www.asli.org.uk
office@asli.org.uk

# BEST PRACTICE GUIDE FOR BSL/ENGLISH INTERPRETERS WORKING IN MENTAL HEALTH

By Esther Rose Bevan

## Association of Sign Language Interpreters

The Association of Sign Language Interpreters (ASLI), established in the United Kingdom in 1987, is a forum for professional discussion on issues relating to sign language interpreting and interpreting services. ASLI aims to encourage good practice in sign language interpreting and to support fellow professionals by:

- Providing a forum for professional discussion on interpreting related issues.
- Promoting, raising and maintaining standards in interpreting.
- Encouraging training and other initiatives.
- Supplying information to interpreters and consumers.
- Promoting research in areas relevant to interpreters or interpreting services.
- Advising and co-operating with others interested in sign language interpreting.

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## Overview of the Best Practice Guide

As 40% of Deaf people experience mental health problems in their lifetime, compared to 25% of the rest of the population (Hindley, 2000), it is likely that most BSL interpreters will undertake mental health assignments during their career. This Guide aims to prepare interpreters for working in Mental Health settings, equipping them with points to consider both prior to accepting and during the booking.

BSL/English interpreters working in this specialist field are members of the clinical team (Waddell, 2016). Mental Health Practitioners (MHPs) are not typically trained to work with interpreters (Rosenberg et al., 2007) and often feel detached and powerless working through an interpreter (Raval 1996). A collaborative approach is recommended (Napier & Cornes, 2004) and this Guide aims to help interpreters understand how to work with a MHP in a therapeutic setting.

Interpreters need to be transparent on idiosyncrasies in affect, communication or mannerisms. Extensive experience in the Deaf community is required to manage sign variants.

Interpreting in this domain can be physically, emotionally and mentally demanding (Cokely, 1992; Moser-Mercer, 1998). Interpreters may be traumatised by distressing sessions (Harvey, 2003; Tribe and Morrissey, 2003). In addition to this Guide and attending relevant training, interpreters should engage in clinical supervision and reflective practice.

## Key Points:

- Interpreters must be qualified and registered before working in this domain. This is a legal requirement, as stated in the NHS Accessible Information Standard and supported by the Mental Health Act Code of Practice.
- A Deaf interpreter should be booked if the Deaf patient uses a different sign language to BSL, or if their BSL is atypical. Best Practice recommendations in the Guide also apply to Deaf interpreters.
- Be aware of the potential vicarious trauma caused by interpreting highly distressing conversations.
- The interpreter should have ongoing clinical supervision and opportunities for reflection.
- The interpreter should meet with the Mental Health Practitioner before the session to explain their role in this domain.
- The interpreter and MHP should discuss the purpose, jargon, tools and other practicalities for the session.
- The interpreter should not be alone with a patient.
- The interpreter should be transparent about any idiosyncrasies in the patient's language or mannerisms during the session.
- The interpreter and MHP should debrief at the end of the session.

## Best Practice 1: Registered Sign Language Interpreters and Legal Obligations

1.1 When knowingly entering this complex domain, British Sign Language (BSL)/English interpreters must be registered with a regulatory body. Registration with the National Registers of Communication Professionals working with Deaf and Deafblind people (NRCPD), and/or the Scottish Association of Sign Language Interpreters (SASLI), ensures members are qualified in BSL, English and interpreting, have the appropriate insurance and hold a Disclosure and Barring Service clearance (DBS) or equivalent police check. An interpreter may be hearing or Deaf.

1.2 Interpreters should wear their registration ID cards. Mental Health services and practitioners can verify registration status online or by checking the interpreter's registration ID card. If legal proceedings are involved, the MHP may make a copy of the card.

1.2 Several laws in the UK support the provision of BSL Interpreters.

1.2.1 The Human Rights Act 1998 stipulates that public bodies, including the NHS, should provide services that are non-discriminatory, actively promote equality and respect the needs of hard-to-reach and minority communities.

1.2.2 The Equality Act 2010 states that Deaf people who use BSL constitute an officially recognised minority cultural group in the UK and are a population with 'protected characteristics'. There is a public sector duty to ensure that service provision does not discriminate access to treatment.

1.2.3 NHS England's Accessible Information Standard (SCII1605 Accessible Information) indicates that all information provided about mental health services for Deaf people and communication with Deaf people must conform to Standard 37. Section 11.5.1, states organisations must ensure that communication professionals (including British Sign Language interpreters and Deafblind manual interpreters) employed in health and adult social care settings have appropriate qualifications; have Disclosure and Barring Service (DBS) clearance; are subject to a regulatory body Code of Conduct and complaints process; have appropriate insurance; and engage in continuing professional development.

1.2.4 The Mental Health Act Code of Practice, Section 14.116-117, states that the AMHP involved in the assessment should be responsible for booking and using registered qualified interpreters with expertise in mental health interpreting, bearing in mind that the interpretation of thought-disordered language requires particular expertise. Relay interpreters (interpreters who relay British Sign Language (BSL) to hands-on BSL or visual frame signing or close signing) may be necessary, such as when the deaf person has a visual impairment, does not use BSL to sign or has minimal language skills or a learning disability. Reliance on unqualified persons or health professionals with only limited signing skills should be avoided. Family members may (subject to the normal considerations about patient confidentiality) occasionally be able to assist a professional interpreter in understanding a patient's idiosyncratic use of language. However, family members should not be relied upon in place of a professional interpreter, even if the patient is willing for them to be involved.

## Best Practice 2: The Interpreter working in Mental Health

**The interpreter is a non-clinical member of the multi-disciplinary team. They may be Deaf or hearing. They should be familiar with the therapeutic environment where they can expect to have access to conversations about psychiatric assessment procedures, therapeutic models, psychometric tools, medication, mental illness, and the Mental Health Act. Bookings vary and may include a simple business meeting, a complex family therapy meeting, a Care Programme Approach meeting, or a psychiatric emergency where someone is volatile and in need of rapid tranquillisation.**

2.1 Registered BSL/English interpreters interested in working in the Mental Health domain should demonstrate a high level of interpreting skill and have had a wealth of experience working within the community since attaining Registered status. They should be able to manage working in a wide variety of clinical meetings and therapeutic sessions.

2.2 Team interpreting or co-working, where one or more interpreters work together, is the industry standard in complex assignments such as mental health where interpreting is required for periods of over one hour. Interpreters begin to experience mental fatigue after approximately 20 minutes of work, leading to errors in production and a diminished ability to recognise errors (Vidal, 1997). Team interpreting ensures consistency and accuracy.

2. 3 The interpreter should have a clear understanding of the different clinical roles in a multi-disciplinary team and be mindful that Deaf MHPs may also work with hearing or Deaf patients.

2.4 The interpreter should be familiar with psychotherapeutic models, psychiatric terminology and medication.

2.5 Where appropriate, interpreters may advise or comment on issues relating to language use, communication difficulties, Deaf cultural norms and the interpreting process.

2.6 Clinical supervision and reflection are necessary to work safely and effectively in this domain.

2.7 Demands vary when working in the community, inpatients and forensics, and with children or adults. Some Trusts and services have their own interpreting policies, communication profiles and contractual arrangements. It is advisable to become familiar with these local resources and practices.

## Best Practice 3: Boundaries and Supporting Guidance

**The interpreter should consider additional ethical boundaries whilst maintaining the Standards set out by their regulatory body.**

3.1 Ideally the same interpreter(s) would work in a series of sessions to allow for continuity. A lack of consistent interpreter impacts the patient (Waddell, 2016), restricts engagement and may damage therapeutic relationships.

3.2 It is advisable to avoid work with the Deaf patient in another setting whilst engaged in the therapeutic process and for at least 6 weeks after it has ceased.

3.3 The ASLI *Best Practice Guide for Mental Health Practitioners Working with BSL/English Interpreters* is on the ASLI website and can be shared with MHPs.

3.4 Interpreters should be aware of specific instructions and guidance provided by Trusts, private hospitals, forensic services and children services.

3.5 The interpreter must maintain the highest standards of professionalism and integrity and seek to reflect credit on their profession, whilst continually maintaining and developing their professional skills and knowledge.

3.6 All Registered interpreters are expected to abide by a Code of Conduct stipulated by their registering body. For example: NRCPD Code of Conduct; National Occupational Standards in Interpreting; SASLI Code of Conduct. These are available via the NRCPD and SASLI websites.

## Best Practice 4: Preparation

**Interpreters should take appropriate steps to prepare for the assignment. The interpreter and MHP should meet prior to the session to discuss how best to work together to facilitate an effective therapeutic relationship with the patient.**

4.1 The interpreter should explain that they will inform the MHP of any unusual features in communication. See Best Practice 6: Language Considerations.

4.2 In a group setting, the interpreter should ask the MHP to inform all participants that any communication in the session will be interpreted, including asides or private utterances. This may be particularly sensitive with children and families present. Discuss this during the pre-session meeting so the MHP can manage the group safely.

4.3 The interpreter should determine the following:

4.3.1 The MHP's aim(s), therapeutic approach and the nature of the session.

4.3.2 Whether this is the first session or part of a series of sessions.

4.3.3 Relevant information, such as: issues or concepts that may be raised, background, diagnosis, name and type of medication. For children, this may include school, important teachers, friends etc.

4.3.4 Therapeutic techniques that may be used, such as being deliberately provocative, e.g. a family therapist may tell the interpreter to stop mid-session in order to observe the family's response.

4.3.5 Specific linguistic challenges, such as psychometric testing and asking open/closed questions.

4.3.6 Risk history may be relevant. Consider seating arrangements so there is a clear exit route.

4.3.7 You may also need to discuss lighting, seating and breaks.

## Best Practice 5: Safety

**Working in mental health settings is varied and the majority of bookings will not become volatile. However, it is important to remain aware that there is an element of risk in this domain and interpreters must be cautious. Be aware of the position of panic alarms and ways to exit the room easily. The interpreter should ask the MHP beforehand if there are any risks, particularly when working in a hospital, with either adults or children.**

5.1 The interpreter can leave the session at any time if they feel unsafe, even if the MHP remains.

5.2 The interpreter should not be alone with a patient, and should arrive and leave with the MHP.

5.3 The interpreter should not assist in physically restraining a patient, although they may be required to interpret the instructions/discussions.

5.4 The interpreter should be trained in personal safety techniques, e.g. breakaway training.

## Best Practice 6: Language Considerations

**Some Deaf patients may use BSL in an unusual way: this is commonly called idiosyncratic language. Some Deaf patients use a dual mode of communication, speaking and signing, incorporating idiosyncrasies.**

6.1 Some Deaf patients are not able to communicate in BSL; or have had limited early exposure to language; or have disabilities that interfere with language production/comprehension. It is best practice to recommend that the MHP book an appropriately experienced Deaf Interpreter with the necessary mental health training and DBS check for any future sessions.

6.2 Many specialist Deaf Mental Health Services have communication profiles for their patients and work with Deaf professionals who can advise on the patient's use of language, e.g. specific signs/words they use.

6.3 Normal strategies such as breaking complex details into smaller units, consecutive interpreting and giving examples can be problematic in this domain. Although consecutive interpreting in a meeting environment may allow the patient space to contribute to a frenetic group discussion, in a therapeutic session the MHP may feel out of the loop when the facial expressions are not simultaneous with the speech (Russell, 2005; Waddell, 2016). Check with the MHP in the pre-session meeting or in the session itself before using any of these strategies. Consider reflecting on this in the post-session meeting and supervision.

6.4 It may be necessary to use other strategies to make communication more effective, such as drawing, using pictures and/or objects and role-play.

6.5 Idiosyncratic language can be difficult to interpret and interpreters may be tempted to try to make sense of what is being said and render it in clear grammatical sentences. The MHP, however, needs the interpretation to be transparent and as near to the source message as possible so that they are aware of possible language disorder, dysfluency or psychosis. Covering up any language idiosyncrasies can cause the patient to remain undiagnosed or to be misdiagnosed.

6.6 Any idiosyncratic communication or observed linguistic nuances should be explicitly described during the session or post-session meeting. The MHP needs the clearest possible picture of the patient's presentation. Examples include:

6.6.1 Copying, repetition, speed, signing space, pauses, signing style, eye gaze, movements, sounds, etc.

6.6.2 Changes in the patient's communication. This might be a noted acceleration in the patient's signing/speech, their affect is altered and appears muted or flat etc.

6.7 During long pauses, the interpreter may look slightly away from the patient, to reduce pressure to respond.

## Best Practice 7: Assessment Tools

**Results of standardised assessment tools can be questionable if they are not administered using BSL versions that have undergone reliability testing and**

**validation on the Deaf population. It is worth noting that some tools have been validated and endorsed for use in their BSL versions by the originators. These include the PHQ-9 BSL (measures depression), GAD-7 BSL (measures anxiety), WSAS BSL (measures difficulties in functioning), and CORE-OM (measures global distress) (Rogers et al., 2013a; Rogers et al., 2014). Other tools are helpful for gathering clinical information, such as the hallucination assessment in BSL (Atkinson, 2006). The process of producing the validated BSL versions of the assessment tools can be complicated as it involves rigorous translation/adaption protocols and piloting with Deaf populations (e.g. see Rogers et al., 2013b). They are available in a fixed, standard form in BSL that is delivered by means of online access or DVD.**

7.1 It is within the interpreter's role to advise the MHP of the above information.

7.2 Be aware of the risks of questionable results when using a tool that has not been validated on the Deaf population (Cromwell, 2005). That is because the psychometric properties of the tool will not yet have been established for the BSL version (Rogers et al., 2017) or an ad hoc translation may fail to capture or understand the original intent of the question in the source language. This means that the scores that result may be misleading or inaccurate. Establishing the appropriate clinical cut-offs for the validated tools is another issue; this means the score that indicates a reason for concern. In the case of PHQ-9 BSL and GAD-7 BSL for example, the clinical cut-offs were found to be lower than those of the English version (Belk et al., 2016; Young et al., 2017).

7.3 For current information on what psychometric tools in BSL are available in relation to mental health, contact: Dr. Katherine Rogers, Social Research with Deaf People, (SORD) University of Manchester, katherine.rogers@manchester.ac.uk. Guides on the application and use of these BSL assessment tools are also available.

## Best Practice 8: Debriefing and Reflective Practice

**As often as possible, the interpreter should reflect on their practice. This can initially be with the MHP immediately after the session to review how it went. This is an**

**opportunity to briefly discuss any concerns that arose during the session, as well as things to bear in mind for the following session. In addition, interpreters should also seek clinical supervision to reflect on their working practice.**

8.1 After the session, the interpreter and MHP should debrief to discuss the following issues, if relevant to the session:

8.1.1 Language or translation issues and Deaf cultural norms.

8.1.2 Any distressing material raised, as this can cause vicarious trauma or be a negative trigger for the interpreter.

8.1.3 Therapeutic concerns, such as transference or projection which may have occurred, as this could be helpful to the MHP.

8.1.4 Improvements for subsequent sessions. The interpreter may want to inform the MHP of language needs (e.g. suggest the need for a Deaf interpreter) or available resources (e.g. assessment tools, research on Deaf people hearing voices etc.).

8.2 Staff interpreters in specialist Deaf mental health services should have regular supervision to reflect on their practice (Dean & Pollard, 2001). This should also be made available to freelance interpreters in those services.

8.3 Regular continuing professional development should be accessed to help interpreters reflect and improve on current practice.

8.4 Interpreters should consider their work balance and include less emotive interpreting bookings (Schwenke, 2012).

8.5 Take time to consider the implications of working in a triad and how this may affect the therapeutic relationships. Issues such as trust, power and dependence may be a concern for all involved.

## Best Practice 9: Confidentiality and Information Sharing

**Interpreters are to keep information about patients' mental health and sessions strictly confidential. However, there are a small number of situations where it is safe to disclose the minimum amount of information.**

9.1 Examples of appropriate disclosure:

9.1.1 To reflect on interpreting practice in a supervision session. However, interpreters should not reveal any identifying information.

9.1.2 If a patient is trying to contact the interpreter or asking for clinical advice, the interpreter should direct them to their MHP. If possible, inform the MHP of this contact. Boundaries may be an issue with some patients and the MHP will need to be made aware of this.

9.1.3 If the interpreter is exposed to information that suggests risk to a child or vulnerable adult's safety and wellbeing, the case holder for the patient must be informed or, in their absence, contact the MHP's manager.

9.1.4 If there are concerns that a patient may harm themselves or others, disclose this to the MHP. If that is not possible, seek advice on how to report the concern to the local safeguarding team in social services.

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## Other Sources

The link for the British Society for Mental Health and Deafness is here: www.bsmhd.org.uk.

## Definition of Terms

**The following terms are used in this Guide or are relevant to the subject of interpreting in this domain. Definitions are provided to establish the meaning of terms as used within this Guide and may not be in everyday use.**

**Assessment:** When someone is unwell, healthcare professionals meet with the person to talk to them and find out more about their symptoms so they can make a diagnosis and plan treatment. This is called an assessment. Family members should be involved in assessments, unless the person who is unwell disagrees.

**Care Plan:** Mental health professionals assess an individual's needs then draw up a care plan with them when they first start offering them support. People should be given a copy of their care plan and it should be reviewed regularly. Service users, their families and carers can be involved in this discussion.

**Care Programme Approach (CPA):** A way of assessing the health and social care needs of people with mental health problems and coming up with a care plan that ensures people get the full help and support they need.

**Child and Adolescent Mental Health Services (CAMHS):** CAMHS provide individual and family work helping children and young people under the age of 18 who experience emotional difficulties or mental health problems.

**Deaf Interpreter:** A Deaf person with a known track record in working in community interpreting setting and may be a Registered interpreter or translator. Ideally the Deaf interpreter should also meet the criteria required for an interpreter (see following section).

Deaf interpreters have knowledge of working within both Deaf and hearing cultures. In mental health appointments, they work with patients who use atypical or idiosyncratic sign language as a result of mental ill health and/or socio-linguistic factors. Other people who benefit from working with a Deaf interpreter are those:

- With a visual impairment (for example, Usher syndrome).
- Who have a language disorder or communication problems.
- Who use sign languages other than BSL.

**Interpreter:** A British Sign Language (BSL)/English interpreter working in a mental health setting must:

- Have at least 3 years post qualification interpreting experience.
- Be qualified and registered with the National Registers of Communication Professionals working with Deaf and Deafblind People (NRCPD)/Scottish Association of Sign Language Interpreters (SASLI).
- Hold a criminal record check (DBS , PVB i or AccessNI).
- Have undertaken mental health training for interpreters.
- Attend on-going, structured supervision to reflect on the impact of this work.

NB: Interpreters may be hearing or Deaf.

**Mental Health Act (1983):** The Mental Health Act is a law that allows for the compulsory detention of people in hospital for assessment and treatment of a mental illness.

**Mental health:** Someone's emotional and psychological ability to cope with the normal demands of life. This affects how they handle stress, relate to others and make choices.

**Mental health domain:** Any situation in which a mental health professional is attending to a patient's emotional and mental wellbeing.

**Mental Health Practitioner (MHP):** They may also be referred to as therapist, professional, doctor, nurse, counsellor etc. The MHP may be Deaf or hearing.

**Multi-disciplinary team (MDT):** A team made up of a range of both health and social care workers.

**Patient:** The user of the mental health service. This word has been chosen for this Guide to avoid confusion and distinguish it from 'client', where the patient is the MHP's client and the MHP is at the interpreter's client.

**Psychosis:** A mental state in which someone may show confused thinking, think that people are watching them and see, feel, or hear things that other people cannot.

**Section:** The Mental Health Act is a law divided into sections. It includes instructions for assessment, treatment, patients' rights and the rules around involuntary detainment to a mental health hospital or compulsory engagement with Community Mental Health services. Before being lawfully sectioned (detained), the patient will be assessed by Mental Health Practitioners to make sure that it is necessary for assessment, treatment and monitoring.

**Session:** This may be one of a variety of meetings, assessments or therapy sessions where the interpreter is booked to interpret for patients and MHPs. During these sessions, the interpreter is an integral part of the multi-disciplinary team.

**Supervision:** There are three advised supervision types: clinical interpreting supervision (for space to reflect on interpreting practice/models and cases), peer supervision and management supervision (if the interpreter is a member of the staff team in a MH service).