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**BEST PRACTICE GUIDE FOR  
MENTAL HEALTH  
PRACTITIONERS WORKING WITH  
BSL/ENGLISH INTERPRETERS**

**By Esther Rose Bevan**

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## 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 cooperating with others interested in sign language interpreting.

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## Structure of the Best Practice Guide

The Guide is divided into two sections:

### Initial Considerations

1. Booking an Appropriate BSL/English Interpreter
2. Assessment Tools
3. Health and Safety
4. Confidentiality

### The Session

5. Preparation before the Session
6. During the Session
7. After the Session
8. Deaf Awareness
9. Legal Obligations

## Overview of the Best Practice Guide

This Guide aims to help Mental Health Practitioners (MHPs) understand how to work effectively with BSL/English interpreters in therapeutic sessions.

Deaf people often prefer to undergo therapy with a MHP fluent in BSL (Cabral, 2013). If this is unavailable (or if they prefer) they may undergo therapy with a hearing MHP who does not sign. In this case, it is recommended that MHPs and BSL/English interpreters work collaboratively (Napier & Cornes, 2004).

Mental Health Practitioners are not typically trained to work with interpreters (Rosenberg et al., 2007). Hearing MHPs who are working with Deaf patients often feel detached and powerless working through an interpreter (Raval, 1996). This leads to interventions becoming simplified (Raval & Smith, 2003) and MHPs report not feeling able to use their full range of skills (Pollard, 1994).

BSL/English interpreters working in this specialist field are non-clinical members of the multi-disciplinary team (MDT) (Waddell, 2016). They must adopt an additional skill set, which includes transparency on idiosyncrasies in affect, communication or mannerisms. MHPs should note that 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 & Morrissey, 2003), meaning it is important to allow time to meet with them before and after to prepare and debrief.

Procurement arrangements in public services can make it difficult for MHPs to have control over booking interpreters. Agencies may employ interpreters who are not trained or skilled to work in mental health settings or send a different interpreter each session. A lack of consistency impacts on the patient (Waddell, 2016), restricts engagement and may damage therapeutic relationships. This Guide offers insight into considerations when booking an interpreter and when working in a triad.

For a greater understanding of the interpreter's responsibilities, see the *ASLI Best Practice Guide for BSL/English Interpreters working in Mental Health* (2018) on the ASLI website and the Codes of Conduct from the National Registers of Communication Professionals working with Deaf and Deafblind People ([www.nrcpd.org.uk/code-of-conduct](http://www.nrcpd.org.uk/code-of-conduct)) and the Scottish Association of Sign Language Interpreters ([www.sasli.org.uk/policies](http://www.sasli.org.uk/policies)).

## Key Points

- It is a legal requirement that interpreters are qualified and registered with a governing body before working in this domain, as stated in the NHS England Accessible Information Standard and supported by the Mental Health Act Code of Practice.
- Sessions scheduled longer than an hour need a break and/or an additional interpreter to co-work during the session.
- Schedule 10 minutes prior to the session to discuss the purpose, jargon, tools and other practicalities for the session.
- Schedule 10 minutes at the end of the session to discuss any communication concerns that arise and to debrief.
- The interpreter should inform you of any dysfluency or idiosyncrasies, e.g. repetition, signing style, eye gaze.
- Never leave the interpreter alone with the patient.
- Be aware that the patient may have anxieties about being identifiable and trusting the interpreter.
- Be aware of the interpreter's wellbeing and possible vicarious trauma.
- It may be beneficial to book a Deaf Interpreter if the Deaf patient uses a different sign language to BSL, or if their BSL is atypical.

Please review the Definition of Terms section of the Guide for terminology, definition and rationale.

## Initial Considerations

### Best Practice 1: Booking an Appropriate BSL/English Interpreter

- 1.1 Deaf people are not homogenous. An initial appointment will help define individual communication needs and preferences. These should be made clear on the patient's file, if they are to be seen by other services or MHPs.
- 1.2 Provision of interpreters is to be in accordance with the NHS Principles for High Quality Interpreting and Translation Services in Primary Care (2016). An appropriate interpreter working in mental health settings is: qualified, registered, insured and has more than three years post-qualification experience. They will have undergone some mental health training for interpreters and have ongoing supervision. Where possible, this also applies to Deaf interpreters (although there are currently no qualifications for the intralingual BSL/BSL interpreting that is done by Deaf interpreters).
- 1.3 Book the interpreter immediately. It can be some time before the appropriate interpreter is available. Booking in advance avoids unnecessary complications.
- 1.4 For sessions scheduled longer than one hour, two interpreters are required.
  - 1.4.1 Interpreters begin to experience mental fatigue after approximately 20 minutes of interpreting, leading to errors in production and a diminished ability to recognise errors (Vidal, 1997).
  - 1.4.2 Team interpreting ensures consistency and accuracy. This is the industry standard in complex assignments, such as mental health appointments, for periods of over one hour.
  - 1.4.3 Typically, the team comprises two interpreters exchanging every 15-30 minutes. The interpreter delivering the interpretation is the active interpreter. The other interpreter monitors, assists and supports the active interpreter.

1.5 For ongoing sessions, it is best practice to book one or two interpreters in advance. If there are frequent weekly sessions, a small pool of three or four is advisable.

1.5.1 This allows for consistency, trust and familiarity.

1.5.2 When interpreters are familiar with the patient's communication style, they will be able to inform you of any changes during the debrief.

1.5.3 You may wish to record relevant communication issues and discuss them with the others in the pool, during pre-session meetings.

1.5.4 Interpreters may decide not remain for the duration of the therapeutic relationship and you may want to review this from time to time.

1.6 Book a Deaf interpreter if your client is affected by:

- Limited early exposure to language.
- Disabilities that affect language production or comprehension.
- Uses a different sign language to BSL.
- Uses atypical BSL.

The Deaf interpreter works alongside the BSL/English interpreter.

1.7 Interpreters' registration ID cards should be visible. Mental Health services and practitioners can also check registration status online. If legal proceedings are involved, the MHP may take a copy of the card.

1.8 Do not request or accept the patients' family, friends and supporting professionals to act as interpreters. They are untrained, lack the necessary skills and confidentiality is compromised (Juckett, 2005; Thompson & Woolf, 2004). Children must never be placed in this difficult and prematurely adult role.

1.9 It is inappropriate to communicate in the session by writing notes. If the patient requests this, or requests an untrained person interpret, as the previous point, it may be indicative of trust issues with interpreters and could be explored in therapy.

1.10 Have a pre-session meeting with the interpreter and a debrief.



## Best Practice 2: 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. Rogers et al., 2013b). They are available in a fixed, standard form in BSL that is delivered by means of online access or DVD.

- 2.1 Discuss any tools that you will be using with the BSL/English interpreter.
- 2.2 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 have 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, as 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).
- 2.3 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](mailto:katherine.rogers@manchester.ac.uk). Guides on the application and use of these BSL assessment tools are also available.

## Best Practice 3: Health and Safety

Interpreting in mental health settings can be physically, emotionally and mentally demanding (Cokely, 1992; Moser-Mercer, 1998). BSL/English interpreters experience a high incidence of Occupational Overuse Syndrome and Carpal Tunnel Syndrome. They may

also be traumatised by a highly distressing session (Harvey, 2003; Tribe & Morrissey, 2003).

- 3.1 The interpreter may require a short break at some point. If the appointment is scheduled to be longer than one hour, two interpreters are required. Discuss with the interpreter how you will manage this.
- 3.2 Inform the interpreter of any risk history of which they need to be aware. Plan seating accordingly.
- 3.3 Use the time in the debrief to discuss any personal impact, issues or concerns the interpreter might have.
- 3.4 Never leave the interpreter alone with the patient at any time. If you need to leave the room, the interpreter is to leave with you. This is for everyone's safety.

#### **Best Practice 4: Confidentiality**

Interpreters will keep information about sessions and patient mental health confidential.

- 4.1 Interpreters are bound by the National Registers of Communication Professionals working with Deaf and Deafblind People (NRCPD) Code of Practice to keep all information about patients and their sessions confidential.
- 4.2 The following safe disclosures may occur:
  - 4.2.1. After the session during the debrief.
  - 4.2.2 In a supervision session when reflecting on interpreting practice.

## The Session

### Best Practice 5: Preparation before the Session

To work effectively, the interpreter will need to know any information that may be relevant to the patient in the session. Practical logistics also need to be considered.

#### 5.1 Issues to discuss:

5.1.1 The aims and nature of the session.

5.1.2 Relevant issues or concepts that may be raised in the session e.g. background, diagnosis, medication. For children, this may include school, important teachers and friends, etc.

5.1.3 Use of therapeutic techniques, assessment or psychometric tools.

5.1.4 Relevant risk history.

5.1.5 Dynamics between the interpreter, the MHP and the patient.

#### 5.2 Practicalities such as:

5.2.1 Lighting. Facial expressions are important when communicating with Deaf people. To be seen clearly, the room must be well lit and no one should sit directly in front of a light source, such as a window.

5.2.2 Seating. The interpreter will sit next to you so that the patient can see you both in one field of vision.

5.2.3 Seating. If the patient's risk history could affect seating plans, please inform the interpreter before the session.

5.2.4 Breaks. Agree a plan with the interpreter before each session, as sessions may vary.

## Best Practice 6: During the Session

Working in a triad can affect the dynamics of your session. Issues such as trust, power and dependence may be a concern for all three participants.

- 6.1 Opportunities to contribute are powerful for Deaf people. You may find issues arise with Deaf patients that would not ordinarily have the same importance with hearing patients.
- 6.2 Eye contact and eye gaze may be used differently by Deaf people. Address the patient directly, rather than looking at the interpreter. This will also enable you to pick up non-verbal communication. During long pauses, the interpreter may look slightly away from the patient, to reduce pressure to respond.
- 6.3 Allow the interpreter in group sessions to finish signing before the next person contributes. This gives the Deaf patient equal opportunity to contribute.
- 6.4 Depending on the complexity of the language or conversation, interpreters may switch between simultaneous and consecutive interpreting. Consecutive interpreting is useful when the interpreter and Deaf person have limited shared language. It is likely to be more content-accurate. Simultaneous interpreting can be more affect-accurate, as the patient's facial expressions are seen at the same time the words are interpreted.
- 6.5 Inform all attendees in group meetings that everything said and signed will be interpreted, including asides and private discussions. This may be particularly sensitive with children and families. If this is a concern, discuss it during the pre-session meeting, so you can manage the session safely.
- 6.6 The Deaf community is small and it is probable that the interpreter and Deaf person may have met before, or will meet again at some stage. They may have mutual friends. Trust may need to be explored for the triad to be effective.
- 6.7 Historically, professionals working with Deaf people may have been perceived as paternalistic and, in some instances, controlling. Many Deaf people have experienced oppressive colonisation, where decisions are made about their language and deafness by people who are not Deaf (Ladd, 2003). A power imbalance exists when a Deaf person has a therapeutic relationship with a MHP who is not Deaf. Be mindful that these issues may become apparent in the session.

### **Best Practice 7: After the Session**

After you have shown your patient out, schedule 10 minutes with the interpreter to review and debrief (Tribe, 2008).

- 7.1 Issues to discuss:
- 7.2 Clarification about language or Deaf cultural norms.
- 7.3 Distressing content or if anything was triggered for the interpreter.
- 7.4 Transference or projection that may have occurred.
- 7.5 Consider improvements for following sessions, e.g. booking a Deaf Interpreter.

### **Best Practice 8: Deaf Awareness**

Deaf Awareness training will equip Mental Health Practitioners to work effectively with Deaf patients.

- 8.1 Deaf Awareness training for MHPs will equip them in providing high quality mental health care (NHS England, 2016).
- 8.2 Deaf people have considerable difficulties accessing and using primary mental health services (JCPMH, 2017, p. 6 & 9).
- 8.3 Some specialist Mental Health services for Deaf people in the UK are providing Deaf adults and children with primary, tertiary and forensic services (JCPMH, 2017).

### **Best Practice 9: Legal Obligations**

It is a legal requirement to book qualified and registered BSL/English Interpreters.

- 9.1 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.
- 9.2 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.
- 9.3 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.
- 9.4 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.

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## Other Sources

The link for the British Society for Mental Health and Deafness is here: [www.bsmhd.org.uk](http://www.bsmhd.org.uk).

## Definition of Terms

The following terms are either 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.

**Association of Sign Language Interpreters (ASLI):** A professional association of qualified and trainee BSL/English Interpreters in England, Wales, Northern Ireland and Scotland.

**British Sign Language (BSL):** A visual-spatial language used by British Deaf people. BSL is not English. It has all the linguistic and cultural elements of any natural language and has different grammatical and conversational rules.

**Consecutive Interpreting:** The process whereby the speaker or signer has completed one or more ideas in the source language and pauses while the interpreter transmits that information. This results in a very high standard of accuracy in the interpretation's content (Russell, 2005, p.136).

**Deaf:** Refers to an individual who is part of a linguistic and cultural minority, whose preferred language is a signed language.

**Deaf Interpreter:** A Deaf person with a known track record in working in community interpreting setting and may be a registered interpreter or translator.<sup>1</sup> 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 non-Deaf 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.

**Hearing:** A term used in the Deaf community to refer to an individual who is not d/Deaf.

**Interpretation:** The production of an interpretation from one spoken or signed language into another that is functionally equivalent and meaningful for all participants.

**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, or AccessNI).
- Have undertaken mental health training for interpreters.
- Attend on-going, structured supervision to reflect on the impact of this work.

**National Registers of Communication Professionals working with Deaf and Deafblind People (NRCPD):** A national, regulatory body for BSL/English interpreters in the UK (NRCPD website) <http://nrcpd.org.uk>

**Registered Sign Language Interpreter (RSLI):** A registration category with the National Registers of Communication Professionals working with Deaf and Deafblind People (NRCPD), demonstrating competency in a broad range of domains. The Mental Health Act and the NHS England Accessible Information Standards require interpreters working in mental health settings to be Registered Sign Language Interpreters with NRCPD, or an

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<sup>1</sup> Deaf interpreters become qualified as translators (English/BSL) to work in the media or translating websites, etc, and as interpreters (BSL/ASL or BSL/ISL). There are no qualifications for much of the work done by a Deaf interpreter (ie working within BSL with Deaf clients).

equivalent body. Although additional training in mental health settings is available, professional accreditation to be a recognised, trained Mental Health Interpreter is not.

**Scottish Association of Sign Language Interpreters (SASLI):** The registration and membership body in Scotland for British Sign Language (BSL)/English interpreters.

**Simultaneous Interpretation:** The process of interpreting into the target language at the same time as the source language is being delivered (Russell, 2005, p.136).

**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 a member of the staff team in a MH service).