drive. This platform was chosen as it was easier to reach a wider list of potential health and social care participants.

The questionnaire was piloted with 4 respondents: a psychiatrist, social worker, senior practitioner and a health and social care manager who were employees within the Sheffield health and social care sectors to ensure relevance of questions to the study, appearance and layout of the questionnaire, clarity of instruction, and any modifications, additions and time needed to complete it.

2.2.2 Focus Groups and Semi Structured Interviews

To gain further insight into respondents' views about the questionnaire outcomes, participants in the questionnaire were invited to take part in either a focus group or semi structured individual interview. Ten people expressed their wishes to be interviewed and were interested in exploring their views further. Two focus groups of three participants each were arranged at a time and place convenient for them such that six participants took part in total, of which five were female and one male. The first group consisted of two therapists and a senior practitioner, whilst a social worker, psychologist and mental health worker formed the second. The four semi-structured individual interviews consisted of two females and two males including a psychiatrist, a senior practitioner, psychologist and a manager (Appendix2 list a set of questions used to guide the interviews).

2.4 Study Procedure

Discussion with community mental health team managers was initiated at an early stage to provide more explanation regarding this work and to collect 'consent to be contacted forms' from potential participants prior to sending out the questionnaire. In addition, based on a request from potential participants, the researcher was invited to attend a few meetings to provide more information about the study. To ensure a maximum response rate, a cover letter was sent to all participants informing them about the possible benefits of the research and reminders were sent to thank early respondents and urge late ones to take part.

The focus group interviews were organised to gain further insight into the outcomes of the questionnaire themes because they have the advantage of exploring participants' opinions in a relatively short time and allow the generation of nuanced points of views to validate the findings (Morgan, 1996, Gibbs, 1997). Individual interviews, on the other hand, were used to elicit further information about

participants' feelings on specific issues and to provide in depth knowledge and understanding on these topics. Participants were asked to reflect and comment on the impact of language and cultural difficulties identified in the questionnaire on their different personal work practices, and the way each individual dealt with such difficulties. Their views about interpreting service provision and the main reasons to refer BME patients to the transcultural team and whether any advantages were experienced were further explored. Finally, the issue of confidentiality when working with both interpreters and TMHWs and the views about the importance of mental health training within this field were further discussed. The focus groups and semi-structured interviews lasted one hour each and were audio-recorded and transcribed for further analysis to ensure accuracy of the reported texts. Appointments for the focus groups and interviews were arranged with each individual at a time and place suitable for them within Sheffield Health and Social Care Trust premises. The same list of guided questions (Appendix 2) was used with both focus groups and semi-structured interviews and participants were asked to sign a consent form prior to starting. This research received ethical approval from the Sheffield University Research Ethics Committee.

2.5 Analysis

The results of the questionnaire appeared in a spreadsheet format analysed within the Google account. A summary of the results was shown giving a breakdown of answers to every question in an easy to read graphic format. The open ended responses were imported from the drive and were grouped and carefully classified into categories of general themes in accordance with Barney and Glaser's (1967) grounded theory methodology. The frequency of categories, the participants' references, and the uniqueness of certain themes and areas of interest were coded and further explored with participants who agreed to take part in the semi structured individual and focus group interviews.

3. RESULTS

3.1 Preliminary Questionnaire Results

A total of 92 participants completed the questionnaire. The study was aimed at highlighting four main areas to answer the research question: (1) identifying the language and cultural issues that apply to HSCPs, (2) the experience when working through an interpreter,(3) the experience when working with a TMHW, and (4) recommendations to address the issues of language and cultural barriers.

3.1.1 The Main Language and Cultural Issues Facing HSCPs in their Work Remit

Of participants, 64% identified the difficulty of communicating through interpreters as one of the main language barriers when working with BME patients. In all, 60% of participants acknowledged the limited access to translated materials and resources, whilst 55% admitted to the lack of knowledge of BME patients' cultural perspective on mental health issues and felt that BME patients lack the understanding of terminology and concepts related to mental health in addition to the literary issues of some patients. Of participants, 37% drew attention to the limited training available to work cross culturally.

3.1.2 The Experience of Working with Interpreters

Of respondents, 87% acknowledged the fact that briefing interpreters prior to encounters establishes good communication. 63% agreed that interpreters ask for clarification and 61% believed that interpreters have the ability to explain language meaning related to cultural beliefs. The results of this research have some general agreements related to the common problems of working with interpreters. 59% thought interpreters do not always interpret non-verbal communication while 51% believed they may change what the HSCP say. 48% felt the presence of interpreters affects confidentiality and disclosure of information, and 46% believed interpreters lack the training, knowledge, and ability to deal with chaotic mental health settings, and finally 31% agreed that they may exclude HSCPs from the communication in some cases.

3.1.3 The Experience Working with Both Interpreters and TMHWs

Out of the 92 participants who took part in the questionnaire, 72 participants (79%) had a joint working experience with both interpreters and TMHWs and 67% of them (61) felt that working with TMHWs is more effective than working with an interpreter. In all, 23 participants (26%) felt that working with an interpreter is as effective as working with a TMHW, while only 6 participants (6.5%) believed working with an interpreter is more effective than working with a TMHW.

3.1.4 The Experience of Working with TMHWs

Participants reported the experience of TMHWs in the mental health field to be of a high-quality standard which helped HSCPs to understand and address the different cultural perspectives. 77% (71) of those participants reported that TMHWs are able to educate, advocate, build trust and bridge the communication barriers with BME patients and 74% (69) believed they enabled patients to access health information in their languages. Additionally, 61% (56) felt that TMHWs can understand the variable health concepts and non-verbal expressions. 73% (68) believed they are able to address the specific cultural needs and 54% (50) thought they engage better with BME patients, however 31% (29) felt that conflict might arise when TMHWs share the same background as the BME patient.

3.1.5 Recommendations to Address the Language and Cultural Issues:

Of respondents, 69 (75%) recommended the implementation of in-house training for interpreters to enhance their awareness of mental health issues. 57 (62%) also recommended the development of links with the diverse BME organisations to bridge the gap between services and BME communities and 53 (58%) recommended the employment of qualified and trained interpreters as a step forward to provide appropriate linguistic and cultural services. In all, 45 (48%) suggested the development and expansion of the transcultural team to respond to the needs of the community.

In response to the open-ended questions related to other issues experienced when working with interpreters, participants pointed out two main categories. The first focused on issues related to the use of interpreters such as common language problems, communication difficulties and role of conflict as shown

in Table 2. The other category emphasised the practical skills of qualified interpreters, mainly the ability to engage with BME patients, mental health knowledge, cultural understanding and the importance of briefing interpreters.

Issues Related to Using Interpreters	Frequency of occurrence	Examples of Participants' Comments
Common language Problems - Non accuracy/losing meaning/misinform /incorrect information/no way to check - Omission/loss of information/longer sentence for shorter answers. - Edition and alteration of information - Medical terminology - Dismiss symptoms/non verbal	14 8 3 2 2	"*When dealing with clients from a BME background who have little or no understanding of English, it is difficult to get the full picture through an interpreter, especially if the interpreter present omits or edits information" (BN8).* *"On occasions I have found interpreters omitting some important information that the patients may have disclosed but because the interpreter does not realise this, they have omitted it as they have felt it is not important" (BN28)* *"Things are not being translated as they are, interpreters adding their own view points and not listening to the patients carefully" (BN90).*
Communication difficulties - No direct communication/limit response/affect interaction/break the flow/inability to get the full picture. - Prolonged conversation/chatting. - Not speaking the language. - Inability to ask sensitive questions	6 3 2 1	*On one occasion I worked via an interpreter who had prolonged conversation with the patient. The interpreter was giving information to the patient which I had not said which was very unhelpful for me as a therapist" (BN6).* *"I have had experience with one interpreter when seeing someone who was especially traumatised in his own country where the client physically attacking the interpreter due to poor mental health. This was hard to avoid as communication difficulties made this more difficult to anticipate. Working with interpreters sometimes breaks the flow of the conversation and make assessment more difficult..." (BN12)* *"... I've had interpreters who do not speak English sufficiently well to interpret, and who I do not think shall be doing the job..."(BN42).*
Role Conflicts - Confidentiality issues/disclosing information - Role change/over involvement/giving their opinion/dictate what to say - No training/non understanding of mental health issues - Racism and conflict issues - Attendance	8 6 4 2 1	"*...On this occasion, I cannot be certain about what was said, however, I felt that the interpreter put across her own view/opinions and information to the extent that the interpreter kept having to translate what was being said between her and the patient-without me having said anything or asked any questions..."(BN6).* *"...Recently, families from a culture with an immigrant community refused interpreting support as they feared racism from the interpreter" (BN11).* *" If the service user is angry and swears it can cause anxiety for interpreter on what to translate and he may edit some language" (BN33).* *"Patients find it difficult to accept interpreters in sessions due to fear that confidentiality will be breached within their community"(BN52).*

Table 2: Examples of Participants' additional comments about the Issues related to using interpreters

The question which focused on the expertise that TMHW might bring to the service reported a unanimous acknowledgement of their cultural understanding, direct communication, mental health work experience, and ability to engage and maintain confidentiality with BME patients as shown in (Table 3).

The Expertise of TMHW in Mental Health	Frequency of Occurrence	Examples of Participants' Comments
Cultural/religious understanding - Awareness, understanding of cultural beliefs/needs - Consultation and mediation between HSCP and BME	25 9	*"The Transcultural Team Manager in the past has given advice on a specific cultural group and information about that cultural groups opinions in certain matters of health and religion etc. This helped us enormously in being proactive and working with patients and their family sensitively" (BT10).* *"Cultural understanding, increase awareness of what some of the issues affecting a particular community may be. Access to culturally appropriate translation information..." (BT28).*
Engagement with BME patients	15	*"They have the knowledge base of the cultural needs that I would struggle to comprehend and the practical skills and knowledge to help people with mental health problem. I think the transcultural team is a real asset to the trust and helps to forge community links that we would otherwise struggle to develop..." (BT55).* *"Knowledge of culturally appropriate service and guidance on how best to access and manage BME client in crisis" (BT27).* *"...Ability to be supportive and build trust with clients, break down stigma and help clients have compassion for family members with mental health problems" (BT40).*
Direct communication - Conducting therapy/adaptive therapy in mother tongue - Explanation and understanding of complex terminology - Educating and providing culturally appropriate translated materials	11 7 3	"*It would be amazing to have more therapist in IAPT that can deliver psychological interventions in patient's mother tongue as having an interpreter- a third person in the room- is often a disadvantage*" *(BT7).* *"...Able to build a trusting and therapeutic relationship as there is no language barriers" (BT28).* *"A considered understanding of complex barriers to communication" (BT52).* *"A better understanding of cultural needs and therefore better ability to empathise and break down any barriers in communication and trust" (BT86).*
Experience in Mental health - Awareness of mental health issues/cues /symptoms - Improving assessment - Expertise and knowledge of care needs - Increasing access and understanding of health inequalities/stigma	13 7 10 11	*"TMHW have a greater understanding of mental health issues and how they might be evident in a client. These include both the verbal and non verbal cues that can be symptomatic of a disorder. Compared to an interpreter with no or little knowledge of mental health, TMHW understand both the medical and language discourse used by clients. i.e the way of thinking that can be expressed through language and social boundary that defines mental health" (BT8)*

Table 3: Examples of Participants' comments about the expertise of the Transcultural mental health workers

Further recommendations to address the issues of language and cultural barriers included the additional needs of BME patients with disabilities and to ensure specific supervision is provided to interpreters. Moreover, participants highlighted the need to address the importance of recruiting and employing more BME workers who are able to address BME patient's issues through direct communication as well as developing adaptive therapy models which are more suitable for BME needs.

3.2 Focus Groups and Semi-Structured Interviews

Participants reflected on five main areas that came out of the questionnaire: (1) the impact of language and cultural difficulties on the work remit, (2) their views about the interpreting service and its impact on the relationship with patients, (3) the expertise that differentiates TMHW from interpreters, (4) the issue of confidentiality when working with both interpreters and TMHWs and finally, (5) views about the importance of training for interpreters to equip them with the skills needed to work proficiently in this field.

3.2.1The Impact of Language and Cultural Difficulties on the Work Remit

Due to language differences, participants reported longer sessions which can be quite stressful for clients and can discourage them from attending therapy sessions. Moreover, interviewees highlighted that without understanding patients' communication needs and their concepts of mental health, a number of BME patients will be detained, stripped of their civil liberty and have treatment enforced upon them. The unavailability of equivalence of mental health concepts in other languages was reported to cause difficulties in persuading patients about 'Western medical views' as patients are not able to apprehend the purpose and meaning of therapy. Participants also pointed out that reliance on interpreters may lead to the inability to give follow up appointments which can affect the work dynamic and process of treatment as interpreters of certain languages may not be available, particularly in crisis situations:

> "S*ometimes the interpreters are not available so you have to wait for one or two weeks for certain languages to be available and when it is actually you come to be with the interpreter...sometimes you have to talk about mental health, what they are feeling, thinking and there might be difficulty in translating about understanding from the British perspective to what one is used to and sometimes translation can be quite difficult for the interpreter to get across."* (Participant 3, Group A)

The non-availability of BME therapists or adaptive models which can discourage patients from being actively involved in therapy and expressing themselves properly were highlighted. Participants pointed out that therapies such as cognitive behavioural therapy are based on writing a diary and if patients are unable to read or write, they will not be able to understand the benefits of such therapy or engage with it:

> "*...BME clients are from different countries and education is different and the way they do and express things is different and when you try to follow a typical form of therapy, sometimes it doesn't work because the person sometimes doesn't understand why this therapy is offered to them."* (Interviewee 4)

Difficulty in understanding BME cultural concepts of mental health can cause difficulty for HSCPs in providing appropriate support to patients:

> *"the issue for me was to be able to assess and understand people's communication needs and styles, being able to interpret their concept of health, illness and wellbeing in terms of cultural background and be able to translate that into my own ethno western centric views of health illness, being able to modify communication issues around treatment, medication and mental illness which do not always translate to other people's cultural views." (*Interviewee 3)

Moreover, 'Western treatment therapy models' often do not fit with patients' beliefs and asking sensitive questions such as "have you thought about harming yourself" may aggravate some patients. Therefore, building rapport or properly engaging with patients can be very difficult.

3.2.2 The Views about Interpreting Services and its Impact on BME Patients

Generally, participants highlighted the valuable support and positive experience and commitment of interpreters in assessment and therapy sessions. However, they acknowledged the problems related to interpreting complex mental health concepts and understanding 'Western perspectives' of talking therapy which often leads to loss of vital information. They pointed out that the omission of emotional sentences can affect the whole meaning and impact negatively on building rapport and relationships with patients:

> *"...the direct relationship, the emotional content that you have with the client is broken in this sense, you don't have direct kind of contact...you can't really guess if the client is making any progress or not." (*Interviewee 4)

They added that the inability to explain things properly to patients or wording them differently may lead patients to misunderstand their illness. Moreover, they acknowledged that the use of interpreters can change the dynamic of the session particularly when they take over, either through side conversations with clients without telling workers the outcomes of such prolonged conversations, or through role changes when patients address their problems indirectly to interpreters:

> "*I was sort of saying for example how are you feeling about this and the interpreter was answering how you think he is feeling about this."* (Participant 2, Group A)

> *"A few weeks ago I had a patient and it was difficult to have eye contact, she was sobbing and sobbing but she was looking at the interpreter all the time because she felt she was talking to him ...but it was me who was supposed to build this relationship with her.*" (Participant 1, Group A)

While participants considered consultation with interpreters about cultural issues can be quite useful, they felt some interpreters overstep their boundaries and offer advice without consulting HSCPs which undermines the worker' role or can make things worse. Furthermore, participants highlighted the fact that matching the non-verbal communicated words particularly when interpreters leave patients talking for a long time leaves the worker wondering if accurate interpretation is taking place:

> "*... you ask a simple question a typical sort of are you ever violent to your wife and there is a long conversation between patient and the interpreter back and forth and at the end the interpreter will turn back and say no and the worker thinks 'what is going on?'*" (Interviewee 1)

Equally, when interpreters are drawn into patients' family dynamics during assessments, inexperienced interpreters may face difficulties in dealing with such scenarios, particularly if workers are unable to understand the language or are unaware of the problem to offer support:

> *"you're working with a client and the client is part of the family and the family are all involved ... and the interpreter got bombarded with different people and he has to try to manage that rather chaotic set of communication and because the white worker doesn't always know what is being said, it is quite difficult to help this person in that scenario." (*Interviewee 3)

Finally, participants pointed out that some interpreters are unable to communicate the information properly, and rather than interpreting word for word what the patient is saying, they may communicate what they think the patient is saying or filter it through their own knowledge which is completely different:

> "*Interpreters sometimes are not able to convey what the patient said, I have been in meetings sometimes and the interpreter is not able to convey correctly to the doctor what the client said because they don't have English vocabulary."* (Participant 3, Group B)

3.2.3 The Expertise which Distinguishes TMHW from Interpreters

Participants explained that TMHWs are a specialist team who have compatible language skills and background knowledge in mental health:

> *"...because of their experience of working with the client, they have better understanding, better assessment, better engagement, better investigation into cases, better information to the client and better therapeutic sessions and quality services similar to what is offered to the general community."* (Interviewee 4)

Participants acknowledged that the massive strength of the TMHW is their ability to build rapports and form trusting relationships with patients which enables the disclosure of important information through direct communication and can lead to better understanding of BME patients' issues and needs:

> *"how can people get through stress and depression, it is through forming relationships...to me it is the massive strength to the Transcultural Team, they are able to form relationships, guaranteed, they are able to cut the whole level of barrier, the transcultural team have a great way of working."* (Participant 2, Group B).

Moreover, participants believed that having a transcultural team will send a clear message that cultural issues are important and need addressing which will make both workers and patients more confident in the service. Participants pointed out that TMHWs are able to advocate thoughtful considerations of BME cultural needs to their colleagues (HSCP) which will provide valuable support in understanding the different cultural concepts and beliefs of BME patients and enhance their cultural competency:

> "*If other teams have a problem with a BME client, TMHWs will be around and can be asked about what they think, they can assist in the supervision, advise the team, perhaps do one or two consultations ... do short pieces of work...give their input ... or give advice in the care plan where there are culturally appropriate needs..."* (Interviewee 2)

For all these reasons, participants believed that TMHWs' input goes beyond just offering linguistic input; it expands to offer BME clients meaningful care packages where they can access all social work resources within all community mental health teams.

3.2.4. The Clinical Implications of Confidentiality Issues

Overall, participants acknowledged the fact that patients are more willing to work with TMHWs than interpreters. This is mainly because patients are often more content to work with a qualified and professionally trained worker who will abide with the rules and regulations of the health service:

> *"If a worker breached confidentiality, an action will be taken and it could mean the end of his/her career." (*Participant 2, Group B)

Working with interpreters on the other hand is considered by participants to be less regulated because:

> *"Patients know nothing of the interpreting agency and if the interpreter breaks the confidentiality, he might not be allowed to do interpretation within the community but he can easily move to another job."* (Participant 3, Group A)

Still, participants felt the issue of confidentiality is open to doubt because:

> *"Patients usually feel ashamed of other people's reactions to their mental health and often have a disorder of perception where they have fears and thoughts that people talk about them."* (Interviewee 3*)*

Participants pointed out that patients sometimes can experience both dynamic fears of the community and refuse to work with some qualified BME workers. Participants clarified:

> *"This is mainly because ethnic communities are relatively small, people know each other in the community and there have been allegations about possible breach of confidentiality."* (Participant 2, Group B)

Interviewees acknowledged the need to address such issues, and when required, to try to arrange interpreters from other cities as a sign of protecting confidentiality. Additionally, participants pointed out the importance of assuring patients of confidentiality issues at the start of the session so that interpreters will also be aware and notified of the consequences:

> *"I always start the session with the client telling them we abide with confidentiality, rules and regulation and the interpreter follows also the same regulations so the client is satisfied for confidentiality issue and also it is a kind of warning for the interpreter as well that this is you know what we are looking for."* (Interviewee 4)

3.2.5 Mental health training

Participants acknowledged the importance of training in mental health settings as it equips the worker with the essential skills needed to deal with difficult situations as well as enabling the worker to rely and extract information properly to and from the patients in order to offer quality care service. Although shadowing a worker was seen as a good idea, participants differ in their opinions:

"… I don't think it will represent too much of a problem apart from not everyone will want to.*"* (Participant 1, Group A)

"They definitely need to practice how to explain and approach the different kind of questions, to have a good handle of how to say the correct words, because mental health needs specific knowledge of mental health and terminology." (Interviewee 2)

"I can see some training regarding increasing mental health awareness for the interpreter as the idea of shadowing doesn't sound right to me." (Participant 3, Group A)

"They can sit as observers, however the session might take longer and drain the time of the professional." (Interviewee 1)

While participants believed the majority of interpreters working with the Trust have good language and interpreting skills, they felt that interpreters were not trained well enough to deal with difficult mental health scenarios or understand the purpose of the interaction with some being more proficient than others. Therefore, they draw attention that interpreters should be allowed the opportunity to improve their knowledge further in this field where dedicated interpreters may become specialist interpreters in mental health services:

"*It will be a good idea to have a pool of interpreters trained locally to work with a main language …where interpreters and workers start to know each other and have a basic induction about mental health services, followed by further specific training of different assessment situations."* (Interviewee 3)

4. DISCUSSION AND CONCLUSION

Differences in language use between HSCPs and interpreters and the non-existence of equivalent terms and concepts are well documented in translation theories. Catford (1965), Nida and Taber, (1974) and Qia Hu (1994) all argue that total compatibility or the concept of conveying the same message in another language is not always possible and can affect interpreters' abilities to bridge the communication. The outcomes of this study are well supported by research which indicates that the use of medical terms by HSCPs, and the inability of some interpreters to relay information correctly to patients, can affect the understanding of patients and lead to potential clinical consequences (Kareem and Littlewood, 1992; Lago, 1996; Lee, 1997; Westermeyer and Janca, 1997; Farooq and Fear, 2003; Imberti, 2007). Yet, it could well be argued that the unavailability of any systematic review to check and ensure accuracy makes it difficult for a number of HSCPs to judge whether the interpretations are accurate or of low quality.

In addition, the study revealed that up-to-date subject knowledge and understanding of mental health terms and concepts, as well as having accessibility to information resources, were the main assets of the TMHWs which differentiate them from interpreters. This is quite consistent with medical interpretation research previously carried out (Putsch, 1985; Lee, 1997; Farooq and Fear, 2003; Beartriz-Hale, 2007; Schapira et al, 2008). However, It should be emphasized that the abilities of TMHWs to communicate directly with patients in their own languages not only enabled patients to express themselves clearly without the difficulty expressed when using interpreters, but, more importantly, addressed other communication issues facing HSCPs when working with patients with additional

disabilities, hearing difficulties and learning disabilities which can form an additional barrier when communicating with these groups.

There were lessons learnt about the importance of briefing interpreters prior to the meeting with BME patients. Doing so not only enhances the interpreters' knowledge about the assignment and enables them to focus more on the purpose of the session and the requirements of the client, but it can also highlight any concerning issues and allow interpreters the opportunity to ask for clarification which is well recognized by Lee (1997), Tribe and Morrissey (2004), and Tribe and Lane (2009) to be valuable. Despite the recognition of the importance of briefing interpreters, participants agreed that time constraints, combined with issues such as arranging appointments with interpreters and interpreters' attendance, were perceived as the main obstacles to briefing interpreters. Participants explained that due to language differences, the sessions tend to be longer, or in the case of interpreters' late arrival, HSCPs may have little chance to discuss the patients with them. Participants also admit that the lack of briefing often limits the standard of interpreters' performance and can affect their concentration on maintaining accuracy. Accordingly, there is a lack of awareness of HSCPs regarding the level of supervision and support interpreters receive, especially after being exposed to communicating the traumatic experiences of BME patients. Therefore, particular attention should be drawn towards recognising the importance of debriefing interpreters to ensure they are able to talk about their experiences and reduce any emotional distress experienced during the session, and to enable them to regain their composure after delivering the therapeutic session. Moreover, further research around the context of time constraints merit additional exploration and study.

Although similar observations on the importance of understanding patients' cultural beliefs and values were carried out by Kareem and Littlewood (1992), Sue et al (1992), Tribe (1999) and Thomas et al (2009), the findings of this study revealed that while interpreters are able to highlight cultural factors and provide solicited opinions, they cannot intervene in the patient's care or take the initiative to promote culturally sensitive treatment. Based on this outcome, specific attention should be drawn to the value of the TMHWs' consultancy role, where they were found to act as a bridge between patients and the statutory services, offer appropriate advice to undertake assessment in a culturally specific way, and deal with patients in a considerable manner. One can conclude that addressing cultural issues is more important because the different cultural meanings can sometimes cause greater difficulties in understanding than language.

The issue of confidentiality when using interpreters in mental health settings was perceived by a number of participants as one of the main obstacles for patients when seeking help. Families are usually worried about confidentiality particularly when they come from a small social community where there is stigma around seeking support. Patients who have been tortured or experienced physical assault and political imprisonment not only find it particularly challenging to talk about their difficulties with interpreters, but they often refuse to have interpreters present, preferring instead to persevere with broken English. The findings of this study are quite consistent with other studies which have voiced BME patients' concerns about not wanting to work with interpreters such as Miller et al (2005) , Bhui and Morgen (2007)

and Kenynejad (2008). In addition, based on the participants views, it emerges that patients are more content to work with professionally trained transcultural workers due to the consistency and continuity of care which is crucial in building trusting relationships with BME patients.

Due to the complexity of interpretation in the mental health field, having bilingual workers who combine language skills and appropriate mental health training and understanding was considered to provide quality care services for BME patients. However, participants emphasized differentiation between the roles of the TMHW from the interpreter. They highlighted the significant role of the TMHW and pointed out the importance of avoiding the compromisation of their role as a substitute for interpreters as this can change the dynamic of the session and cause confusion amongst patients. This is particularly salient in this climate where resources are limited and there is a need to utilise the expertise of both. Participants argued that they will not be able to accomplish their work without the help of interpreters. Therefore, they emphasized the necessity for interpreters to enhance their performance and skills in this field. Although numerous research studies such as Shuttleworth (2001), Tribe and Ravel (2003) and Gile (2009) acknowledged the importance of training interpreters to enhance their standards, this study recommends practical in-house training within the mainstream services which is believed to give interpreters the opportunity to establish better understandings of possible case scenarios, increase their awareness of mental health concepts, and improve the quality of interpreting. However, this area will still need further exploration in relation to the procedure and development of such a training programme.

5. LIMITATIONS

It was quite difficult to give general views or generalizations about interpreters as there is a wide variation in the competence of each interpreter and their experiences. The word 'effective' is very dependent on the particular individual interpreter or worker and therefore, this may have not been well received or understood by participants. This study was aimed at exploring the role of TMHWs compared to interpreters in providing linguistically and culturally appropriate treatment modalities in achieving positive outcomes for BME patients from the HSCPs' perspective. In order to confirm these findings, further research should be directed towards exploring the BME patients and interpreters' views and experiences with the intention to fully understand the challenges they may face when accessing and working within the mental health field.

COMPETING INTERESTS

AUTHOR HAS DECLARED THAT NO COMPETING INTERESTS EXIST

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Appendix 1: **Language, Culture and mental health: A study exploring the role of transcultural mental health worker in Sheffield, UK**

*Required

I have been informed about the nature of this study and willingly consent to take part in it. I understand that I may withdraw from the study at any time. Tick the BOX

☐

Name: Optional .....

1. What is your job title *Please tick as appropriate

No.	Job Title	
1-1	Psychiatrist	
1-2	Psychologist	
1-3	Social worker	
1-4	Transcultural Mental health worker	
1-5	IAPT (Increased Access to Psychological Treatment)	
1-6	CDW (Community Development Worker	
1-7	Other (Please specify) _____	

Place of Work * Please select as appropriate

- South East Community mental health team
- South West Community mental health team
- North Community mental health team
- West Community mental health team
- Other Please specify in the box below

2. **About your experience of communication with Black and Ethnic Minority (BME) patients * Have** you experienced any language or cultural barriers when communicating with BME patients? Please tick as appropriate

2.1.a	In every encounter with BME patient	
2.1.b	On average more than 50% of the encounters with BME patients	

2.1.c	On average less than 50% of the encounters with BME patients	
2.1.d	In no encounters - **Please Go to Q.4**	

3. Your Description of the language and cultural barriers that applies to you.
*Pleas tick one or more of these issues as appropriate.

No	Issue	
3.1	I do not feel that BME patients always understand the terminology related to therapeutic intervention	
3.2	I find it difficult to engage BME patients in talking therapy	
3.3	I do not always have the appropriate cultural knowledge to understand the BME patients' perspective (cultural and ritual point of views)	
3.4	It is difficult to build trust and acceptance by BME patients.	
3.5	It is difficult to have adaptive therapy models which have cultural and religious contents	
3.6	There are limited resources of translated materials and information	
3.7	Conflicts may get in the way of therapeutic intervention when Sheffield Health and Social Care (SHSC) professionals come from the same country as the patients but differ in views	
3.8	There is limited training available to work cross culturally	
3.9	Literacy problems of BME patients	
3.10	Facing dilemmas when surrounded by different people from different cultures in one room	
3.11	It is difficult to communicate through interpreters	
3.12	Others, please specify _____ _____ _____	

4. **Your experience when working with interpreters with BME patients**

4.1 Do You use interpreters? Please tick one of the following as appropriate

4.1.a	In every encounter with BME patient	
4.1.b	On average more than 50% of the encounters with BME patients	
4.1.c	On average less than 50% of the encounters with BME patients	
4.1.d	In no encounters - **Please Go to Q.6**	

5. These are statements with five possible answer choices for each statement: strongly agree, agree, neither agree nor disagree, disagree and strongly disagree. Please mark your level of agreement or disagreement with each statement:* Please answer all questions

No.	Statement	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
5-1	Interpreters provide effective communication					
5-2	Interpreters lack the knowledge of technical terms					
5-3	Interpreters may change what I say					
5-4	interpreters omit a lot of information					
5-5	Briefing the interpreters before the encounter establishes good communication					
5-6	Interpreters do not always interpret the non-verbal communication					
5.7	Interpreters tend to give their own opinion even when they are not asked.					
5.8	Interpreters have a good understanding of cultural meaning					
5.9	Interpreters reduce effective direct communication with patient					
5.10	Interpreters approach to addressing the questions may aggravate the situation					
5.11	Interpreters interpret the surface meaning only					
5.12	Lack of word for word interpretation which in some cases is vital					
5.13	Interpreters ask for clarification of meaning					
5.14	Interpreters' presence affect patients disclosing personal and confidential issues					
5.15	Interpreters are able to explain language meanings related to beliefs, behaviour and culture					
5.15	Interpreters can feel embarrassed to address sexual or sensitive issues					
5.16	Interpreters provide additional information not intended or said by the patient					
5.17	Interpreters dissuade patients from disclosing information related to culture and religion					
5.18	Interpreters hide and/or omit patients' views about traditional healing					
5.19	Conflict arises when interpreters and patients come from the same country but differ in views					
5.20	Interpreters lack the training in dealing with mental health issues					
5.21	Interpreters may exclude the health and social care professionals from the communication with the patients					

5.B. Please list in the box below any other issues you experienced when working with interpreters.

6 (TMHP)

6.1 Did you work with Transcultural Mental Health Professionals?

6.1.a	In every encounter with BME patient	
6.1.b	On average more than 50% of the encounters with BME patients	
6.1.c	On average less than 50% of the encounters with BME patients	
6.1.d	In no encounters	

6.2 If your choose answer 6.1.d, please state the reasons by ticking the answer that applies to you. Pleas tick one or more of the issues as appropriate

6.2.a	It is very hard to get a referral to the Transcultural Team	
6.2.b	I certainly not heard of the Transcultural team	
6.2.c	I believe they do the same work as interpreters	
6.2.d	Other reason please specify : _____ _____ _____	

7. These are statements with five possible answer choices for each statement: strongly agree, agree, neither agree nor disagree, disagree and strongly disagree. Please mark your level of agreement or disagreement with each statement:

No.	Statement	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
7.1	TMHW engage better with BME Patients					
7.2	TMHW can build trusting relationship					
7.3	TMHW address the specific cultural needs of BME					
7.4	TMHW can understand the variable linguistic expressions					
7.5	Conflict may arise when TMHP share same background but differ in views					
7.6	TMHW can bridge the communication problems					
7.7	TMHW can advocate on behalf of BME patients					
7.8	TMHW enable the access of health information					
7.9	TMHW are trained to deal with mental health issues					

7.10	TMHW are able to handle sensitive questions					
7.11	Joint work and consultation with TMHW increase the cultural awareness of SHSC					
7.12	TMHW can educate BME community					
7.13	TMHW are not always neutral between SHSC professionals and BME patients					

8. What expertise the Transcultural Health workers might bring to the service?

9. Health Professionals?*

9-1	Yes	
9-2	NO	

10. Select one of the following statements *Please tick appropriate response and explain why
    - Working with an interpreter is as effective as working with a Transcultural Mental Health Worker
    - Working with an interpreter is more effective than working with a Transcultural Mental Health Worker
    - Working with a Transcultural Mental Health Worker is more effective than working with an interpreter

11. Please refer to your answer from the previous question and explain why in the space provided below.

12. A the issues of language and culture barriers for BME patients? Please tick as appropriate (you may tick more than one answer)

    a. The implementation of in- house training for interpreters to increase their awareness of mental health issues.
    b. Employing qualified and trained interpreters in the mental health field as a step forward to provide linguistic and culturally appropriate service.
    c. Training BME individuals to be able to work cross culturally in the mental health field.
    d. Developing the example of the 'Transcultural team' to respond to the community needs.
    e. Having a Transcultural in-house consultation to coordinate work and enhance cultural competence of the HSCP.

f. Developing a consultation forum between interpreters, Health and Social Care Professionals and BME Transcultural mental Health Workers
g. Developing practical training programmes for HSCP delivered by accredited and credible BME community members to apprehend the needs of the diverse communities.
h. Developing links with the diverse BME organisations to bridge the gap between services and BME communities

Please list here any other recommendation to address the issues of language and cultural barriers for BME patients

_____
_____
_____

13. Any additional comments?

_____
_____
_____

Thank you for completing this questionnaire

Appendix 2: Set of Questions used to guide focus groups and individual semi-structured interviews

Date:

Participants:

No.	Questions
	Probe questions to be used during the interview as appropriate: such as why, How, in what way? Could you give examples/illustrate or explain more
1.	Can you tell me about the main language difficulties you have experienced when working with BME clients?
2.	Can you give me an example of how this impacted on the service you provide?
3.	Can you tell me about any specific cultural issues related to your work?
4.	How do you deal with such issues when you work with BME patients?
5.	What is your experience when working with interpreters? Can you give examples
6.	Can you describe any specific issues related to the use of interpreters in your service provision?
7.	Did you work with the TMHW before? Can you describe your experience?
8.	What was the main reasons for referring clients to the TMHW service?
9.	What are the advantages of using the TMHW when compared to interpreters?
10.	How important is these advantages in your area of work?
11.	If you didn't work with the TMHW before, why not?
12.	What is your opinion about integrating a model of in-house employment of interpreters within the mental health service?
13.	How could it be achieved?
14.	Any other comments?