

ASLIA Mental Health Interpreting Guidelines

Contributed by Jemina Napier
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Guidelines for interpreting in mental health settings

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1. Definitions

1.1. Field of mental health - Specialist mental health services -secondary and

tertiary services. (It is worth noting that MH situations can occur anywhere in community interpreting, however this code addresses specialist services.)

1.2. Client - This is the service user. They may also be known as consumer, patient, etc.

1.3. Clinician -They may also be known as therapist, professional, doctor, nurse, counsellor etc.

1.4. Mental Health Interpreter (MH interpreter) - An Auslan/English Interpreter who is working in the field of mental health. Ideally they will have had training and experience interpreting in this field. The MH interpreter may be Deaf or hearing.

1.5. Session - This can be a variety of meetings, assessments or therapy where the MH interpreter is booked to interpret for clients and clinicians.

2. Professional Conduct

(ASLIA CoE, no. 1) Auslan interpreters shall be unobtrusive, but firm and dignified at all times. All participants in the interpreted setting shall be considered clients of the Interpreter.

2.1. Pre-session meeting with the client - It is the responsibility of the

MH interpreter to try to arrange to meet the client before the session. This is to clarify their role. It is also to establish the language needs of the client and gauge their understanding of Auslan.

2.2. Pre-session meeting with clinician- The MH interpreter is considered part of the clinical team. It is their responsibility

to try to arrange to meet the clinician before the session. This is to establish:

- 2.2.1. The aim of the session
 - 2.2.2. The role of the MH interpreter
 - 2.2.3. Optimum physical conditions such as seating and lighting
 - 2.2.4. Key issues that may be raised in the session
 - 2.2.5. Background and risk history of the client (It may be possible to read the clients file in some services)
 - 2.2.6. Relevant details that may be raised such as names, diagnosis, relevant medication and correct spelling, etc.
 - 2.2.7. Therapy techniques that may be used. For example it has been known for some family therapists to ask the interpreter to stop interpreting, with the purpose of seeing the family dynamics and their response. It would be useful for the interpreter to be aware of this possibility before hand.
- 2.3. Post-session meeting with the clinician - The MH interpreter should try to arrange to meet the clinician after the session. This is to ensure:
- 2.3.1. The MH interpreter has an opportunity to share any feedback they may have about language or communication such as idiosyncratic language use, speed, use of signing space, use of pauses, signing style or the occurrence of unusual movement components in their signing.
 - 2.3.2. Any communication issues can be clarified
 - 2.3.3. Where distressing material has been discussed, the clinician and the MH interpreter should allow time for emotional debrief
 - 2.3.4. Discussion of therapeutic concerns such as transference/counter transference, that may have occurred, can be discussed as it may be helpful to the clinician.
- 2.4. Advocacy - The MH interpreter is not an advocate.
- 2.5. Safety -
- 2.5.1. The MH interpreter should not be responsible to supervise a client.
 - 2.5.2. The MH interpreter should consider their own safety with respect to being alone with a client. If the clinician leaves the room, the MH interpreter should leave with them.
 - 2.5.3. They should not assist in physically restraining a client.
 - 2.5.4. All staff MH interpreters must ensure they are trained in safety techniques. Freelance interpreters should consider this. The clinician should inform you in the pre-session meeting if the client has a risk history. If no information is offered, the MH interpreter should ask for it for.

2.6. Dress - The MH interpreter should dress appropriately so the Deaf participant will have clear access. They should wear plain, non-distracting clothes, where the colour of their shirt is skin contrasting.

3. Accuracy

(ASLIA CoE, no.5) Interpreters shall render the message faithfully, always conveying the content of the message and the spirit of the speaker, using language most readily understood by the person(s) whom they serve.

3.1. Interpreting idiosyncratic language

3.1.1. The MH interpreter must always tell the clinician if there is uncertainty of any degree with the interpreting process.

3.1.2. Any odd or repetitive language must be interpreted as near to the source message as possible to the clinician. Trying to 'repair' this into 'good-English' may cover up symptoms of language disorder, dysfluency or psychosis.

3.1.3. If the client is unclear or appears to be using idiosyncratic or non grammatical language it is appropriate to interpret in the "third - person" by using more description of the persons communication style, rather than attempting to find coherent meaning. An example might be "The client is using a lot of words that do not form a sentence: phone, house, spy, phone, watch. I can't be sure but I think there is no link between them"

3.2. Meeting language needs- In some situations there will be varying language needs. It is important to discuss in the pre-session meeting who you are interpreting for and at what level. If appropriate the MH interpreter may choose to interpret consecutively. They may also work with a Deaf Interpreter.

3.3. Deaf relay interpreters - Some clients may have a language disorder, visual difficulties, communication problems, or use sign languages other than Auslan. For these clients it is useful to have a Deaf relay interpreter present. The relay interpreter will interpret between Auslan and other signed communication or written English. There are many ways of co-working with a relay interpreter and it is important to discuss the method with them before hand.

3.4. Foreign language interpreters - In some circumstances you will be co-working with a foreign language interpreter. It is important to meet with them before the session to arrange how you will work together, such as how the information will be "chunked".

3.5. Jargon - The clinician might use jargon and abbreviations in their session. They might assume that the MH interpreter will modify the language to make it accessible for the client. Extensive use of jargon may go unchallenged if it is easily interpreted. However clinicians have a responsibility to use accessible language and the MH interpreter may remind them of this.

4. Confidentiality

(ASLIA CoE, no. 2) Interpreters shall keep all assignment related information confidential.

4.1. Client sessions - It is imperative that any information about clientsessions and their mental health is fully confidential, according to the ASLIA CoE. It is also important to be aware of the confidentiality policy within the service you are working.

4.2. Sharing information - The MH interpreter may discuss the assignment with other members of the interpreting and

clinical team. They may provide feedback to clinical meetings, if deemed appropriate. They can only professionally comment on language and communication.

4.3. Clinical advice - If a client approaches a MH interpreter for clinical advice the MH interpreter should direct them to speak to their clinician. The MH interpreter should not offer clinical advice.

4.4. Child Protection - If the MH interpreter is exposed to information that suggests risk to a child's safety and well-being, they should speak to the clinician to make them aware of the concerns.

4.5. Risk of harm - If outside a session, the MH interpreter is exposed to information about a client that suggests severe risk of harm to themselves or others, the MH interpreter should discuss the issue with their supervisor/mentor before deciding if any action should be taken. If they are not able to do so, they should speak to the clinician involved, or find advice from other more experienced MH interpreters.

5. Competence

(ASLIA CoE, no.3) Interpreters shall accept assignments using discretion with regard to skill, setting and clients involved.

5.1. Supervision -It is important that interpreters regularly reflect on their work practices and the impact the content can have on their interpreting. There are different models of supervision that should be considered.

5.1.1. Supervision of interpreting skill

5.1.1.1. Regularly film and observe your work

5.1.1.2. Find a mentor to discuss work practice and dilemmas with.

5.1.1.3. Find observation and shadowing opportunities in MH settings

5.1.1.4. Arrange supervision with an experienced MH interpreter.

5.1.2. Group supervision - A group of interpreters can meet to discuss strategies for self care, whilst providing support, feedback, emotional support and the opportunity to debrief. It may be possible to arrange for a facilitator with clinical experience.

5.1.3. Peer supervision - An unfacilitated group or pair of interpreters meeting regularly to discuss issues and offer support.

5.1.4. Reflective practice - The MH interpreter uses a log/diary to record their reflections about each interpreting session. They use it to record their thoughts on language and emotional issues that have arisen for them during the session. Over time they try to identify their own emotional 'black spots' and strategies for dealing with these whilst working. The aim is to become aware of the self and what you bring to the job in terms of emotional reactions and experiences. Joint reflective practice sessions could be organised with colleagues and clinicians.

5.1.5. Personal therapy - If a MH interpreter feels that personal issues and experiences are impacting their ability to practice or if they feel that working in a mental health field is bringing up emotional issues, they may seek personal therapy outside work. This should be separate from any other supervision arranged in the service.

5.2. Training/Shadowing - The MH interpreter is responsible for their continual professional development, in both generic interpreting skills and issues relevant to mental health. It is strongly recommended that you shadow or receive training in this field.

5.3. Types of assignments - Each meeting has its own jargon. The MH Interpreter should attempt to familiarise themselves with common terminology used in these contexts. Some examples of assignments in the mental health field are:

5.3.1. Assessments - This may involve taking developmental, psychological or medical history. It may also involve asking a series of questions about the clients' emotional and mental state. With children, this may involve play and observation.

5.3.2. Therapy - There are many varieties of therapy, some examples are: counselling, psychotherapy, couple therapy, family therapy, dance therapy and art therapy.

5.3.3. Clinical meetings - usually clients are not present at these meetings. Clinicians usually discuss clients' care, new assessments and new referrals at these meetings. Particularly complex or difficult cases may be discussed.

5.3.4. Case Conferences/Ward Round/Network meetings - These meetings usually involve multidisciplinary and multiagency professionals involved in a clients care. They feedback current care provided and plan future care. The clients may or may not be at this meeting.

5.3.5. Business meetings - These meetings usually raise staffing, financial, policy and service planning issue.