



the columns

correspondence

Lost in translation

Working with their patients through interpreters has become a frequent requirement for psychiatrists, particularly in inner-city areas. The increase in immigration, which includes people in need of mental healthcare, has meant that many psychiatric assessments cannot be conducted without such assistance (Tribe & Ravel, 2002). Treatment is invariably based on the trust that patients have, or not, in mental health professionals. An interpreter, who may be someone that patients have never seen before or may never see again, could represent an unknown person that may not be trusted. One additional emerging problem that we have been encountering at our practice is that some 'interpreters' may have agendas of a political nature that lie outside their contractual remit within the mental health services.

We have been referred many patients who have fled persecution in their native countries and suffer from sequelae of trauma, including torture. Both the assessment and treatment of these patients depend on the disclosure of their experiences. If they are unable to communicate in English, the assistance of a trustworthy interpreter is necessary. However, their countries of origin may regard such information as politically sensitive and potentially damaging, and would prefer for it to remain undisclosed. Our own experience, and that of other colleagues, indicates that there may be some interpreters with apparent links to such regimes. There is a growing concern not only that these particular interpreters may not always accurately translate, but also that they may breach confidentiality. Moreover, health services other than mental health services may rely on interpreters for communication with patients under their care. Dissemination of confidential information to third parties can potentially have serious consequences for patients should they decide to return to their native countries, as well as for their relatives and friends back home.

Many interpreters are recruited through agencies that may not be in a position to fully ascertain their credentials or qualifications. In the circumstances, it is preferable to rely on well-known and

appropriately referenced interpreters whenever possible in order to ensure confidentiality and safety for this patient group. A practical alternative may be to use the services of translators who are either established in the UK or who originate from a different country but are proficient in the patient's language.

TRIBE, R. & RAVEL, H. (2002) *Working with Interpreters in Mental Health*. Brunner-Routledge.

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Legislative discrimination against people with mental health problems

A young, male patient with complete remission of his symptoms of schizophrenia realised to his consternation that section 136 under the Mental Health Act 1983 came up on Criminal Records Bureau check (enhanced disclosure). The patient had since his breakdown 3 years ago successfully returned to his university studies and was simply applying for a holiday job as a gardener at a local rest home when he discovered the problem.

As part of his university course he will have to do a placement year in a company and fears that the disclosure will lead to discrimination against him in the competitive selection process. We were advised by the trust solicitor that the local chief constable would have discretion to remove the information from the disclosure form. This was denied as 'the details were factual at the time'.

In our view this is stigmatising and unnecessary. Adding this information to a person's criminal record sends out a signal that people with mental health problems are inherently dangerous and need to be excluded from certain areas of work. If people with mental health problems are dangerous that should be reflected in their actual convictions, not by having had a breakdown requiring a section. Surely, the police would never keep a record of

patients with diabetes or gall bladder problems.

We wish to draw attention to the overlooked area of mental health legislation as a barrier to employment for those with mental illness. According to a new study, only 14.5% of people with schizophrenia were in competitive employment (Rosenheck *et al*, 2006). Unquestionably, allowing discrimination as described above to continue is not going to facilitate improvement in this number. In the absence of national guidelines it seems absurd that the police have unrestricted powers to make decisions of this nature regarding matters in which they have not been trained. This area needs to be urgently addressed to reduce the burden of stigma and discrimination on an already vulnerable group of people.

ROSENHECK, R., LESLIE, D., KEEFE, R., *et al* (2006) Barriers to employment for people with schizophrenia. *American Journal of Psychiatry*, **163**, 411–417.

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Insidious undermining of the liaison nursing role

Kewley & Bolton's survey (*Psychiatric Bulletin*, July 2006, **30**, 260–263) of London liaison psychiatric services raises concerns that government pressures to observe 4-hour targets in accident and emergency (A&E) departments may have compromised liaison input for other general hospital patients. Almost all teams surveyed fell short of College recommendations regarding service provision (Royal College of Physicians & Royal College of Psychiatrists, 2003) and the recent threats to liaison services in Oxford and London suggest that resources will not become available to meet these standards. Compounding this issue is the trend towards merger of crisis resolution teams and liaison psychiatric nursing teams to cut service costs. Community patients in crisis may tend to be prioritised over patients within the hospital, irrespective of the level of need. This undermines the