ORIGINAL PAPER

Language Barriers in Mental Health Care: A Survey of Primary Care Practitioners

Camille Brisset · Yvan Leanza · Ellen Rosenberg · Bilkis Vissandjée ·
Laurence J. Kirmayer · Gina Muckle · Spyridoula Xenocostas · Hugues Laforce

Abstract Many migrants do not speak the official language of their host country. This linguistic gap has been found to be an important contributor to disparities in access to services and health outcomes. This study examined primary care mental health practitioners' experiences with linguistic diversity. 113 practitioners in Montreal completed a self-report survey assessing their experiences working with allophones. About 40 % of practitioners frequently encountered difficulties working in mental health with allophone clients. Few resources were available, and calling on an interpreter was the most common practice. Interpreters were expected to play many roles, which went beyond basic language translation. There is a clear need for training of practitioners on how to work with different types of interpreters. Training should highlight the benefits and limitations of the different roles that interpreters can play in health care delivery and the differences in communication dynamics with each role.

Keywords Mental health · Primary care · Migrants · Linguistics barriers · Interpreters

Introduction

Increasing linguistic and cultural diversity due to globalization and migration to Western countries poses challenges for health care systems. Many migrants do not speak the official language of the host country. The province of Quebec, for example, includes 12.1 % of allophones (i.e., locally defined in Quebec as individuals whose mother tongue is neither English nor French, the two official languages [1]), and about 0.9 % of the population does not speak either official language. These percentages rise to 32.5 and 2.6 % respectively for Montreal, Quebec's largest city [2]. Linguistic barriers in health practitioner-client[1] communication are one of the most important contributors to health disparities, and can lead to inappropriate medical diagnoses [4], higher rates of treatment dropout [5], recurrent hospitalizations and longer stays, poor adherence to medication and treatment recommendations, lower client satisfaction, and greater risk of medical errors with more serious consequences [6]. These data underscore the need for access to linguistic services, as prescribed by the Quebec law on health and social services [7].

The issue of language is particularly important in mental health care as the dialogue between clients and

C. Brisset · Y. Leanza (✉) · G. Muckle
École de Psychologie, Université Laval, Pavillon Félix-Antoine Savard, 2325 rue des Bibliothèques, Quebec, QC GIV 0A6, Canada
e-mail: Yvan.Leanza@psy.ulaval.ca

E. Rosenberg
Department of Family Medicine, McGill University, Montreal, Canada

B. Vissandjée
Faculté de sciences infirmières, Université de Montréal, Montreal, Canada

L. J. Kirmayer
Division of Social and Transcultural Psychiatry, Department of Psychiatry, McGill University, Montreal, Canada

S. Xenocostas · H. Laforce
Centre de santé et de services sociaux de la Montagne, Montreal, Canada

---

[1] The term "client" was chosen over "service user" or "patient" in this paper, as mental health practitioners in Montreal appear to favor its use [3].

practitioners is central to both diagnostic assessment and treatment. Language is the principal means by which clients express their lifeworld[2] and practitioners convey their understanding of clinical situations [9]. The few existing studies on mental health and language barriers have consistently shown that members of linguistic and ethno-cultural minorities make less use of mental health services than the dominant groups, for comparable levels of distress [10, 11]. This lower rate of utilization has been attributed to differences in socioeconomic status between populations (migrant vs. non-migrant). However, there is evidence that linguistic and cultural barriers are important contributors to the observed differences in access to care, particular in systems with universal health insurance, like Canada [10, 12]. Lack of attention to language and culture can prevent the establishment of adequate communication and trust between allophone clients and their practitioners [13].

The implementation of specific measures for allophones, particularly newcomers, was deemed essential in the 2005–2010 plan of the Quebec Ministry of Health and Social Services. Some specialized services do exist for migrants, refugees and Canadian Aboriginal peoples in Montreal [14]. A key feature of these specialized services for allophones is the involvement of interpreters. There is evidence that systematic use of interpreters in health care can improve access to care, the accuracy of diagnosis, and treatment outcomes [15–17].

The effective integration of interpreters into health care presents several challenges. Firstly, appropriate techniques are specific to the type of interpreter in the health care system: professional interpreters versus ad hoc interpreters. Professional interpreters (PIs) refer to a person who has received some kind of formal training in interpretation, and ad hoc interpreters (AIs) are untrained individuals, often a family member, healthcare staff member, or even a stranger in the waiting room, who are called on to interpret. Although working with PIs is preferred for ethical reasons and because it is associated with better clinical outcomes [15], many clinical encounters involve AIs [18, 19]. Secondly, practitioners must also be aware of the many roles interpreters can take on in addition to basic language translation [20]. For example, Leanza [21] proposed a typology of interpreter's stances, each encompassing a variety of roles. In the *linguistic agent* stance, interpreters are limited to translating and aim for impartiality and neutrality. As *system agent*, the interpreter seeks to transmit to the client the dominant biomedical discourse with its norms and values. In this stance, cultural differences are minimized or ignored, the dominant culture is favored, and interpreters act as bilingual professionals. In the *lifeworld agent* stance, interpreters play the roles of cultural informants, mediators, or advocates. Cultural differences are acknowledged and the migrant's values and norms are conveyed to the practitioner. Finally, the stance of *integration agent* occurs outside the context of the consultation where interpreters may help migrants find resources, make sense of cultural differences, and adapt to the cultural milieu. Thirdly, no matter the type or the stance of the interpreter, the presence of this third person poses many relational challenges that influence the quality of care. The inclusion of an interpreter changes the dynamics of power, trust, and control in the clinical encounter [22].

Despite the importance of interpreter's in mental health [17], there is limited knowledge about their use in primary care settings [23, 24]. As part of a larger mixed-method project, the present study examined language issues among primary care mental health practitioners (family physicians (FPs) and other professionals) working with allophones in Montreal and discussed the challenges and complexity of such practice. The objectives were to identify: (1) current practices with allophone clients and available resources; (2) language services requirements; (3) practices in working with interpreters; and (4) representations of interpreter roles in mental health. We expected that practitioners who had more experience working with allophones would develop greater knowledge and skill in working with interpreters. Specifically, we hypothesised that:

Hypothesis 1 Practitioners with a higher proportion of allophone clients would be more aware of available linguistic resources.

Hypothesis 2 Practitioners with a higher proportion of allophone clients would develop greater linguistic skill or knowledge.

Hypothesis 3 The number of linguistic needs identified by practitioners would increase with the number of their allophone clients.

Hypothesis 4 The number of times practitioners called upon an interpreter would increase with the number of allophone clients.

Methods

Survey Instrument

The survey instrument was developed by reviewing previous studies presenting descriptive data on practices with allophone clients and by requesting copies of the questionnaires used from the authors. Six questionnaires were obtained [18,

---

[2] The Lifeworld refers to contextually grounded experiences oriented toward understanding and consensus through negotiation, as opposed to the System, which relates to decontextualized rules oriented toward efficiency and success [8].

19, 25–28] and used to develop a self-administered survey to address the study objectives. The initial instrument was developed in French and then translated into English by a professional translator. To check accuracy, the English version was then back-translated into French by a second translator unfamiliar with the original instrument [29]. Discrepancies were resolved through group discussion.

The final instrument consisted of 23 general descriptive questions exploring the resources available to mental health practitioners working with allophone clients, their use of each resource, their linguistic needs, their practices in working with interpreters (current practices, reported influencing factors, satisfaction and perceived advantages/difficulties) and their representations of the interpreter's roles according to Leanza's typology [21]. Questions about advantages and difficulties of working with interpreters were based on the existing qualitative literature [30–32]. Response choices for questions on perceived difficulties in working with allophone clients, linguistic needs, perceived satisfaction in working with interpreters and client's appointment keeping to treatment used a 5-point Likert scale (from 1 = "not at all" to 5 = "extremely"); questions on perceived factors influencing the use of professional interpreting services used a 3-point Likert scale (1 = "negative influence"; 2 = "no influence"; 3 = "positive influence"). For all other questions, participants indicated applicable items on a provided list.

Participants and Procedure

Surveys were sent in September 2011 by email to Montreal-based primary care mental health practitioners from six community Health and Social Services Centers (HSSCs)[3] and three crisis centers (estimated N = 250) via their service coordinator. Reminders were sent 2 months later. Family physicians (N = 2,402) were contacted by Canada Post using the Collège des Médecins du Québec's mailing list; only physicians working within the same territory as the HSSCs were included in the study. It is important to note that it was not possible to remove names of FPs who do not provide primary care mental health care to allophone clients before the surveys were mailed.

Data Analysis

Data on perceived difficulties in working with allophone clients, linguistic needs, perceived satisfaction in working

with interpreters and client's appointment keeping were reported as means. Comparison between and within groups were examined using t tests. The remaining data was reported as frequencies, and differences between groups were tested with z-scores [33]. Frequencies for interpreter's role characteristics were also ranked by researchers, then averaged for each stance, and compared with a Kruskal–Wallis test to estimate the importance of each stance. Chi square analysis and Bravais–Pearson correlations were performed to test the hypotheses.

Ethics approval for the study was obtained from Research Ethics Board (REB) of the de la Montagne HSSC as the primary REB in this multicenter project.

Results

A total of 113 questionnaires were returned. Participants were FPs providing mental health care (56.2 %, n = 63), and mental health workers (43.8 %, n = 50), including social workers (15.2 %), psychologists (11.6 %), and nurses (3.6 %). The remaining 13.4 % were members of a variety of mental health professions including psycho-educators. The mean age was 45.14 years (SD = 12.44), 73.2 % were female, and they had been practicing an average 18.35 years (SD = 13.48). The majority were Canadian citizens (96.5, 5.3 % of whom had two nationalities), and 3.5 % were non-Canadian citizens (from Europe and North Africa). Most participants spoke French (97.3 %), followed by English (70.8 %), Spanish (19.4 %), Italian (7.1 %) and Arabic (4.4 %); 74.3 % spoke at least two languages. Respondents had been working with allophones for an average of 14.16 years (SD = 11.22). On average, they estimated that 20 % of their patients were allophones, who mainly came from Asia/Middle East (39.7 %), and Central/South America (26.5 %).

Available Resources and Their Use

Although the majority of respondents reported "sometimes" having difficulties working with allophones presenting mental health problems (Mean = 3.06, SD = 1.01), 37.6 % of them had "frequently" or "very frequently" encountered such difficulties. Of all practitioners, 35.4 % had access to linguistic resources through their institutions and 23.9 % had themselves been solicited to interpret. Resources available at respondents' practice sites included the ability to call an interpreter (43.4 %), multilingual specialized health care website (39.8 %), multilingual brochures (17.7 %), multilingual telephone menus (6.2 %), signs/instruction posters (5.3 %), name tags (1.8 %), and automatic translation of prescriptions (0.9 %). About six percent also reported using online multilingual resource material they had located on their own.

---

[3] In Quebec, health services and social services are integrated into administrative units, called Health and Social Services Centres (HSSCs). These institutions ensure accessibility, case management, follow up and coordination of services for the population of a geographically defined region. There are 94 HSSCs throughout the province and 12 in Montreal.

Compared to respondents with few allophone clients, practitioners with a higher proportion of allophone clients did not appear to be more aware of the available linguistic resources ($\chi^2(4) = 2.80$, ns) nor were they more likely to develop linguistic skills or knowledge to overcome linguistic barriers ($\chi^2(8) = 5.66$, ns), contrary to hypotheses 1 and 2.

Linguistic Needs

As presented in Table 1, access to PIs in person was considered to be the most important potential resource, followed by having a list of bilingual staff members ($t(78) = 2.94, p < .01$), then multilingual brochures ($t(78) = 2.18, p < .05$). FPs expressed a significantly lesser need to access PIs than did other practitioners, whether the service was offered in person or remotely (PI in person: $\text{Mean}_{FP} = 3.86$, $\text{SD}_{FP} = 1.33$, $\text{Mean}_{others} = 4.66$, $\text{SD}_{others} = .54$, $t(79) = 3.20$, $p < .01$; remote PI: $\text{Mean}_{FP} = 2.94$, $\text{SD}_{FP} = 1.20$, $\text{Mean}_{others} = 3.88$, $\text{SD}_{others} = 1.23$, $t(77) = 3.36$, $p < .01$). Results also showed that the number of identified linguistic needs did not increase with the number of allophone clients ($r = -.09$, ns), contrary to hypothesis 3.

Working with Interpreters

Current Practices

Seventy percent of practitioners had worked with an interpreter; 62.3 % did so "once a month or less", 28.6 % "between once a month and once a week" and 9.1 % "once a week and more", and 2.6 % had received training on how to work with an interpreter.

Table 1 Practitioners' rating of importance of linguistic resources (n = 82, 1–5)

Resources*	Mean (SD)
Access to a professional interpreter in person	4.17 (1.16)
List of staff members who speak different languages	3.71 (1.16)
Multilingual brochures	3.39 (1.10)
Remote professional interpretation services	3.32 (1.29)
Volunteer interpreter	3.31 (1.16)
Multilingual specialized health care website	3.14 (1.25)
Multilingual resource material on the Internet (other than that provided by the institution)	3.06 (1.19)
Automatic translation of prescriptions	3.00 (1.39)
Signs/instruction posters	2.87 (1.18)
Multilingual telephone menus	2.78 (1.21)
Name tags for staff members indicating languages spoken	2.46 (1.18)

* Rated on Likert scale (from 1 = "not at all" to 5 = "extremely")

Practitioners principally relied on someone close to the client (family or friend; 57.1 %) to interpret, then a PI in person (55.8 %), a non-health care staff member at their work place (secretary, etc.; 36.4 %), a health care practitioner (35.1 %), a volunteer from a community organization (15.6 %), a remote PI (11.7 %) and an unknown person (someone in the waiting room; 7.8 %). However, 56.6 % of the time practitioners do not know what type of interpreter they were working with.

As expected, the number of times practitioners called upon an interpreter increased with the number of allophone clients ($r = .32$, $p < .001$), consistent with hypothesis 4. However, practitioners did work more frequently with AIs (81.2 %) than with PIs (67.2 %; $\chi^2(1) = 7.21$, $p < .01$) independently of the number of allophone clients they had.

Reported Factors Influencing the Use of Professional Interpreting Services

As shown in Table 2, practitioners chose PIs because they were fluent in the spoken colloquial language, because it was possible to have the same interpreter for all visits with the same client, and because practitioners believed the choice of a PI enabled them to meet their professional responsibilities. The main barriers to calling upon PIs were problems with required administrative procedures.

A higher proportion of FPs than other mental health practitioners chose PIs because of their knowledge of the Quebec health system (75.8 vs. 43.5 %, z = 2.45, $p < .01$) and of community resources (66.7 vs. 39.1 %, z = 2.04, $p < .05$). But the cost was a greater obstacle for them (55.9 vs. 20.0 %, z = 2.77, $p < .001$).

Satisfaction in Working with Interpreters and Appointment Keeping

Generally speaking, practitioners were satisfied working with interpreters (Mean = 3.63, SD = .60). However, they were more satisfied with PIs (Mean = 3.84, SD = .73) than with AIs (Mean = 3.16, SD = .45, t(50) = 4.53, $p < .001$).

As presented in Table 3, clients were perceived to be more likely to keep their appointments when there was an interpreter of any kind than when there was no interpreter. However, they attended more regularly when a family member, a friend, or a PI in person was involved than when an AI from the institution (other health care practitioner, secretary, etc.) interpreted for them (t(42) = 2.49, $p < .01$ and t(36) = 0.83, $p < .05$, respectively).

Advantages and Difficulties of Working with Interpreters

Practitioners were also asked to indicate on a provided list the difficulties and advantages they encountered in working

Table 2 Reported factors influencing practitioners' decision to use professional interpreting services (%, n = 60)

	Negative influence	No influence	Positive influence
The interpreter has a good knowledge of the spoken colloquial language	0.0	7.1	92.9
The same interpreter can be booked for client follow-up	0.0	14.0	86.0
Practitioners' sense of professional responsibility	1.8	17.2	81.0
The interpreter can provide information on the history and culture of the client's country of origin	1.8	25.0	73.2
The interpreter is completely neutral	3.7	25.9	70.4
On-site presence and immediate availability	23.6	12.7	63.6
The interpreter can provide the client with information on the Quebec health network	3.7	33.93	63.0
The interpreter is familiar with outside resources	3.7	42.6	53.7
The interpreter accompanies the client to other appointments and/or errands outside of the consultation	6.0	44.0	50.0
The interpreter has knowledge in the area of mental health	3.8	49.1	47.2
Encouragement/support from the hierarchy	9.8	54.9	35.3
The interpreter is able to help assess the client and decide on treatment/care	19.2	51.9	28.8
High cost for the service	38.6	61.4	0.0
Practitioners' unfamiliarity with the access procedure	44.2	53.8	1.9
Complicated administrative procedures	48.2	44.6	7.1

with interpreters. As shown in Table 4, reported advantages were greater with PIs than AIs, while difficulties were more frequent with AIs.

Practitioners perceived that both AIs and PIs had the advantage of providing knowledge of the spoken colloquial language and the client's culture and history. In contrast to AIs, PIs were also considered to offer the advantages of knowledge of the health care system and of specialized mental health vocabulary. Both AIs and PIs were perceived to lack knowledge of community resources that could be useful to the client, and this was viewed as a difficulty by practitioners in their practice.

When considering the practice itself, reported difficulties were the same for both types of interpreters, and principally concerned the increased time required for consultation and

Table 3 Clients' appointment keeping according to the type of interpreter (n = 59)

Clients' appointment keeping when…*	Mean (SD)
… accompanied by a family member or friend	3.95 (1.13)
… a PI in person service is offered	3.84 (1.25)
… accompanied by a volunteer from a community organization	3.68 (1.17)
… a remote PI (over the telephone) service is offered	3.56 (1.97)
… someone from the institution can interpret for them	3.30 (1.50)

* Rated on Likert scale (from 1 = "not at all" to 5 = "extremely")

the practitioner's lack of training. PIs were perceived to be more reliable in the quality of transmitted information, and to allow practitioners more control over the consultation, and more support from their institutional hierarchy. Results were not as clear cut with regard to mental health aspects. Practitioners reported difficulties conveying their empathy with both type of interpreters. Working with PIs or AIs was perceived neither as a difficulty nor an advantage in gaining access to the client's emotional state and in fostering the practitioner-client relationship (i.e., therapeutic alliance).

Interpreter's Role Characteristics

On a list of 16 characteristics based on Leanza's typology [21], participants were asked to indicate the five most important ones. As presented in Table 5, practitioners had fewer expectations of AIs than PIs.

While there were no differences in the importance of each interpreter's stance (AI: $\chi^2(3) = 5.83$, ns; PI: $\chi^2(3) = 6.05$, ns), there was a gradation in the importance given to each characteristic. Participants considered the stance of linguistic agent as the most important, followed by integration agent, lifeworld agent and system agent. Interpreters were expected above all to provide complete and accurate translations, as well as sociocultural information pertaining to the client, and to welcome him/her in his/her own language, using the appropriate greeting rituals. Issues of neutrality and empathy were also highlighted. The least frequently chosen characteristics were those involving greater autonomy of the interpreter (to give health care advice, to participate in the therapeutic process, and to defend the client's point of view).

Discussion

Our study aimed to describe current practices, priorities and perspectives of primary care mental health practitioners in working with allophones. Our findings demonstrate a clear need to overcome language barriers in Montreal cross-linguistic care, as supported by Papic and colleagues

Table 4 Practitioners' rating of advantages and difficulties in working with interpreters (%, n = 57)*

	AI		PI	
	Advantages	Difficulties	Advantages	Difficulties
Related to the interpreter				
Knowledge of the spoken colloquial language	39.0	13.0	59.8	11.7
Knowledge of client's culture and history	34.4	18.2	46.9	15.6
Knowledge of health care network/system	1.6	35.1	32.9	11.7
Knowledge of specialized mental health vocabulary	1.6	40.3	36.0	24.7
Knowledge of community resources that could be useful to the client (outside the health care system)	7.8	35.1	7.3	18.2
Related to the practice				
Control of the consultation	14.1	22.1	36.0	15.6
Working with the same interpreter for all of the same client's appointments	28.1	16.9	35.9	23.4
Access to client's emotions	30.0	33.8	42.2	29.9
Quality of information	29.7	41.6	57.8	28.6
Quality of relationship (therapeutic alliance, trust, etc.)	21.9	40.3	32.8	32.5
Transmission of my empathy	12.5	32.5	31.2	28.6
Time required for consultation	–	52.0	–	49.4
Training and supervision available	0.0	29.9	10.9	32.5
Support from institutional hierarchy	0.0	13.0	25.0	18.2

* Each item was formulated separately as an advantage (e.g., better knowledge…) and a difficulty (e.g., lack of knowledge…), and for each type of interpreter. The numbers presented in the table refer to the percentage of practitioners who considered the item as an advantage and/or a difficulty stemming from AIs and/or PIs

work on family physicians' attitudes to the care of migrant patients [34].

The survey revealed that for primary care mental health practitioners in this multilingual urban milieu:

1. Having access to interpreters was considered as the most important resource to overcome language barriers, but the great majority of practitioners had not been trained to work with interpreters;

2. Most of the time practitioners were not aware of the type of interpreter with whom they were working;

3. Most interpreted consultations involved AIs drawn from the client's family members or friends. This finding is consistent with the existing literature [34–36]. AIs offer the advantage of immediate availability (being present at the same time as the client), continuity (being present for each consultation), trust by clients [37] and they do not necessarily convey clients' disagreement or resistance about the diagnostic and treatment [38].

4. Clients were perceived to come to their appointments more regularly when accompanied by a family member or a PI in person than when an AI from the institution's staff interpreted for them.

5. Practitioners may neglect to call upon PIs because they are unaware of available linguistic services and the procedures to access these resources. Compared to other practitioners, FPs expressed less need to access professional interpreting services, perhaps due to time constraints, or a view of family members as natural caregivers that displaced attention from their role as interpreters [32]. Nonetheless, it has been well-established that the quality of care can be compromised with AIs [16, 17, 38, 39].

6. While professional interpreting service costs are relatively low compared to other health care expenditures [6], the perceived expenses to the institution were a preoccupation for practitioners. The paradox here is that there is evidence that use of interpreting services leads to net cost savings. The initial costs are higher, but the systematic use of interpreters prevents the escalation of problems and so reduces long-term costs [40, 41].

7. Our data suggest that the magnitude and variety of efforts made by practitioners to accommodate allophone clients were independent of the number of allophone clients they saw in their practice.

8. Accessing clients' emotions and conveying empathic understanding with the help of an interpreter appeared to be very challenging for many primary care mental health practitioners. Their ideal interpreter was a language professional specializing in mental health who also knew the culture and the local social network or community resources. In this respect, PIs were a closer to this ideal than AIs. This finding is congruent with practitioners' expectations of interpreters' roles.

Table 5 Practitioners' rating of interpreters' expected stances and role characteristics (%, n = 69)

	AI	Rank*	PI	Rank
Linguistic agent				
Provides accurate translations	44.2	2	74.1	1
Translates everything that is said	45.5	1	72.8	2
Is completely neutral (adds nothing to what is said)	32.5	6	58.1	4
Transforms the content of dialogue to make it comprehensible	24.7	8	28.6	8
Mean rank		*4.25*		*3.75*
Integration agent				
Welcomes clients in their own language, using the appropriate greeting rituals	33.8	4	44.2	5
Accompanies clients to other appointments and/or errands outside of their consultation (e.g., the pharmacy)	26.0	7	19.5	10
Mean rank		*5.5*		*7.5*
Lifeworld agent				
Is able to provide practitioners with socio-cultural information pertaining to the client	39.0	3	67.6	3
Is able to provide the client with socio-cultural information on the local culture (how institutions function, how a consultation works, the roles of health care practitioners, etc.)	18.2	11	32.5	7
Is able to help resolve differences in values with respect to care/treatment	18.2	11	18.2	11
Gives personal information on clients that they did not provide themselves	24.7	8	13.0	13
Defends the client's point of view in the event of disagreement	5.2	15	5.2	14
Mean rank		*9.6*		*9.6*
System agent				
Shows empathy toward the client	33.8	4	35.1	6
Is able to ask the client the appropriate questions and give a summary of his/her answers	23.4	10	28.6	8
Is able to discuss the client's symptoms, their seriousness and how they are expressed, and to help practitioners make a diagnosis	14.3	13	16.9	12
Is active in the caregiving/psychotherapeutic process (acts like a co-therapist)	10.4	14	5.2	14
Gives the client health care advice	5.2	15	3.9	16
Mean rank		*11.2*		*11.2*

* A small rank indicates a characteristic of great importance

First and foremost, interpreters were expected to adopt the stance of linguistic agent [21]; that is, to maintain a neutral and impartial position in the consultation and to intervene on the level of language translation. However, our respondents also expected interpreters to provide information that was not explicitly articulated within the context of the consultation. This could be sociocultural information that pertains to the client (e.g., traditional care, representations of illness or religious rituals), which would give practitioners a better understanding of the client's situation, personal information (provided by AIs who knew the client socially), or sociocultural information about the host culture to the client (in the case of PIs who were knowledgeable about the Quebec context). To a lesser extent, interpreters were expected to show empathy to the client and welcome them in their own language, using the appropriate greeting rituals. Each of these three role characteristics is specific to a particular stance: respectively, those of lifeworld agent, system agent, and integration agent [21]. Thus, interpreters were expected to play very different roles that went well beyond basic translation, and

which could be perceived as contradictory if not clarified. For example, how is the interpreter expected to show empathy while remaining neutral? Clarifying these tasks requires knowledge of the stances/roles that interpreters can play and of the associated ethical and pragmatic issues. Unfortunately, our study suggests that many practitioners are not fully aware of these different stances/roles and the associated pragmatic, clinical and ethical issues. While the core issues in providing mental services with interpreters appear very similar to those in broader health services (e.g., neutrality [42], continuity [43], costs for the institution [44], etc.), the specificities of mental health interpreted interventions were difficult for practitioners to identify.

This study is the first of its kind in Canada and contributes to the sparse literature on current practices with allophones in mental health in the province of Quebec. The study has important limitations. The survey did not cover the entire island of Montreal as only half of the HSSCs and crisis centers agreed to participate. Nevertheless, the participating centres were diverse and located in the districts of the city with the greatest concentration of allophones.

The survey did not allow us to distinguish FPs working in HSSCs and those in private practice, and such data on practice setting might have given added insight into the results. The self-report measures in the survey only provided general, descriptive data. Further work is needed using interviews of mental health practitioners to gain a better understanding of the issues involved in improving the quality of practice with interpreters, as well as to guide development of appropriate training. Investigating the impact of mental health interpreting with measures of psychological constructs such as empathy, attachment or working alliance may provide better understanding of the interpersonal issues involved in working with allophones and interpreters. Such studies would be innovative in the field of community interpreting.

Conclusion

This survey of primary care practitioners' providing mental health care in Montreal revealed a lack of linguistic resources and training, and a lack of clarity about the roles interpreters can play. The results highlight the need for better organization of institutional services, and for the development of specific training for professionals in working with interpreters in the field of mental health. This training would include practical information on available linguistic resources, and the implications of different modes of working with an interpreter. Some cross-cultural courses are offered to practitioners in Montreal and in the province of Quebec [45, 46], but the time spent on issues of interpreting is clearly insufficient in light of the survey findings. Professional training needs to address the following questions: What are the communication dynamics in the consultation when three protagonists are present? What are the key elements that favor a successful interpreted intervention in mental health? What are the advantages and limitations of working with interpreters? And lastly, what are the possible stances/roles of the interpreter? Training also needs to acknowledge differences between professional interpreters and ad hoc interpreters. Attention to issues of interpreting can improve allophones' access to services as well as the quality of the care, and so reduce unnecessary treatments and expenses. Considering the professional responsibility practitioners hold in the encounter and their influence over the consultation process [47], understanding their perceptions and experiences is crucial for framing policy, training and practice standards in multilingual health care [34].

References

1. Oxford English dictionary online. Allophone, n.2. In: Oxford University Press; 2013.
2. Statistics Canada. Linguistic characteristics of Canadians: language, 2011 census of population. Ottawa: Minister of Industry; 2012.
3. Laforce H. Personal communication. 2010.
4. Divi C, Koss RG, Schmaltz SP, Loeb JM. Language proficiency and adverse events in US hospitals: a pilot study. Int J Qual Health Care. 2007;19:60–7.
5. Morrison TB, Wieland ML, Cha SS, Rahman AS, Chaudhry R. Disparities in preventive health services among Somali immigrants and refugees. J Immigr Minor Health. 2012;14:968–74.
6. Jacobs E, Chen AH, Karliner LS, Agger-Gupta N, Mutha S. The need for more research on language barriers in health care: a proposed research agenda. Milbank Q. 2006;84:111–33.
7. Ministry of Health and Social Services. Quebec's mental health action plan 2005–2010. Quebec City: Ministère de la Santé et des Services sociaux; 2005.
8. Habermas J. The theory of communicative action. Oxford: Polity Press; 1991.
9. Leanza Y, Miklavcic A, Boivin I, Rosenberg E. Working with interpreters. In: Kirmayer L, Rousseau C, Guzder J, editors. Cultural consultation: encountering the other in mental health care. New York: Springer; 2014. p. 89–114.
10. Kirmayer LJ, Weinfeld M, Burgos G, du Fort GG, Lasry JC, Young A. Use of health care services for psychological distress by immigrants in an urban multicultural milieu. Can J Psychiatry. 2007;52:295–304.
11. Snowden LR, Yamada AM. Cultural differences in access to care. Annu Rev Clin Psychol. 2005;1:143–66.
12. Chen AW, Kazanjian A, Wong H. Why do Chinese Canadians not consult mental health services: health status, language or culture? Transcult Psychiatry. 2009;46:623–41.
13. Sadavoy J, Meier R, Ong AY. Barriers to access to mental health services for ethnic seniors: the Toronto study. Can J Psychiatry. 2004;49:192–9.
14. Vissandjee B, Hemilin I, Gravel S, Roy S, Dupéré S. La diversité culturelle montréalaise : Une diversité de défis pour la santé publique [Montreal's cultural diversity: a variety of challenges to public health]. Santé Publique. 2004;17:417–28.
15. Karliner LS, Jacobs EA, Chen AH, Mutha S. Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. Health Serv Res. 2007;42:727–54.
16. Flores G. The impact of medical interpreter services on the quality of health care: a systematic review. Med Care Res Rev. 2005;62:255–99.
17. Bauer AM, Alegria M. Impact of patient language proficiency and interpreter service use on the quality of psychiatric care: a systematic review. Psychiatr Serv. 2010;61:765–73.

18. Bischoff A, Tonnerre C, Eytan A, Bernstein M, Loutan L. Addressing language barriers to health care, a survey of medical services in Switzerland. Soc Prev Med. 1999;44:248–56.

19. Kuo DZ, O'Connor KG, Flores G, Minkovitz CS. Pediatricians' use of language services for families with limited English proficiency. Pediatrics. 2007;119:920–7.

20. Hsieh E. Interpreters as co-diagnosticians: overlapping roles and services between providers and interpreters. Soc Sci Med. 2007; 64:924–37.

21. Leanza Y. Roles of community interpreters in pediatrics as seen by interpreters, physicians and researchers. Interpreting. 2005;7: 167–92.

22. Brisset C, Leanza Y, Laforest K. Working with interpreters in health care, a systematic review and synthesis of qualitative literature. Patient Educ Couns. 2013;91:131–40.

23. Dodd W. Do interpreters affect consultations? Fam Pract. 1984; 1:42–7.

24. Eytan A, Bischoff A, Rrustemi I, et al. Screening of mental disorders in asylum-seekers from Kosovo. Aust N Z J Psychiatry. 2002;36:499–503.

25. Bischoff A, Tonnerre C, Loutan L, Stalder H. Language difficulties in an outpatient clinic in Switzerland. Soc Prev Med. 1999;44:283–7.

26. Flores G, Torres S, Holmes LJ, Salas-Lopez D, Youdelman MK, Tomany-Korman SC. Access to hospital interpreter services for limited english proficient patients in New Jersey: a statewide evaluation. J Health Care Poor Underserved. 2008;19:391–415.

27. Torres ME, Parra-Medina D, Bellinger JD, Johnson AO, Probst JC. Rural hospitals and Spanish speaking patients limited english proficiency. J Healthc Manag. 2008;53:107–20.

28. Bradshaw M, Tomany-Korman S, Flores G. Language barriers to prescriptions for patients with limited english proficiency: a survey of pharmacies. Pediatrics. 2007;120:225–35.

29. Campbell D, Brislinm R, Stewart V, Werner O. Back-translation and other translation techniques in cross-cultural research. Int J Psychol. 1970;30:681–92.

30. Miller KE, Martell ZL, Pazdirek L, Caruth M, Lopez D. The role of interpreters in psychotherapy with refugees: an exploratory study. Am J Orthopsychiatry. 2005;75:27–39.

31. Raval H, Smith JA. Therapists' experiences of working with language interpreters. Int J Ment Health. 2003;32:6–31.

32. Rosenberg E, Leanza Y, Seller R. Doctor-patient communication in primary care with an interpreter: physician perceptions of professional and family interpreters. Patient Educ Couns. 2007; 67:286–92.

33. Lowry R. Calculator 3: significance of the difference between the results of two separate polls. 2008. Available at: http://faculty.vassar.edu/lowry/polls/calcs.html#ca3. Accessed 28 Aug 2013.

34. Papic O, Malak Z, Rosenberg E. Survey of family physicians' perspectives on management of immigrant patients: attitudes, barriers, strategies, and training needs. Patient Educ Couns. 2011; 86:205–9.

35. Bischoff A, Hudelson P. Access to healthcare interpreter services: where are we and where do we need to go? Int J Environ Res Public Health. 2010;7:2838–44.

36. Hudelson P, Vilpert S. Overcoming language barriers with foreign-language speaking patients: a survey to investigate intra-hospital variation in attitudes and practices. BMC Health Serv Res. 2009;9:187.

37. Edwards R, Temple B, Alexander C. Users' experiences of interpreters: the critical role of trust. Interpreting. 2005;7:77–95.

38. Leanza Y, Boivin I, Rosenberg E. Interruptions and resistance: a comparison of medical consultations with family and trained interpreters. Soc Sci Med. 2010;70:1888–95.

39. Diamond LC, Schenker Y, Curry L, Bradley EH, Fernandez A. Getting by: underuse of interpreters by resident physicians. J Gen Intern Med. 2008;24:256–62.

40. Bischoff A, Denhaerynck K. What do language barriers cost? An exploratory study among asylum seekers in Switzerland. BMC Health Serv Res. 2010;10:248.

41. Hampers LC, McNulty JE. Professional interpreters and bilingual physicians in a pediatric emergency department: effect on resource utilization. Arch Pediatr Adolesc Med. 2002;156:1108–13.

42. Hadziabdic E, Heikkila K, Albin B, Hjelm K. Migrants' perceptions of using interpreters in health care. Int Nurs Rev. 2009; 56:461–9.

43. Nailon RE. Nurses' concerns and practices with using interpreters in the care of Latino patients in the emergency department. J Transcult Nurs. 2006;17:119–28.

44. Gerrish K, Chau R, Sobowale A, Birks E. Bridging the language barrier: the use of interpreters in primary care nursing. Health Soc Care Community. 2004;12:407–13.

45. Centre de recherche et de formation. Formations en interculturel [Cross-cultural trainings]. CSSS de la Montagne, Montreal.

46. Alliance des Communautés Culturelles pour l'égalité dans la Santé et les Services Sociaux. Formations destinées au réseau de la santé [Training for the health care system]. ACCÉSSS, Montreal.

47. Carnevale FA, Vissandjee B, Nyland A, Vinet-Bonin A. Ethical considerations in cross-linguistic nursing. Nurs Ethics. 2009;16: 813–26.