Guidelines for Interpreting in Mental Health Settings

Preamble

Auslan-English interpreters should follow the ASLIA Code of Ethics at all times as this is the primary, guiding tool for professional interpreting practice. However, it is essential to recognise that in mental health settings interpreters may need to work differently. These Guidelines seek to provide guidance to interpreting practitioners and to define parameters of interpreting practice as well as address issues unique to mental health settings.

In developing such guidelines, it is also important to acknowledge that currently within the Australian context it is rare for an Auslan-English interpreter to be embedded as a part of an interdisciplinary mental health team. It is far more common for interpreting practitioners to work alone, as a sole practitioner, in mental health settings, frequently with mental health practitioners with little experience in addressing the mental health needs of Deaf and hard of hearing clients. Further, it is important to note that, longer term, other models of service provision could be considered and developed.

The current situation can mean that some mental health practitioners may also be unfamiliar with how to work effectively with interpreters – either spoken language or Auslan-English interpreters – in a mental health setting. Responsibility for informing mental health practitioners about how to form an effective working relationship lies with both interpreter booking agencies and with interpreters.

Additionally, it is necessary for an interpreter to be aware of the fact that “mental health settings” is not a singular, homogenised setting. Rather, it incorporates a diverse range of clinical settings that span, but are not exclusive to:

- hospital care as opposed to one-to-one work;
- a patient who is mentally well and is seeking to explore changes in day-to-day life compared to chronic psychiatric conditions where the patient is disconnected from reality (e.g. psychosis, schizophrenia);
- service provision where the client may receive a holistic, care-managed approach in the public mental health system in contrast to a patient seeing a private clinician on a one-to-one basis;
- court-mandated participation in the mental health system compared to voluntary participation in a clinical setting; or
- participation in a mental health assessment which can include neuropsych assessment, cognitive evaluation, forensic and psychiatric assessment, etc.

The various clinical settings outlined above can combine and interact to create differing demands on the interpreting professional, sometimes stretching an interpreter’s usual interpreting management strategies that are used in a non-mental health setting. A good working rapport with the mental health practitioner is essential to assist in the development of effective team work between clinician and interpreter,

which in turn allows for in-situ management that addresses the needs of both parties in order that effective work with the patient can occur.

Hence, the development of these Guidelines; however, interpreting practitioners must realise that it is an impossible task to address in them each and every possible scenario that may occur in mental health settings. If too prescriptive, there is a risk that the guidelines would be viewed as providing the only potential solutions to any given treatment setting. It is, therefore, essential for interpreting practitioners working in – or wishing to work in – mental health settings to undertake not only very specific professional development in relation to the setting, but to also undergo direct, professional supervision from an experienced practitioner. Ideally, Auslan-English interpreters working in mental health settings will also choose to undergo regular therapeutic work of their own as this will not only enhance an understanding of the clinical setting, it will – more importantly – provide them with a vehicle for personal reflection to manage the demands of their own inner world and its interaction with the demands of interpreting in mental health settings.

Definitions

Field of mental health – this refers to the specialist area of mental health service provision, in all of its potential forms (e.g. one-to-one counselling, in-patient facilities, etc.). It is worth noting that Auslan-English interpreters may find themselves interpreting in an unrelated community setting with a client who has a mental illness. These guidelines are not designed to provide strategies for managing the interpreting environment in such situations.

Patient or client – this refers to the Deaf or hard of hearing person who is accessing and/or using the mental health service. It is important to understand that this person is the client of the clinician and that, unlike other interpreted settings, it may not be appropriate for the interpreter to view the Deaf or hard of hearing person as their client. Interaction with the deaf person may – arguably should – be limited to the task of interpreting in-situ, whether that be in a hospital ward, in a clinic or in a clinician's consulting rooms. Minimal interaction should occur between the patient and the interpreter outside of the clinician's presence. This means waiting room discussion should not occur. Likewise, if a clinician leaves the client for some reason, then the MH interpreter should also leave the room unless required for interpreting between others who may still be present. For consistency, "patient" will be used throughout this document.

Clinician – this refers to the mental health practitioner who may be a psychiatrist, psychologist, therapist, nurse, counsellor, support worker, etc. This is defined by the particular setting in which the deaf person is seeking treatment.

Mental health interpreter (MH interpreter) – an interpreter who is working in the field of mental health; ideally, the MH interpreter will have had training prior to undertaking work and will have regular professional supervision whilst working as a MH interpreter. A MH interpreter may be either an Auslan-English interpreter or a Deaf Interpreter (DI).

Setting or session – this term can be used for a variety of purposes within the mental health field where the MH interpreter is booked to interpret between clinicians and their client including such purposes as assessments, medication reviews, therapy or case meetings to develop a mental health plan.

Professional Accountability
(ASLIA Code of Ethics 1: Interpreters accept responsibility for all professional decisions made and actions taken. This includes 1.1 Confidentiality; 1.2 Professional Conduct; 1.3 Scope of Practice; and 1.4 Integrity of Service.)

Confidentiality
A cornerstone of interpreting practice is confidentiality. MH interpreting is no different. The MH interpreter may find that more than one MH interpreter – each working as a sole practitioner – shares the responsibility for the interpreting work with a particular patient. If this is the case, a handover of information between interpreters is essential to the interpreting process. For example, this could include particular lexical items used in the source language by either a clinician or a patient and the choice of lexical items used by the MH interpreter in the target language as well as information about the type of discourse that may occur and/or the how a patient refers to certain things, particularly if s/he is unwell and disjointed or dysfluent in his or her communication. This information is important to assist the MH interpreter to manage the flow of the discourse between clinician and patient, but is not to be used to produce smooth, flowing target text from source text that was disjointed or dysfluent.

However, this sharing of information needs to be counterbalanced with the need to protect the patient's privacy. For example, for whatever reason, a patient may talk about certain events with his or her clinician only when using a specific interpreter. This patient choice – whether it is conscious or unconscious – needs to be respected and managed carefully between the MH interpreters who are sharing the interpreting work with the patient. The guiding principle about the sharing of information needs to be how doing so will enhance the interpreting process and, thus, the patient's care.

As well, at times, MH interpreters may be privy to background information about the patient and a well-intentioned MH practitioner may enquire if the interpreter has such knowledge. Specific information should not be shared. Following the appointment, and if appropriate, knowledge about the impact of deafness and how a Deaf person's life experiences may vary when compared with the wider community can be noted by the MH interpreter. However, care should be taken to ensure that the clinician's view of the patient is not skewed by knowledge that is too general and which may not be applicable to that particular patient.

In the case of duty of care in relation to risk of harm to either self or others, it is important for the MH interpreter to know that should they become aware of such risk concerns outside the presence of the MH practitioner, that confidentiality does not bind and the clinician involved needs to be notified of the content expressed by the patient. In part, it is because of this possibility of patient disclosure to a MH interpreter that it is strongly recommended that the MH interpreter does not spend time with the patient outside the presence of the clinician. Interpreters are not trained to manage such scenarios; the clinician is.

Professional Conduct
Working as a MH interpreter, it is essential to have a solid understanding of the various desired outcomes in the broad range of settings in which you may find yourself. This is best gained through professional development *prior* to commencing work in any mental health setting. As well, it is strongly recommended that all MH interpreters undergo professional supervision as a minimum standard of practice.

The MH interpreter cannot expect the MH practitioner to assist in the management of the MH interpreter's well being and professional practice.

It is *not* recommended that a MH interpreter meet with the patient prior to meeting with the MH practitioner. Whilst this is generally considered good work practice in other interpreted settings, in a mental health setting, it creates several risks including, but not limited to:

- the possibility of the patient "bonding" with the interpreter rather than the clinician,
- the patient disclosing information to the interpreter that would be best disclosed to the clinician,
- the possibility of the interpreter unknowingly undermining work done by the clinician, and
- the blurring of professional boundaries with a patient who is, by definition of the setting, in a heightened state of vulnerability.

It is the responsibility of the MH interpreter to try to meet with the MH practitioner prior to first time that s/he interprets for the practitioner. Ideally, half an hour is required in order to ensure sufficient time to discuss the matters noted below. It may be necessary to enlist the assistance of the booking agency to negotiate and/or inform the MH practitioner of the need for this to occur.

The purpose of this meeting is to gain information about:

- the particular purpose(s) of that specific mental health setting,
- the practitioner's approach or framework and how s/he works, which is particularly important to identify as it may change how the MH interpreter renders his/her interpretation (e.g. cognitive behavioural therapy; narrative therapy; psychoanalysis; role play and drama therapy; art therapy; etc.), and
- to ascertain if it is necessary to provide the practitioner with information about working with an Auslan-English interpreter.

Its purpose is not to try to ascertain an idea of expected content of the forthcoming session or to obtain an extensive history of the patient.

Scope of Practice

When working with MH practitioners, whether that be one-to-one or as a part of an interdisciplinary team, the MH interpreter will limit their expertise to interpretation. The MH interpreter is not an advocate. At times, it may be appropriate to assist the MH practitioner(s) with general information about deafness and its implications – including cultural and linguistic implications – and how this may differ from the life experience of the wider, hearing community. This may also include information about the barriers to communication that deafness creates and the important role that both interpreters and deaf-specific services may be able to play in overcoming these barriers.

Integrity of Service

Like any Auslan-English interpreter, the MH interpreter is expected to demonstrate sound professional judgement at all times and to accept responsibility for his or her decisions. MH interpreters will make every attempt to avoid working in MH settings that may create a vulnerability of their own, as this will affect, and potentially damage, the work being undertaken by the clinician and patient.

Again, it is strongly recommended that all MH interpreters undergo professional supervision as a minimum standard of practice. It is further recommended that MH interpreters also undergo regular therapeutic work of their own as this will not only enhance an understanding of the clinical setting, it will – more importantly – provide them with a vehicle for personal reflection to manage the demands of their own inner world and its interaction with the demands of interpreting in mental health settings. The MH interpreter cannot expect the MH practitioner to assist in the management of the MH interpreter's well being and professional practice.

Professional Competence

(ASLIA Code of Ethics 2: Interpreters provide the highest possible quality of service through all aspects of their professional practice. This includes 2.1 Qualifications to Practice; 2.2 Faithfulness of Interpretation; 2.3 Accountability for Professional Competence; and 2.4 Ongoing Professional Development.)

Qualifications to practice

ASLIA considers that the minimum level of NAATI accreditation to work in mental health settings should be Interpreter level accreditation. For Deaf Interpreters, either appropriate course work and/or testing through NABS is required. In addition, ASLIA highly recommends that no Auslan-English interpreter or DI should work in a mental health setting without first undergoing a minimum of 25 hours of professional development that specifically addresses the multi-faceted nature of the mental health context.

Currently, interpreter-specific PD does not exist in all areas of Australia. In the absence of interpreter-specific PD in the MH interpreter's area, it is recommended that MH interpreters undertake training from other providers, such as community-based mental health services (e.g. Schizophrenia Fellowship, Mind Australia, etc.).

Further, ASLIA recommends that MH interpreters undertake ongoing reading and/or professional development in order to develop an understanding of psychopathology, the range of therapeutic frameworks utilised in mental health settings as well as the task of language transfer in such settings (e.g. how discourse may vary in mental health settings, the source language terminology that may be used and its possible equivalence in the target language, etc.).

Faithfulness of interpretation

In a mental health setting, faithfulness of interpretation is difficult to quantify. When working as a MH interpreter, it is essential to understand how the clinician works and the types of cues and information that s/he wishes to have to enable him/her to undertake therapeutic work and/or assessment. This can mean that the MH interpreter works without seeking clarification, instead providing the clinician with the information that something of what the patient said was missed. Or it can mean providing the clinician with information about the patient's disjointed utterances without interpreting it into cohesive English sentences.

In a mental health setting – depending on the working framework and/or the intent of the clinician in that setting – faithfulness of interpretation can mean working as a linguistic informant to the clinician noting when language is disjointed, lacks cohesion and/or is incoherent rather than rendering an interpretation, per se. It is important for the MH interpreter to know that s/he is working faithfully even when what is interpreted does not make sense – it is essential for the MH interpreter to be able to

“let go” of making sense. In this way, the MH interpreter provides the clinician with the text s/he needs to work with the deaf patient.

It may be far more useful – depending on the clinician – to make comment about unusual aspects of the patient’s language; for example, that a patient who is talking about three family members has placed them all in the same signing space instead of in three separate referential locations rather than simply rendering an interpretation of whatever the Auslan text may be. In part, this is why it is crucial for the MH interpreter to work closely with the clinician to become aware of the clinician’s framework and the intent of the assignment.

Accountability
At all times, the MH interpreter is accountable for his/her professional practice, accepting responsibility for the quality of work and the professional decisions made in the course of the work. As noted in “qualifications to practice”, interpreters must be appropriately qualified to work in mental health settings and need to be adequately prepared for the setting.

Part of preparation for the setting must be a dialogue with the clinician to ascertain his/her framework, the nature of the setting (e.g. assessment with regard to an involuntary treatment order under the relevant state or territory’s Mental Health Act, ongoing psychoanalytic therapy, review of medication, etc.) as well as the clinician’s wishes regarding the provision of linguistic information.

Ongoing professional development
As previously noted, this is an essential component of professional practice for the MH interpreter. In order to move in and out of the many and varied settings that comprise “mental health interpreting”, it is necessary to actively engage in the gaining of knowledge about the fields of psychology and psychiatry as these disciplines include many differing theoretical methodologies and approaches. Currency in these is essential to enabling effective interpretation to occur.

Non-discrimination

(ASLIA Code of Ethics 3: Interpreters approach professional services with respect and cultural sensitivity towards all participants. This includes 3.1 Non-discrimination; 3.2 Communication Preferences; and 3.3 Deaf Interpreters.)

Non-discrimination
Mental health interpreting is an area of professional practice that places unique demands on the intrapersonal world of the interpreter. In such settings, irrespective of the patient’s mental state, it is possible to be confronted with both settings and linguistic content that the interpreter may find worrying, distressing and even abhorrent.

It is essential for the MH interpreter to have the intrapersonal skills to manage such content and settings in a respectful and non-judgemental manner, maintaining professional demeanour at all times.

Should it be the case that the MH interpreter requires assistance following a disturbing assignment, s/he is advised to seek professional supervision and/or their own therapeutic process as soon as possible. The MH interpreter cannot expect assistance from the clinician involved in the management of “triggering” events from

the interpreted setting. By undertaking supervision and/or therapy, the MH interpreter is assisted to process and manage what has been a disturbing situation and, thereby, reduce the possibility of vicarious trauma.

Communication preferences
As in any setting, a deaf patient's communication preferences and choices need to be respected. However, it may be important to act in a linguistic informant capacity to the clinician to advise him/her of the varying communication choices made, especially if the MH interpreter is aware that those choices are somehow different, unusual or have changed in some way for the patient.

Deaf interpreters
Mental health interpreting is a field where the services of a DI may be required in order for a full and complete assessment of the deaf patient to occur. It is equally as important for a DI working as a MH interpreter to resist the urge to "make sense" of the patient's utterances that may be incomplete or incoherent. Rather, it is the DI's role to enhance the clinician's access to the language as used by the deaf patient.

Integrity in Professional Relationships
(ASLIA Code of Ethics 4: Interpreters deal honestly and fairly with participants and colleagues while establishing and maintaining professional boundaries. This includes 4.1 Professional Relationships; 4.2 Impartiality; 4.3 Respect for Colleagues; and 4.4 Support for Professional Associations.)

Professional Relationships
As noted previously, the nature of the interaction in a mental health environment – especially in a therapeutic setting, regardless of the MH practitioner's working framework – places the deaf patient in a heightened state of vulnerability. This is a function or product of the therapeutic work and is expected as well as managed by the clinician. However, it is not necessarily expected or fully understood by either the deaf patient or the MH interpreter.

Other relationships that the deaf patient may have with the MH interpreter – be they personal, social or even at a working level – may be confused within the MH setting by the deaf patient and, indeed, by the MH interpreter. As well, it is possible for the integrity of the interpreting to be compromised by this confusion of relationship and boundaries.

Therefore, it is for this reason that ASLIA strongly recommends that under no circumstances should a MH interpreter engage in personal and/or social interaction with a deaf patient for whom s/he interprets in a MH setting.

Even when only a professional relationship exists, a MH interpreter needs to carefully consider undertaking other interpreting work with a deaf patient outside of the mental health setting. This is recommended for both the patient and the MH interpreter's well being. For the interpreter, it may create a situation that can manifest itself with a blurring of boundaries and/or present challenges in relation to impartiality. For the patient, it may provoke distress or embarrassment to see the MH interpreter in another setting.

The MH interpreter is responsible for maintaining strict professional boundaries with any deaf person met through the context of a mental health setting. Conversely, if a

MH interpreter has a personal and/or social relationship with a deaf person, then s/he should not knowingly accept an assignment with that deaf person in a mental health setting. If, upon arrival at an assignment, s/he discovers that the deaf patient is someone within that personal/social circle, the MH interpreter must inform the clinician of this and withdraw from the assignment.

ASLIA acknowledges that this principle may be difficult to adhere to in remote and regional settings, where availability of MH interpreters is limited. However, for the reasons outlined, ASLIA recommends that, whenever possible, this principle is observed and employed by the MH interpreter.

Impartiality
It is essential for the MH interpreter to maintain impartiality and objectivity, even when confronted with disturbing behaviour or linguistic content. If the MH interpreter is not able to manage this through professional supervision or if it is not possible to remain impartial and objective, then the MH interpreter must withdraw from the setting.

Respect for Colleagues
As in any other interpreting situation, the MH interpreter needs to treat his/her colleagues with respect and fairness, ensuring also that colleagues are represented to others respectfully.

Integrity in Business Relationships
(ASLIA Code of Ethics 5: Interpreters establish and maintain professional boundaries with participants and colleagues in a manner that is honest and fair. This includes 5.1 Business Practices; 5.2 Accurate Representation of Credentials; and 5.3 Reimbursement for Services.)

Business Practices
As in any interpreted setting and as outlined in the ASLIA Code of Ethics, the MH interpreter must conduct him/herself in a professional manner.

In particular, in mental health settings – especially therapeutic ones – it is important for the MH interpreter to honour professional commitments made and follow through with his/her obligations. Work should not be terminated unless there are fair and reasonable grounds for doing so. This means that it is important for the MH interpreter to carefully assess work that is offered, endeavouring to ensure that not only appropriate skills are possessed, but also to ensure that the MH interpreter has the intrapersonal resources to manage the work. Also important in this process is for the MH interpreter to ensure that appropriate external supervision is available to him/her to adequately support the MH interpreter to manage the demands of the work. Supervision cannot and should not be managed by the clinician(s) involved in the work.

Accurate Representation of Credentials
As in any interpreted setting and as outlined in the ASLIA Code of Ethics, the MH interpreter needs to be mindful of the skills and experience that s/he has and be careful not to misrepresent those to others in any way or form.

Reimbursement for Services

As in any interpreted setting and as outlined in the ASLIA Code of Ethics, the MH interpreter – when undertaking the work as a private practitioner – will undertake negotiation and collection of fees for interpreting services provided in a professional manner, mindful of the factors outlined in the ethics.

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