A Narrative Enquiry into Mental Health Interpreting in Ireland: The responsibilities of quality service provision

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Abstract

The paper investigates service provision for mental health interpreting in Ireland from a narrative point of view. Informed by the narrative turn in human sciences and the relatively recent developments in the field of mental health interpreting, the paper will look at the definitions of narrative on a micro and a macro level. On the level of macro or meta-narratives, the paper will examine the institutional stakeholders in mental health interpreting service provision in Ireland. On the level of micro-narratives, it will mention the individual participants of the therapeutic triad: the English-speaking mental health professional, the non-English-speaking client/patient and the interpreter. Then, it will pose questions as to who is responsible for service provision and for the co-construction of positive narratives. Finally, the paper will explore avenues for the interpreters to take a greater part not only at the level of micro-narratives, that is, in the actual encounter, but also at the level of macro-narratives, that is, in institutional service provision.

Résumé

Cet article traite des services d'interprétariat dans le domaine de la santé mentale en Irlande, et les considère d'un point de vue narratif. Suivant le tournant narratif des sciences sociales et les développements récents dans le domaine de l'interprétariat de la santé mentale, cet article examine les définitions du narratif aussi bien au micro-niveau qu'au macro-niveau. Au niveau des macro- ou méta-narratifs, cet article considère les intervenants institutionnels dans

le domaine de l'interprétariat de la santé mentale en Irlande. Au niveau des micro-narratifs, les participants individuels du triangle thérapeutique seront mentionnés, à savoir: les professionnels de la santé mentale de langue anglaise, le client/patient de langue non anglaise, et l'interprète. Des questions seront donc posées sur la responsabilité de l'apport de services d'interprétariat, ainsi que sur la co-construction de narratifs positifs. De plus, cet article envisagera les possibilités d'engagement des interprètes non seulement au niveau du micro-narratif, dans la rencontre même, mais aussi au niveau macro-narratif, dans l'apport des services d'interprétariat.

Introduction

The current paper will present you with two stories: the first is about my own experience as an interpreter working with patients and therapists in mental health care and how this led me into interpreting research to seek answers to questions around the responsibility of the interpreter; the second outlines the state of mental health interpreting in Ireland and the responsibilities of the social participants in assuring quality service provision.

My interest in the area of mental health interpreting arose from personal experience as a Hungarian-English interpreter, in particular from two series of therapeutic sessions. The first patient was a young Hungarian Roma woman undergoing psychiatric treatment. Tünde[2] had been a group rape victim violated in front of members of her family. She had great difficulty communicating in general and had no apparent knowledge of English. She fled from the horrific events to Ireland, where she was now living with her family. However, she could not look after her own children and needed constant assistance even with the simplest tasks around the house. She was accompanied to the sessions conducted at a psychiatric unit outside Dublin by her husband, Karcsi.

The second patient was Tibor, a middle-aged Hungarian man, who had left Hungary and spent about ten years in neighbouring Austria. Separated from his wife, he had brought up his children on his own, until he was expelled from his new home country. He then decided to settle in Ireland trying to trace his distant relatives he apparently knew very little about. He had no English and could not communicate in the new environment. With a complicated family background and a great amount of resentment towards everything in the past, he was undergoing counselling for depression as well as psychological assessment with a view to re-socialisation. Unfortunately, as he mentioned on a few occasions, he found it difficult and shameful to open up in front of a female therapist and a female interpreter, but

there were no resources to provide him with male professionals at the time. He was entirely on his own in Ireland, lived in a hostel surrounded by people with whom he did not share a language or culture, and had very few skills to offer a potential employer. His situation was further exacerbated by brain damage caused by a traffic accident which he could not remember very well and could not prove had taken place.

From an interpreter's perspective, both cases were fraught with ethical and professional problems, and I was thoroughly unprepared in every sense. For example, in Tünde's case, I had not even been informed that the interpreting would take place in a psychiatric setting before the first assignment. However, the most disturbing aspect in both cases was that I had a sense that the clients were not telling the truth, at least not in the conventional sense of the word. I felt that I could not completely adhere to impartiality and I began to wonder if my doubt about the truthfulness of their stories was affecting my interpreting. I feared that I, the interpreter, was becoming part of their story.

Emerging interrelated issues

The various ethical and professional problems mentioned above raised a number of questions concerning mental health interpreting situations, including immigration in general, the mental health of immigrants, mental health provision for immigrants, cross-cultural adaptation, difficulties of the adaptation process, means of therapeutic diagnosis and treatment, the role of the interpreter, power relations between the participants, giving voice to the unheard, linguistic and cultural equivalences between the host language and a foreign language. Yet, what interested me most were the stories these patients were telling, the way they were telling them and the way they could be deciphered by the therapist through an interpreter. During these deliberations, the concept of narrative emerged as the main point of my inquiries: the

patients' chronicles intrigued me and I kept looking for a definition of "story," "storyline" or "narrative."

However, from the very beginning, I have had two problems with the term "narrative": firstly, it tends to be used synonymously with other theoretical and methodological concepts such as discourse, meta-narrative, story, which makes it very difficult to find an appropriate definition; secondly, it is used across disciplines, some, but not all, of which are relevant to the current research. Eventually, a particular strain of therapy, developed by Michael White and David Epston, helped me identify more user-friendly working definitions of the concept at the centre of the investigation as well as pointing me in the direction of therapy as an obvious candidate for inspiration.

White & Epston's Narrative Therapy – a tale of two definitions

Narrative Therapy (White and Epston, 1990) seemed a very appropriate model within the context of mental health interpreting for three reasons: firstly, it stood to reason to find help in a discipline related to the area of research; secondly, the patients availing of Narrative Therapy, though not always migrants, are often marginalised or come from a disadvantaged background, which is true of any minority-language speaker who has to avail of the services of an interpreter; thirdly, as suggested by its name, this branch of therapy is based on narrative premises; and finally, in its approach, the therapy generally moves away from a dyadic therapist-patient relationship and allows for other participants in the therapeutic process. It was developed by two practitioners from Australia and New Zealand, Michael White and David Epston, as a means to empower their clients to collaboratively construct a positive narrative of their lives.

Primarily based on the theoretical works of Foucault, Narrative Therapy has evolved within the narrative theory framework and shares characteristics with other narrative therapeutic practices, insofar as it uses narratives for psychotherapy. But the emphasis here is on the enriching experience and empowerment, whereby stories are re-authored and re-constructed for an attentive "audience." This audience could often include family members, co-therapists, and social workers. Compared to the traditional triadic relationship between patient, therapist and interpreter within the traditional community interpreting framework (Mason, 2001; Wadensjö, 1998), the concept of this already extended therapeutic circle would make it easier and less disruptive for an interpreter to enter the scene. In this paradigm, the interpreter could, in theory, become a co-author and a member of the audience at the same time, putting him or her in an intricate but not an intrusive position.

Additionally, Narrative Therapy also helped me distinguish two levels of narrative to work with. On the one hand, White and Epston (ibid.) hold that, through the techniques of Narrative Therapy, practitioners empower their patients to re-tell their subjugated stories in order to re-author and re-construct their own lives. While other therapies are also based on the analysis of stories, here authorship and empowerment are salient to the therapeutic process. The significance of these stories in interpreted-mental health encounters cannot be underestimated: quite often they provide the only means of diagnosis and therapy, and they manifest as testimonies of frustration rooted in the patient's loss of power (of language, of home, of social networks). Thus, at a micro level, this simple notion of a **story**, a life narrative told by the patient and mediated by the interpreter became my first concept definition for "narrative."

On the other hand, on a macro level, these small narratives, or stories, make up one big storyline or in socio-historical terms, a **discourse**. These discourses, or meta-narratives, are produced by those who have the linguistic, social, economic knowledge and power to do so.

Drawing on White and Epston's (ibid.) discussion of Foucault's work, the challenging of existing power relations, otherwise termed as dominant discourses or erudite knowledge, in mental health interpreting service provision has emerged as the second definition of "narrative."

What's the story… in Ireland?

As mentioned in the introduction, Narrative Therapy is a particularly suitable model for mental health interpreting in Ireland for the following three reasons: first, because it has emerged from a discipline the interpreting process under investigation facilitates, namely therapy; second, because issues of empowerment and authorship come to the forefront; and third, because it allows for a more exclusive relationship pattern among the participants. In addition, the application of an Australian-New Zealander model has seemed befitting as Ireland is now experiencing the rate and type of immigration Australia and New Zealand, among other countries, have been facing for generations. The composition of the immigrant population, the variety of ethnic backgrounds of the inhabitants as well as the sociometry of these linguistically and ethnically diverse groups in Ireland is comparable to those that have evolved in the states White and Epston work in.

The similarity of these conditions, and the fact that due to these circumstances Australia and to a great extent New Zealand are also at the forefront of community interpreting research, lends support to the decision to take a theoretical framework from such a distant geographical area as the basis of the current study. The application of narrative theories could not be more fitting elsewhere than in Ireland where the question "What's the story?" or simply "Story?" is a simple greeting in certain well defined dialects. It is another form of saying "how are you," but it clearly displays the embedded oral storytelling tradition

of the Irish, where long narratives were co-constructed with the active participation of the audience, a ritual still documented and dramatised by contemporary playwrights such as Marina Carr, Brian Friel, or Tom Murphy. The connection between the two stories, thus unfolds, if we consider the immediate and extended participants of interpreter-mediated therapeutic sessions in Ireland. The two definitions introduced above, represented in Figure 1, can be allocated to the two levels of environments around interpreting: the actual core session (the story level), and the provision for that session (the social discourse level).

Story **(the core interpreted session participants)**	**Discourse** **(the social participants)**
	The State
The Client	The Community
The Therapist	The Mental Health Services
The Interpreter	The Agencies

Figure 1. Narrative participants in mental health interpreting in Ireland

At the story level, the obvious participants in mental health interpreting, as in most interpreter-mediated encounters, are the **client** (most of the time a patient), the **therapist** (or other mental health professional) and the **interpreter**. While in a specific mental health setting Bot (2005) suggests the name "three-person psychology," Wadensjö (1998) calls them the communicative "*pas de trois*," and in general, Mason (2001) refers to them as "the triad." However, in reality, there are usually more participants, although not always physically present, whose contribution (or non-contribution as the case may be) also greatly affect the outcome of such sessions. They may be family members, social workers, medical doctors, and other individuals who influence the encounter.

At the discourse level, there are further institutional participants, those providing the background for the members of the triad, or polyad. In Ireland, these "invisible" contributors

include: the **State**, the **Community**, the **Services** and the **Agencies**[3]. Once again, if we consider the triad to be writing the actual story mentioned above in the narrative framework, then these institutional participants create the meta-narrative or discourse. While the triad, and above all the interpreter, is responsible for the quality of interpreting in the actual session, the social entities behind the triad members are responsible for the quality of service provision. In the current paper, I am going to concentrate on this higher level, the discursive participants. I will now discuss who holds responsibility for the provision of quality mental health interpreting services: the State, the Community, the Mental Health Services or the Agencies. I will also touch upon how the interpreter(s) could take a more active part in promoting quality services, and thus, constructing a positive narrative.

The Irish State – regulations and guidelines

While the Irish government projects a new image of a multicultural Ireland in the media both at home and abroad (Ahern, 2007), there is not much evidence of this to be found in the relevant legislation. There is no unified immigration policy, and the responsibilities for migrant issues are divided between the Department of Justice, Equality and Law Reform, the Department of Social and Family Affairs, the Department of Education and Science, the Department of Health and Children, the Department of Enterprise Trade and Employment[4]. As a consequence, there is no uniform language policy for immigrants, or minority foreign languages[5].

As for mental health provision, while issues around general mental health are finally receiving some attention, there is no awareness of the mental health of migrants in Ireland. The State is currently operating under the Mental Health Act 2001, which regulates mental health provision and promotion among the general population of the country. In 2006, the

Expert Group on Mental Health Policy (2006) appointed by the government published a report, *A Vision for Change*. A subchapter of the Expert Group's report deals with minority groups and mental health care issues. It is interesting to observe that the report discusses all minority groups together: travellers, gay and lesbian, hard of hearing, and immigrants, which does not reveal an underlying organising principle.

Nevertheless, part of the report is dedicated to interpreting services *per se* (approximately two paragraphs in the over 200-page report), which has been inserted using some of the recommendations provided by the Irish Translators' and Interpreters' Association (ITIA) in response to a request for submissions during the compilation of the report. This short consideration gives laudable recommendations on how interpreters should be able to empathise with the service users (patients/clients) and how they should interpret in a culturally appropriate manner. It also recommends that there should be no ethnic or gender conflict between service user and interpreter and that children or family members of the service user should not act as interpreters. However, the report falls short of including the recommendations of the ITIA for specific training of community interpreters in mental health services, assessment of the interpreters (at least at a basic linguistic level) and some training for service providers, that is mental health professionals[6].

As for quality control, as there are no such regulations in place to demand quality interpreting services, interpreters are still hired without screening or pre-selection and any form of training in general community interpreting issues or in mental health interpreting. It is apparent that the State has no story to tell yet. In order to construct a positive narrative, interpreters can work within the framework of the ITIA, a national association. Here they can publicise the shortcomings of the current system. To the same end, they have been promoting interpreter training, selection and screening, adequate payment and a general regulation of the

industry by drawing attention to the current lack of standards in service provision by approaching government departments, state services, semi-state organisations.

The Community

The community, or the patients' background and social networks, is probably the most important factor to understand in the Irish context, as this lies behind the lack of opportunity to write a unified narrative at the level of social discourse. Ireland has seen positive net migration since 1997, when the growing economy began to attract more immigrants than those who were leaving the country in hope of better opportunities abroad. According to the Central Statistics Office, there has been an unprecedented increase in the rate of immigration, that is, the number of immigrants is exponentially increasing. In 2006 nearly 10% of the population was born outside Ireland, compared to the 5.8% non-native population recorded in the 2002 census.

Unfortunately, there are a few problems around census figures: firstly, many immigrants were not aware that the census was taking place; secondly, some immigrants did not consider themselves as part of the population and may not have understood that the census was aimed to establish the number of persons present or residing in the country on a particular day; thirdly, often fleeing persecution, or coming from formerly mistrustful backgrounds, they did not wish to include their details in a centralised database; fourthly, they were not aware that the census form may be available in their own language[7]; and lastly, they may not have had the linguistic means to communicate about the census.

Very similar difficulties arise with figures circulated by other entities concerning the ethnic and linguistic composition of the migrant population in Ireland. The Department of Enterprise, Trade and Employment (2006) publishes annual figures on work permits issued,

which reveal that citizens of over 120 different countries are in receipt of some sort of a work permit. It is unclear whether this figure includes refugees, some of whom, along with asylum seekers, may also be represented in the figures published by the Office of the Refugee Applications Commissioner (ORAC). There are also some former asylum seekers who are granted humanitarian leave to remain, and whose legal category may be overlooked by either or both of the agencies in questions. Therefore, we do not have a clear figure of either the countries of origin/ nationalities of immigrants or the languages they speak. As far as the latter, where linguistic diversity is concerned, according to research carried out by the Language Centre at the National University of Ireland, Maynooth, there are more than 167 languages currently spoken in Ireland (O'Brien 2006). Some speakers of this great variety of languages arrive with little or no English at all and would need assistance to communicate at the most basic level, which can lead to various degrees of deterioration in their mental health.

Despite the fact that immigrants need to deal with even more stress than the settled population (loss of family and social network, loss of work, home, language, climate, food), there is very little awareness of the mental health needs of immigrants in Ireland. An NGO, Cáirde (www.cairde.ie), is currently surveying attitudes among immigrants to mental health in conjunction with the Academic Theme Leader's Office at Dublin City University. Their aim is "to tackle health inequality experienced by minority ethnic communities and individuals by working through community development to build the capacity of minority ethnic communities and individuals to realise their rights by engaging directly with and influencing the policy system." However, the project is at its early stages, and as yet, there is no information on mental health needs among immigrant communities. Once again, from a narrative point of view, the voices of the community (representing the client) are so diverse that it would be incredibly difficult to author a seamlessly univocal and strong narrative – not

to mention the fact that due to the language barriers, their voices could only be heard, if the communication is facilitated by an interpreter.

Although the linguistic capacities could be provided by interpreters and translators, the community interpreting ethics adopted by the ITIA define a clear role for interpreters, which do not include cultural mediation. Interpreters, therefore, can participate in community projects as long as there is no conflict of interest with their interpreting assignments. However, the willingness on the interpreters' part to carry out work either on a voluntary or on a remunerated basis, whether in mental health care or in other settings, is already a move towards positively constructed narratives at the level of social discourse. The next step is to guarantee that this work is completed at adequate standards.

The Services

As new immigration issues are only being recognised now, and research into the mental health needs of (the so far voiceless) immigrants is only beginning, there is little data available on access to mental health services. The biggest problem is that referral to mental health services is processed through primary care: in most cases, the consultation happens without the presence of an interpreter and there is no opportunity to determine more than physiological symptoms of the patient. As far as mental health services are concerned, we have no definitive list of services where non-English speakers are treated. A directory of mental health services across Ireland provided by the Health Services Executive (www.hse.ie) is a good starting point, but does not include refugee and asylum seeker services, certain regional clinics and voluntary, charitable and non-governmental organisations. The Health Research Board, a government-funded research body, has been collecting information on the country of residence of those admitted to psychiatric facilities.

However, these data only provide details on the country of residence (with a simple distinction between the UK, Northern Ireland and Ireland) but offers no further information on county or at least provincial classification[8] or on the country of origin.

Among the few therapists interviewed for a short pilot study for this research, there seems to be a clear division on the question of multilingual therapy. It transpired through preliminary interviews that some decline to work with clients through interpreters, mainly because they are afraid that interpreters have not been trained in handling psychologically charged situations[9]. These practitioners strongly believe in dyadic therapy. Their view would be in opposition to the basis of Narrative Therapy, where it is accepted that there are necessarily more participants in the therapeutic process than the patient and the therapist. In this narrative framework the presence of the interpreter should be less problematic – at least in theory.

Those therapists who work for centres where there is provision for non-English speaking patients with the co-operation of an interpreter are predisposed to such work by their character, and indeed many of them have gained experience working with interpreters abroad, mainly in developing countries in South America or Africa. These therapists normally recruit and train their own interpreters – at least introduce them to ethical considerations, cultural issues, codes of conduct, in-house post-therapy sessions, and debriefing. In a sense they are trying to author a narrative of considerate inclusive and holistic service provision. However, as the provision of mental health services comes under the aegis of the State, such narrative should also be constructed at governmental and legislative level.

As discussed in the previous section on the minority-language communities, interpreters working for non-governmental services often provide interpreting on a voluntary basis and may be involved in projects related to community-specific issues or mental health care. By their nature, these interpreters are often inclined to construct a healthy, positive

narrative. However, good will cannot replace quality control, and the least to hope for is awareness among mental health professionals that such controls are currently not in place and need to be legislated. Co-operation between interpreters and mental health professionals as well as training of interpreter users may be the key to such realisations.

The Agencies

In state-run institutions or mental health services, interpreters are usually commissioned through translation agencies on an individual case-to-case basis. There is only one NGO service, Spirasi, which uses “in-house” interpreters, although these interpreters, for financial reasons, do not work exclusively for this service. What their involvement entails is that they can work with the service on a continuous basis and have therapeutic support. The professionals working at the psychology services for refugees and asylum seekers run by the State also try to make sure that they employ the same interpreter with the same patient. But by and large, the mental health services or the larger hospital units have either issued a tender for translation and interpreting provision, or have responded to advertising material distributed to a range of venues, or simply looked up agencies in the phone book.

Contracting interpreters through agencies which operate as business entities in themselves would not pose a problem. What is questionable is the quality of provision. Having seen the patchwork composition of every previously discussed stakeholder in mental health interpreting provision in Ireland, it should come as no surprise that translation agencies come in all shapes and sizes: one is a branch of a big multinational company providing language services, interpreting among them, and has substantial infrastructural support; another one has grown out of a university department and is very quality and ethics conscious; a few have very good long-standing translation practices, mainly due to their

originators and/or managers coming from a trained and educated translator/interpreter background.

Most of these agencies are a testimony to the entrepreneurial spirit at the forefront of interpreting service provision in Ireland, which has become a competitive market where the agencies are in a clear middle-man position reaping the financial benefits but not necessarily in a position to have a vested interest in the provision of good quality interpreting delivered by trained and qualified interpreters. Thankfully, there are notable exceptions, those who have a long-term vision of what the interpreting landscape should look like, and who write more than a simple business-driven narrative. For all of the agencies to become conscientious participants of quality service provision, the government service providers would have to demand them to contract only qualified and/or trained and accredited interpreters. This could be achieved through legislation or through an agreement between the stakeholders and for all service providers to take some responsibility for finding more than mere speakers of a particular language, which currently seems to be the only requirement to be recruited as an interpreter by certain agencies.

The story

Returning to our double-layered narrative account, we can recall the interpreter's responsibility for the provision of quality interpreting in the actual mediated therapeutic encounter. However, if there is no responsible narrative constructed by the stakeholders of the social discourse of mental health interpreting provision in Ireland, to what extent are we interpreters responsible, and can we re-construct our own professional narrative? Or, what is the story if the interpreters write it… The native Irish population does not possess the linguistic resources to produce interpreters for such a wide range of languages as described

above, necessary to cater for the 160+ languages currently spoken in Ireland. Therefore, a majority of interpreters will come from a non-Irish background. We are immigrants ourselves, who have become professionals, so we have already written some of our own professional narrative. This, in terms of responsibility, should manifest in further professionalisation of the entire community interpreting scene in the Irish context, including mental health interpreting service provision.

In practical terms, this could manifest in action at all levels of social discourse. As far as the State is concerned, we can lobby members of parliament and local councillors to take language and mental health issues on their agenda. There is already an initiative from the Irish Mental Health Coalition to do so with regard to mental health issues in general. As far as the Communities are concerned, we can raise awareness among our own and help with translation and interpreting to our best ability. As far as the Mental Health Services are concerned, we can, at least informally and tactfully, help therapists by drawing their attention to potential cultural issues within or outside the encounter, or contributing to interpreter-user training[10]. As far as the Agencies are concerned? Well, perhaps their role could be taken over by a national register? Until then, we can but make sure that the story we interpret in the actual therapeutic encounter is constructed properly…

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[1] I would like to acknowledge the financial support I have received from the Irish Research Council for the Humanities and Social Sciences.

[2] All the names have been change to protect the privacy of the patients.

[3] Agencies are business entities who receive a request for interpreting services in a particular language, in a particular setting, at a particular location and time, and contract freelance interpreters to complete the assignment. Thus, they act as a middle-man between the interpreter user and the interpreter.

[4] Since the presentation of the article, a Minister of State with special responsibility for Integration Policy was appointed in June 2007. His responsibilities are shared among issues represented at the Department of Community, Rural, and Gaeltacht Affairs, the Department of Education and Science, and the Department of Justice, Equality and Law Reform.
Also, now there is a relatively comprehensive work permit system in place catering for a wide range of professions and being more inclusive in terms of countries of origin, which would suggest a more deliberate attempt at a unified immigration policy in the State of Ireland.

[5] The Department of Education (2005-06) compiled a report for the Council of Europe with recommendations on future language policy for Ireland This document is primarily concerned with language policy in the educational sector, however, its recommendations, namely the integration of foreign languages at certain levels of education, could also be applied to a wider language provision policy.
As for indigenous minority languages, despite the fact that Irish is the first official language of the Republic of Ireland, it has a practical minority status, and is now protected by the Official Languages Act 2003. Shelta (or Cant), a language spoken by the Traveller people, and other lesser spoken languages along with Irish Sign Language are not officially recognised.

[6] Since the presentation of the paper, the HSE Intercultural Health Strategy was launched in March 2008. Unfortunately, this does not expand on the scope of interpreting issues in a meaningful way and refers back to *A Vision* in its recommendations. Funds for the implementation are also very scarce.
As the most recent development in a very specific area of community interpreting related to mental health care, it should be mentioned that the Dublin Rape Crisis Centre (www.drcc.ie) has published recommended guidelines for interpreters and interpreter users. Supported by government funds, the Centre compiled the handbook (available online from June 2008) with the assistance of interpreter trainers, mental health services, agencies and interpreters who participated in courses run by DRCC and who have all provided feedback for the publication.

[7] At the time of the writing of this article, the census of 2006 could be accessed from the CSO website in the following languages: Chinese, Czech, French, Latvian, Lithuanian, Polish, Portuguese, Romanian, Russian and

Spanish. However, in the case of languages using diacritical marks or non-Latin script alphabet, the information page was barely legible or not legible at all.

[8] The HRB are running a pilot project, WISDOM in Co. Donegal, the most north-western county in the Republic of Ireland, which contains information on patients who have been admitted to psychiatric services. The details include place of birth, ethnicity, citizenship, religion and need for translation services. Should the latter arise, a further question of the particular language sought is prompted. A full nationwide service is due to be introduced in 2010 (www.hrb.ie).

[9] Unfortunately, their assumptions are well-founded. There is currently no training available for mental health interpreters in Ireland. Many of the interpreters have no interpreting qualifications at all, that is, they have not received training either in their respective countries or in Ireland, so many lack the skills as well as ethical and professional awareness. There is only one graduate certificate course in community interpreting available at fourth (graduate) level run by Dublin City University (SALIS), but currently there is no tertiary training for interpreters, community or otherwise, available in Ireland at all. Some NGO mental health services provide an introduction to their own activities and some information on mental health in general as well as pre-session consultations and post-session debriefing, however, this is no substitute for sufficient specialised training, which is currently unavailable in the country.

[10] I am aware that this is a very contentious issue and I would not advocate self-appointed lecturing of therapists by interpreters or providing unwanted "cultural advice." However, I can imagine case-independent services established for therapists to turn to on cultural matters of communication or local customs. Greg Turner, the MAPS Education & Development Coordinator at the Queensland Transcultural Mental Health Centre, in his talk "A Collegial Model of Mental Health Interpreting in Australia" given at the Critical Link 5 conference outlined a service they operate where therapists can call on cultural advisors (in half of the cases trained therapists themselves) for advice on the cultural background of a particular patient. While complete anonymity may be maintained, the interpreter can walk into a situation where s/he won't be expected to become a cultural broker and can conduct professional services.