

Working through interpreters in old age psychiatry – A Systematic Review

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Abstract

Background: The literature on interpreting and interpretation services is limited in old age psychiatry, and few countries have quality standards when such services are utilised. The aim of this paper was to appraise the effect of the use of interpreters in psychogeriatrics.

Method: We conducted a systematic search of the literature to meet the following objectives: To assess the impact of a language barrier in psychiatric assessment and management, to assess the effect of the use of interpreters on patient satisfaction and quality of care, to identify good practice and make recommendations for research and practice in the field of old age mental health. Exclusion and Inclusion criteria were applied to the research literature. Qualitative and quantitative papers were included. Final stage studies were assessed in accordance with quality ratings, independently by the authors.

Results: Three original research studies met the final criteria stage, and identified obstacles to care pathways exist for BME patients, psychiatric distress through the use of an interpreter is possible and interpreter services are inadequate and unacceptable.

Conclusion: Low number of overall papers fitting the review criteria highlights the need for research in this area. None of these papers were UK based, but provide a platform for areas of exploration within old age psychiatry in the UK. Given the factors of globalisation and migration it is inevitable that psychiatric services will urgently need to address translation and interpretation as embedded services provided to set quality standards.

Keywords: Interpreters, Old Age Psychiatry, Psychogeriatrics, BME

INTRODUCTION

Language is the principal investigative and therapeutic tool in psychiatry. Interference or inadequate communication impairs our ability to assess patients comprehensively. This is most evident in situations where patient and professional are separated by a language barrier, creating a state of dependency on an interpreter, who holds the key to mutual understanding. In today's multi-racial society, particularly in larger cities, it is not uncommon to encounter such a situation, where particular skills are required of both interpreter and doctor. A survey of 1000 professionals working in different psychiatric services in Australia found that more than one-third reported having contact, at least on a weekly basis, with patients with whom effective communication was either limited or impossible because of language barriers (Minas *et al*, 1994).

The proportion of Black and minority ethnic older people over the age of 65 has progressively increased in UK from 1% in 1981 to 8.2% in the 2001 population census (Shah, 2007, Royal College of Psychiatrists, 2009). However, old age services are not adequately meeting the mental health needs of ethnic communities. For example, black and minority ethnic (BME) individuals are generally under-represented in dementia services. Research suggests that individuals with dementia from BME communities are less likely to receive a diagnosis or receive it at a later stage than their White British counterparts (Beatie *et al*, 2005; Bowes and Wilkinson, 2004; Purandare *et al*, 2007).

The combination of being old, belonging to an ethnic minority group, and having a mental illness presents a triad of societal disadvantage. The added disadvantage of not being a native speaker presents a further barrier to psychiatric care. Inadequate communication due to lack of fluency in

English is perhaps the single most important factor which is often responsible for poor access and dissatisfaction with the services. Chinese people in Manchester did not seek help from their GP for dementia because of difficulty in communication due to language, despite being fully aware of the disease and its symptoms. The language barrier was singled out as the main difficulty that the Chinese older people encountered in daily life (Wai Yin Chinese Women Society, 2007). In a study of elderly Asians in Leicester, Lindsey *et al* (1997) reported that the knowledge and understanding of services were significantly worse compared to the white population. Furthermore, the levels of dissatisfaction were higher and 79% were unable to read or write in English in the Indian groups.

Migrant populations also exhibit a higher incidence of mental illness compared with native populations (Westermeyer, 1989) but the language barriers are not limited to ethnic minorities. The high number of refugees and internally displaced persons worldwide due to various conflicts, diverse native populations speaking entirely different languages in the same country and virtually non-existent boundaries in areas such as Europe means that clinicians face language barriers in their clinical practice routinely.

Language plays an important role in all psychiatric assessments. It has specific significance in old age psychiatry when assessing an individual for potential dementia. The standardised assessment tool for dementia is the Mini-Mental State Examination (MMSE) (Folstein *et al.*, 1975). As a screening tool, the MMSE lacks validity in individuals who cannot speak English and can lead to an over diagnosis of dementia (Pandav *et al.*, 2002.). Crucial decisions such as deprivation of liberty safeguards, capacity and consent rely on proper communication and a lack of proper

interpretation can hinder these, leading to important legal and ethical conundrums.

The accuracy of meaning is lost where an unskilled interpreter simply translates. This is well illustrated in the cases of two suicides by Spanish-speaking patients who had been managed by English-speaking psychiatrists working through interpreters. It was concluded that the patients' emotional suffering and despair were underestimated in the interpretation process (Sabin, 1975). Farooq *et al* (1997) identified a range of errors communicating with people who needed an interpreter. In the analysis of audiotaped interviews in which identical questions were used for interviews conducted through interpreters and by a bilingual psychiatrist, even basic information such as the number of children a patient had, was misinterpreted. In psychiatric practice cultural issues further complicate the interpretation process. Both Putsch (1985) and Westermeyer (1990) give examples of situations in which interpreters actively dissuaded patients from disclosing vital information which was seen as stigmatising their culture or religion. Similarly, Psychotherapy relies on language and socio-cultural context. Even for bilinguals, psychoanalysis appears to have less benefit in the second language than in the mother tongue (Greenson, 1950), possibly because using the former does not allow access to important areas of the intra-psychic world. Therapists also have the difficult task of establishing a trusting therapeutic relationship with the patient in the presence of a 'third party'.

This review aims to systematically appraise the effect of the use of interpreters in psychogeriatrics. The primary objective of the review is to assess the impact of a language barrier in assessment and management in old age psychiatric practice. The secondary objectives are to assess the effect of the use of interpreters on patient satisfaction and quality of care, identify good practice and make

recommendations for research and practice in the field of old age mental health. The effect of different types of interpreters such as professional interpreters, lay interpreters and telephone interpreters will also be assessed.

Methods

Literature Search and Data Sources

The following data sources were searched for publications between 1966 and 2011:

- 1 PubMed
- 2 PsycINFO
- 3 CINAHL
- 4 Cochrane Library.

We found in previous reviews that a substantial number of papers from developing and non-English speaking countries is published in journals not indexed in mainstream databases and devised a search strategy using the Google which identified a number of papers, which could not be found when the search was limited to scientific data bases only (Farooq *et al*, 2009). This strategy was considered especially important for this review which focuses on communication across many different languages. Therefore, we conducted a search using World Wide Web in Google Scholar, employing the search term Medical Interpreters and Mental Health. The search included literature in all languages. We also searched the reference lists of included and excluded studies for additional papers. Bibliographies of systematic review articles published in the last five years were also examined to identify relevant studies.

Search terms

The literature search of these databases was performed using following search terms:

1. **Interpreter:** as the keyword and with the appropriate default Medical Subject Heading term for interpreter (translating). For the purposes of this study we used a broad definition of interpreter to include any third-party present in a clinical interaction whose role was to facilitate oral language interpretation between a clinician and patient (NCIHC, 2001). An ad hoc interpreter was defined as:

“... an untrained person who is called upon to interpret, such as a family member interpreting for her parents, a bilingual staff member pulled away from other duties to interpret, or a self-declared bilingual in a hospital waiting-room who volunteers to interpret”. (NCIHC, 2001)

Interpreter services were defined as any intervention involving an interpreter that was intended to enhance language access for a patient who does not share the therapist's/health workers' language, including the use of any type of interpreter (from trained professional interpreters to ad hoc interpreters, including family members, friends, and untrained medical or non-medical staff), and telephone interpreter services.

2. **Age:** We included studies which defined old age as sixty years or above. The following terms were used: age or aging; older; elderly or late onset; or 60, 61, 62, 63, 64, or 65 years, or "dementia" or "Alzheimer's".

3. **Outcomes:** The following search terms were also used: quality of health care, patient satisfaction, communication barriers, language and physician-patient relations, and communication errors.

Inclusion/Exclusion Criteria All articles which met the following inclusion criteria were included:

(1) Peer-reviewed publication including:

(2) Studies which published data about use of professional and nonprofessional interpreters in old age as defined above.

(3) Studies addressing the use of interpreters in counseling and psychotherapy.

In view of the paucity of literature on the subject, we included any type of articles reporting primary data. Quality criteria described below was used to assess the published literature, however no articles were excluded on the basis of this quality assessment. We excluded articles in which examination of the title and/or abstract confirmed that the focus was not on interpreters in mental health. Review articles that did not report primary data and other articles such as opinion pieces were also excluded.

Data collection, analysis and selection of studies

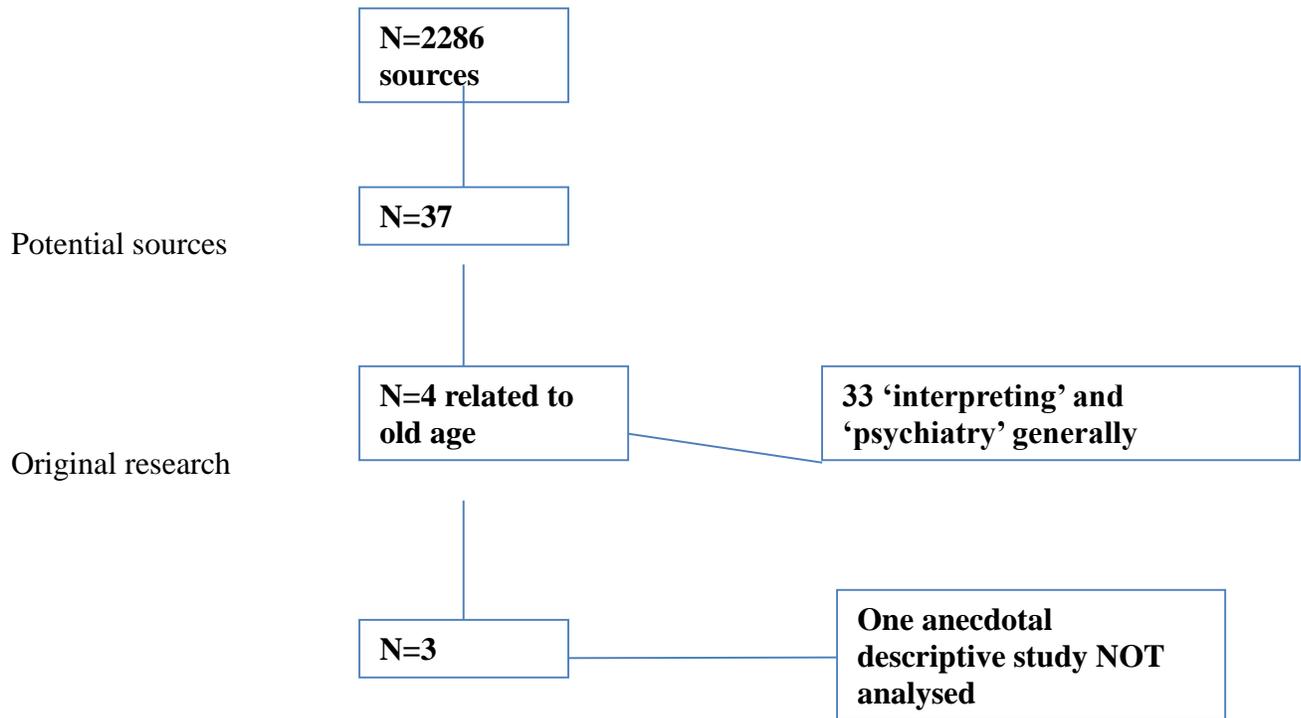
Titles and abstracts of studies identified through searches of electronic databases were independently read and assessed by two reviewers. Two reviewers assessed full copies of studies

which met the inclusion criteria independently. Any uncertainties concerning the appropriateness of studies for inclusion in the review were resolved through consultation with a third reviewer. Reviewers were not blinded to the name(s) of the study author(s), their institution(s) or publication sources at any stage of the review.

The initial scoping search produced 2,286 publications across all databases. We identified 37 potential sources which could contain relevant data. These included 33 journal articles and four books. Only four publications related specifically to ‘old age’; 33 addressed ‘interpreting’ and ‘psychiatry’ generally. Three articles presented original research (Parnes and Westfall, 2003; Hasset and George, 2002; Sadavoy *et al.*, 2004). One article (Shah, 1997) reports an ‘anecdotal descriptive account’ of interviewing elderly people from ethnic background in a psychogeriatric service in Melbourne and does not report any data. Therefore, only three papers met the inclusion and exclusion criteria and present original research in the field of ‘old age’ AND ‘psychiatry’ AND ‘interpreting’. None of these papers present UK based research. One is a quantitative study reporting from Australia (Hasset and George, 2002), one is a qualitative study from Canada (Sadavoy *et al.*, 2004) and one is an American Case Study (Parnes and Westfall, 2003).

Figure 1: Flowchart of search and filter strategy

Original scoping search



Data to be extracted

Two reviewers independently read relevant abstracts and full text studies. A data extraction table was devised (see Table 2) in order to extract the following items.

1. Study type
2. Country
3. Quality rating
4. Aim
5. Participants
6. Method
7. Results
8. Conclusion

Quality assessment of studies

Papers were assessed for quality based on modified checklists from standardised assessment tools. The Quantitative study was rated according to a checklist influenced by Mukadam *et al*'s (2010) adaption of Boyle (1998) and supplemented by criteria from the Critical Appraisal Skills Programme (CASP, 2006). The Qualitative study was rated using a CASP (2006) checklist. The authors did not identify a standardised quality scale for Case studies. For this review, the Case Study quality scale was generated by criteria stipulated by Quinn Patton (2002) and supplemented by CASP (2006).

Each of the respective scales were out of a total of 10 points; 1 being lowest quality rating and 10 being the highest quality rating. Disagreements regarding scoring were rectified through re-examination and collaboration with the co-authors. Points were awarded on the explicit data unequivocal in the paper. No points were awarded for implied information. For example, for the question regarding ethical considerations, if this was not specifically stated, a point would not be awarded.

Enter Table 1 here

Results

In view of the limited literature which provides very little quantitative data and heterogeneous methodologies it is not possible to present a quantitative summary of the results. We therefore describe the main findings for each study separately (see Table 2). We originally aimed to conduct a Meta-analysis, where studies are considered to have sufficiently similar participants, interventions, comparators and outcome measures. We only present specific studies which report

original data; review papers are not analysed here. The salient findings from the reviews and opinion papers are presented in the discussion to give a broader overview of the field

Enter table 2 here

Hasset and George (2002) describe the use of interpreters as part of a larger study on the topic of access to community psychiatric services by older adults in Australia over a one year period. They compared the socio-demographic and clinical variables between Non English speaking background (NESB) older people with those of English speaking backgrounds (ESB). There were 531 referrals to the old age psychiatric community services during the 12-month period. The mean age of the total sample was 77.68 (SD, 10.11) years. The gender distribution was 296 (61.7%) females, and 184 (38.3%) males. They found that that only a relatively small proportion of the NESB group had acquired proficiency in English, even though the mean number of years that they had lived in Australia was 28.92 (SD 24.14).

Interpreters were used in 78.8% of patients for whom English was not their preferred first language. There were no overall significant differences in the clinical diagnoses of the two groups, although there was a trend for the NESB group to be less frequently diagnosed with an affective disorder, and more frequently diagnosed with a primary psychotic disorder. In terms of outcome following the assessment process, there was a trend for the NESB group to require an admission to the inpatient unit, and they were slightly less likely to receive ongoing case management. However, authors provide no data on whether these differences were due to the language barrier or had any association with the use of interpreters.

Sadavoy *et al* (2004) aimed to identify and describe barriers to access to mental health services encountered by old age persons in Canada using a qualitative methodology. The study data was gathered from 17 focus groups. These focus groups comprised of elderly patients and families, family doctors, and agencies involved in providing services to ethnic communities. Focus groups were conducted at local community sites and at time periods acceptable to the various participants, avoiding mainstream institutional settings such as hospitals.

The authors identified a number of barriers to adequate care for the older people from ethnic minorities. They found that all groups demonstrated a surprisingly low level of awareness of the available services. Seniors and families said that they were almost always required to bring their own language interpreters, since institutions paid little attention to the need for cultural sensitivity. They felt that relying on family members as interpreters posed number of problems. For example, patients could not disclose private information, or family members may be unable or unwilling to accompany seniors. Reluctance to be interviewed with an often-young family member (whose language skills are generally better than those of the parent or grandparent) was identified as a significant barrier to effective care. Authors found that Chinese physicians and other caregivers were unwilling to initiate a referral if Chinese-speaking staff were not available.

In a case report, Parnes and Westfall (2003) describe the case of an elderly lady who developed severe anxiety with the use of interpreters. This case highlights peculiar problems associated with use of interpreters in an older population. They describe the case of an elderly woman who was experiencing repeated falls and pneumonia. The patient needed assessment to judge her capacity

to maintain her independent living status. A professional interpreter was used as per hospital policy, instead of her daughter who accompanied her and could have acted as interpreter. At the follow-up visit, the patient was quite distressed. The patient reported that during 6 weeks leading up to the appointment, she had become quite anxious and often tearful in anticipation of the use of an interpreter. She thought that perhaps part of the reason for the third party interpreter was to facilitate an (unwanted) change in her living situation or because there was a medical concern or diagnosis that her daughter was not translating to her.

DISCUSSION

This is the first systematic review of use of interpreters in psychogeriatrics. A major limitation of this review is that only three studies describing the use of interpreters in mental health services are included. None of these studies relate to UK based research. The lack of published research conducted in this field is a significant finding. This reflects the almost total neglect of research in to linguistics in old age mental health. This is despite the fact that in mental health the diagnosis and therapy is almost entirely dependent on verbal communications with the patient and relatives. This lack of research perhaps reflects the inadequate attention older people from ethnic minorities have received both in practice and research. The lack of literature in old age mental health linguistics is in sharp contrast to systematic reviews of evidence in general health care (Flores, 2005) and other fields such as radiotherapy (Gargan and Chianese 2007). Despite this, we can still draw findings from these three papers and utilise them as a platform to begin investigative research in the UK psychiatric setting, with a view to generating policy recommendations.

(Insert Table 3)

Due to the limited literature in the field of old age psychiatry we will extrapolate the findings from literature in adult psychiatry to supplement the findings of the present study to suggest guidelines for UK clinical practice and research.

Interviewing older patients in their own language for constructs like cognitive function is associated with multiple difficulties, as well as the added complexity of interpretation. Shah (1999) provides a descriptive account of the difficulties experienced in interviewing a series of 12 elderly Gujaratis in their own language by the author (who could speak Gujarati) that were referred for services on 14 occasions. Examining patients for cognitive signs and symptoms caused the most difficulty. All patients spoke Gujarati, but only two could speak English. Most patients could not read or write their mother tongue and many had never used a pen or pencil. Therefore the obvious challenge of using the 'Clock Draw Test' (Freedman, M.I *et al.*,1994) becomes apparent.

In old age the lack of effective communication due to inadequate interpretation has far more implications than simply missing an odd diagnosis. Shah and Higginbotham (2008) highlight the issues of language barrier in the assessment of decision making capacity. It is pointed out that the Code of Practice in the UK accompanying the Mental Capacity Act (2005) recognises the role of language and culture in the application of the Act. The successful assessment of capacity requires that the assessor has fluency in the subject's language, and most importantly has the appropriate vocabulary for the concepts discussed during the assessment and advocates provision of written information. With conflicts of interests and lack of appropriate training this can pose significant problems when relatives and bilingual health workers are used. The code of practice recommends

that professional interpreters should always be used for the purposes of the Act. However, it appears that professional interpreters do not have any training in assessment of complex concepts such as mental capacity (for which an equivalent vocabulary may be lacking in many languages). Furthermore mental health professionals do not understand the difficulties associated with use of interpreters in such situations. Similarly, the case report by Parnes and Westfall (2003) highlight peculiar problems associated with the use of interpreters in an older population. In this case an elderly individual reported that during the 6 weeks leading up to the appointment, she had become quite anxious and often tearful in anticipation of the use of an interpreter. She thought that perhaps part of the reason for the third party interpreter was to facilitate an (unwanted) change in her living situation or because there was a medical concern or diagnosis.

At the level of service provision lack of proper communication due to language barriers may partially explain low use and dissatisfaction with mental health services for elderly people from ethnic minorities. Several studies show that elderly people and their families from several black and minority ethnic groups are adequately aware of GP services and make good use of these services (Bhalia and Blakemore, 1981; Barker, 1984; McCallum, 1990, Donaldson, 1986; Balarajan *et al.*, 1989; Gillam *et al.*, 1989; Lindsay *et al.*, 1997b; Livingston *et al.*, 2002). However, the number of Black and minority ethnic elderly people from ethnic minorities using old age psychiatry services remains low (Shah and Dighe-Deo, 1997). Hasset and George (2002) showed that elderly individuals from Asia and other small ethnic communities were less represented in referrals to the service than would be expected from census data. This discrepancy is extremely surprising given the community prevalence of dementia and depression is either similar or higher among black and minority ethnic elders when compared with the indigenous older population

The studies included in this review showed a clear need to improve communication and the need to overcome language barriers. Hasset and George (2002) showed that older people from non-English speaking backgrounds were more likely to be poorly educated, and have a low proficiency in English. They found that interpreters were used in 78.8% of patients for whom English was not their preferred first language. However, there is almost no training for mental health professionals (Bhui *et al.*, 1995). Furthermore there does not appear to be a minimum level of quality assurance for translation/interpretation services.

Interpretation is a more complex process than word-for-word translation. It requires the deciphering of two linguistic codes, each with its own geographical, cultural, historical and linguistic traditions rather than word for word translation. Furthermore, possible complications introduced by adding two more relationships to the interview (interpreter–patient and interpreter–interviewer) should not be underestimated (Farooq and Fear, 2010). The accuracy of meaning is lost where an unskilled interpreter simply translates and more interpreter errors occur with untrained, *ad hoc* interpreters. Provision of trained professional interpreters and bilingual health care providers has been shown to have positive effects on the interview process (Flores, 2005).

The following errors are commonly noted in the process of interpreter mediated interviews in mental health, often with clinical consequences. (For details see Farooq *et al* (1997).

Omission and addition

In *omission*, the message is completely or partially deleted by the interpreter. This is more likely to occur with questions about sensitive personal issues, especially when the interpreter is a family

member or has a personal conflict of interest. In the opposite type of error, the *addition*, the interpreter includes in the answer information not expressed by the patient. These errors are more likely to occur when interpreters are not trained and are interviewing with someone who has difficulty in expressing themselves such as in dementia.

Condensation and substitution

In *condensation*, a complicated or lengthy response is simplified and explained, possibly with the use of a paraphrase. This is a particular problem when assessing patients whose thoughts are disordered and whose response is incoherent to the interpreter, who is usually a layperson.

In *substitution* interpreter's replace one concept by another. This is more likely to occur when an interpreter has difficulty in finding a suitable word to express a concept such as a technical term.

Role exchange and normalisation

In *role exchange*, the interpreter takes over the interview, replacing the interviewer's question with his or her own. In *normalisation*, the interpreter attempts to make sense of the patient's phenomenology, missing the point of the psychiatric interview and produces a 'normalised' response to a complicated phenomenon such as aphasic or thought disordered speech.

There are more subtle ways in which interpretation may affect the quality of a psychiatric interview. The way in which the psychiatrist asks the question (making it open or closed) is altered by the interpreter, which may lead to a different answer from the patient. Alternatively, the interpreter may explore the response to the psychiatrist's open question with further closed questions, delivering the results of his or her own investigation rather than obtaining an accurate

response to the original question. Many questions asked by psychiatrists could be considered to be presumptuous, at best, if presented without the benefit of empathic expression, and this may damage the quality of the rapport or, worse still, provoke a hostile response. In dealing with a lengthy response, background information may be excluded, distorting the context and making the answer appear illogical or tangential, and this can lead the interviewer to consider the possibility that the patient has thought disorder.

The clinician's competence and familiarity with the use of interpreters is extremely important. Simple steps such as speaking slowly, using shorter sentences and 'laymen's' language and avoiding technical jargon can avoid many mistakes. A clinician conducting an interview involving two or more people with an alien language and culture may feel threatened by the situation and easily become overwhelmed. In such circumstances, the interpreter may lose sight of his or her role and the situation of 'role exchange' becomes more likely, with the interpreter taking over the interview. Pre and post interview briefings with the interpreter are extremely important. The goals of the psychiatric assessment, the main areas to be assessed and any sensitive issues that are to be explored (e.g. cognitive assessment, capacity) should be outlined before the interview. It may be necessary to discuss the importance of confidentiality, the need for translation of documents and the problems that can arise if the interpreter tries to 'make sense' of a patient's verbalisations. An interpreter-mediated interview can take up to twice as long as a standard clinical interview and will require considerable skill and patience from clinician and interpreter alike. A post-interview meeting with the interpreter is essential to clarify the interview material and the dynamics of the interaction. In the interview, addressing the patient directly instead of through the interpreter helps to establish a better rapport and give control of the interview to the clinician. A statement that is

inconsistent with a patient's non-verbal behaviour should be explored by changing the wording, breaking down the question or asking about a related issue.

Occasionally, a situation is encountered that requires the use of a relative or friend of the patient, or even another patient, as an interpreter. Where possible, these situations should be avoided, given the sensitive and confidential information being captured. Interviews using such interpreters should be confined to essential information and arrangements should be made for a second, more appropriate, interview to be conducted using a qualified interpreter. It must be remembered that the use of such emergency interpreters will greatly increase the number of errors, particularly those involving role conflict and normalisation. Responses such as 'does not know ...' or 'talks irrelevantly ...' should be explored further to look for errors or psychopathology: in such situations, a verbatim translation should be requested. The interpreter may have his or her own agenda or insecurities in such settings. During the interview, however, it is important to keep a focus on the patient. Interpreters' questions and insecurities should properly be addressed later.

Conclusion

This review set out with the objective to systematically appraise the use of interpreters in psychogeriatrics. The main aim was to assess the impact of a language barrier in assessment and management in old age psychiatric practice. This study successfully surveyed and analysed all relevant literature available and identified obstacles as a result of these language studies. The secondary aim was to make recommendations for research and practice to improve care for the elderly using translators. It was not possible to offer any insights into the effectiveness and appropriateness of different types of interpreters: professional, lay and telephone, for example due to an absence of literature. Even though there were a low number of papers identified, the authors

were still able to extrapolate the findings and make recommendations for areas of exploratory research in UK psychiatric services (see table 3). Based on this review, research needs to fall across three areas: firstly, exploring the barriers to using interpretation services for BME elderly persons, secondly, reducing psychiatric distress during clinical-interpreter experience, and thirdly, an audit of translator numbers, abilities and satisfaction with services is required.

Three major factors will influence a rethink of translation/interpretation services in mental health in the next decade. The first issue is globalisation. With fluid sovereign borders, immigration is increasing across the world. Certainly in European countries mental health services are increasingly requiring the assistance of translators. Secondly, demographic changes will also increase the need for such services. Finally, it will also become essential to develop a standard of translation services in mental health that can be measured for its quality and also efficiency. At present such a quality standard is not available in the UK unlike Sweden (see www.regeringen.se/sb/d/3288/a/19564). This omission is disturbing – especially when decisions on human rights are being considered as part of the Mental Health Act. A recent article by Cambridge *et al.*, (2012) suggests that the medical profession and linguists professional associations might join together to press the government to develop national standards in this area of essential communication.

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Table 1: Assessment of Quality of selected studies

	Quality assessment: Quantitative (CASP, 2006, Boyle, 1998)	Quality Assessment: Qualitative (CASP, 2006)	Quality Assessment: Case Study (Quinn Patton, 2002)
	<i>Hassett, A., George, K. (2002).</i>	<i>Sadavoy, J., Meier, R., Ong, A.Y. (2004).</i>	<i>Parnes, B.L., Westfall, J.M. (2003).</i>
1	Target population: Clear inclusion and exclusion Criteria?	Are the aims clearly stated?	Is the study a descriptive account?
2	Was probability sampling used?	Is a qualitative methodology appropriate?	Does it focus on one person?
3	Did respondents' characteristics match the target population: i.e. was the response rate $\geq 80\%$?	Was the research design appropriate to address the research aims?	Is it accessible to the reader?
4	Were data collection methods standardised?	Was the recruitment strategy appropriate to the research aims?	Is all information necessary to understand the case in it's uniqueness provided?
5	Was the measure used valid?	Were the data collected in a way that addressed the research issue?	Is it a holistic portrayal?
6	Was the measure used reliable?	Has the researcher – participant relationship been adequately considered?	Is sufficient information given to understand the case?
7	Have ethical issues been considered?	Have ethical issues been considered?	Information presented clearly ? either thematically or chronologically?
8	Was the data analysis sufficiently rigorous?	Was the data analysis sufficiently rigorous?	Have ethical issues been considered?
9	Is there a clear statement of findings?	Is there a clear statement of findings?	Is there a clear statement of findings?
10	Is the research valuable?	Is the research valuable?	Is the research valuable?

Table 2: Details of selected studies

Author and year	Study Type	Country	Quality Rating (/10)	Aim	Participants	Method	Results	Conclusion
Hassett A, George K. (2002).	Quantitative	Australia	5	Comparison between patients from non-English-speaking backgrounds (NESB) and English-speaking backgrounds (ESB).	480 European and Asian elderly service users	Socio-demographic and clinical variables were retrospectively collated for a 12-month period and analysed according to NESB and ESB status.	40.8% of patients referred to the service were from NESB, and 78.8% of these were assessed with an interpreter.	Nearly half of elderly patients were from NESB. The lower utilisation of the service by certain ethnic groups may reflect obstacles in their pathway to care.
Parnes, B.L., Westfall, J.M. (2003).	Case Study	America	8.5	Descriptive account of an unintentional adverse experience of a formal interpreter in a clinical encounter.	91 year old Greek Female with falls, depression, hypertension	Case Study	The patient reported that up to the 6 weeks leading to the appointment the lady had become quite anxious and tearful in anticipation of a interpreter instead of her daughter.	Psychiatric distress through use of interpreter is a possibility.
Sadavoy, J., Meier, R., Ong, A.Y. (2004).	Qualitative	Canada	8.5	To identify and describe barriers to access to mental health services encountered by ethno-racial seniors.	Seniors, families and service providers in Urban Toronto Chinese and Tamil communities	This participatory project used Grounded Theory methodology to generate areas of inquiry with 17 semi-structured focus groups	Key barriers identified (amongst many others) the inadequacy and unacceptability of interpreter services.	There is a clear need for more mental health workers from ethnic backgrounds, especially appropriately trained psychiatrists.

Table 3: UK Research Implications

Author	Findings	UK Research Implications
Hassett, A., George, K. (2002)	Obstacles to care pathways exist for BME patients	Identify if and where these barriers exist in a UK psychiatric setting
Parnes, B.L., Westfall, J.M. (2003).	Psychiatric distress through use of an interpreter is possible	Investigate mood and quality of life levels for patients using UK interpreter services
Sadavoy, J., Meier, R., Ong, A.Y. (2004).	Interpreters are inadequate and unacceptable	Scoping study on type and number of UK interpreters needed and satisfaction with services