Code of Practice for Sign Language Interpreters Working in Mental Health

ASLI recognises that many Deaf people prefer to communicate in British Sign Language (BSL) with mental health professionals directly, as their first or preferred language. This Code of Practice offers the interpreter guidance for working in the field of mental health, where the client, family member, professional or clinician is a BSL user, and where other parties are not fluent in BSL. When in doubt, BSL interpreters should follow the ASLI Code of Professional Conduct (CoPC).

For information on the skills of Deaf Interpreters please see the Deaf Interpreters Network information at www.asli.org.uk.

1. Definitions

1.1. **Field of Mental Health** – Any situation in which a mental health professional is attending to the emotional and mental well-being of a deaf person. This may be within a specialist mental health service, or elsewhere in the community.

1.2. **Client** – This is the service user. They may also be referred to as consumer, patient, etc. The client may be Deaf or hearing.

1.3. **Clinician** –They may also be referred to as therapist, professional, doctor, nurse, counsellor etc. The clinician may be Deaf or hearing.

1.4. **Interpreter** – A BSL/English interpreter who is working in the field of mental health. Ideally they will have had experience and specialist training in this field.

1.5. **Staff interpreter** – A BSL/English interpreter who is directly employed by the mental health service

1.6. **Session** – This may be one of a variety of meetings, assessments or therapy where the interpreter is booked to interpret for clients and clinicians. During these sessions the interpreter is an integral part of the clinical team. See Appendix 2.

2. Professional Conduct

(ASLI CoPC 1) "*You shall in all cases act in accordance with the high standards appropriate to a professional body. You shall not act to the detriment of ASLI, its members or the profession.*"

2.1. **Communication assessment** – The interpreter should meet clients and establish their communication and use of language, and to explain the interpreter's role. This may be done before, or at the beginning of the session. This should be done as concisely as possible, bearing in mind that any communication outside of the session may have an effect on the content and dynamics of the session itself.

2.2. **Pre-session meeting with clinician** – The interpreter should try to meet the clinician before the session. If this is not possible, the interpreter may ask to see the client's file. However such access is bound by the confidentiality policies of the organisation and the clinician may refuse access. Staff interpreters should ensure that there is a system in place where this pre-session meeting can happen. This is to establish:

- 2.2.1. The clinician's therapeutic aims for the session
- 2.2.2. The role of the interpreter
- 2.2.3. Potential interpreting difficulties. e.g. complex concepts which may need to be explained using pictures, role-plays etc or with the support of a Deaf support worker
- 2.2.4. Optimum physical conditions such as seating, lighting, acoustics and breaks
- 2.2.5. Key issues that may be raised in the session
- 2.2.6. Background and risk history of the client
- 2.2.7. Relevant details that may be raised such as names, diagnosis, form of medication, purpose of medication and spelling, etc.
- 2.2.8. 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 a family's dynamics.

2.3. **Pre-session meeting with co-workers/advocates/support workers - *if present*** - The interpreter should meet their co-worker and other support staff before the session, so they can gain information on the client's use of language e.g. specific signs/words that the client uses, and any other special needs. They should agree how to work together and how to clarify meaning. They may need to check with any Deaf professionals present whether the target BSL is to be aimed at them or the client.

2.4. **Post-session meeting with the clinician and other professionals** - The interpreter should arrange to meet the clinician after the session. Staff interpreters should ensure that there is a regular system in place. This is to ensure:

- 2.4.1. The interpreter has an opportunity to give feedback about language or communication, e.g. idiosyncratic language use, speed, use of signing space, use of pauses, signing style or the occurrence of unusual movement components in signing.
- 2.4.2. Any communication difficulties can be clarified
- 2.4.3. Where distressing material has been discussed, the clinician and the interpreter should have an opportunity for an emotional debrief
- 2.4.4. Therapeutic concerns such as transference/counter transference, that may have occurred, can be discussed, as this may be helpful to the clinician.

2.5. **Advocacy** - The interpreter is not an advocate, promoting the interests of the client. As a member of the clinical team, the interpreter is qualified to comment on language use, communication difficulties and the interpreting process. As part of the clinical team, they can assist in treatment planning by working to ensure that the client understands the language of used in his/her treatment, e.g. recommending that a Deaf interpreter is always present.

2.6. **Safety** –

2.6.1. The clinician should inform the interpreter in the pre-session meeting if the client has a risk history. If no information is offered, the interpreter should ask for it. Seating arrangements should reflect the risk assessment, e.g. the client and interpreter have a clear pathway to the exit.

2.6.2. The interpreter must not be left alone to supervise a client. The interpreter must consider his/her own safety if left alone with clients. If all the clinicians leave the room, the interpreter should leave too.

2.6.3. In some cases the interpreter will be asked to interpret a restraint. The interpreter should not assist in physically restraining the client.

2.6.4. All staff interpreters must ensure they are trained in safety techniques. Freelance interpreters should seek such training too.

2.7. **Dress** - The interpreter should dress appropriately so the Deaf participant(s) will be comfortable watching sign language. Interpreters should wear plain, non-distracting clothes, where the colour of their shirt is skin contrasting. Interpreters should not wear clothes that are in any way seductive or revealing. Jewellery, hair and other adornments should not be distracting.

2.8. **Enhanced CRB checks -** It is essential that interpreters be enhanced CRB-checked for working with children and vulnerable adults.

3. Complete and Effective Communication

(ASLI CoPC 5.1.2) *"Take all reasonable steps to ensure complete and effective communication between the parties, including intervention to prevent misunderstanding and incorrect cultural inference"*

3.1. **Interpreting idiosyncratic language**

3.1.1. The interpreter must always tell the parties in the session if there is any uncertainty in 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 interpreter believes 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 a description of the persons communication style, rather than attempting to find coherent meaning. e.g. "The interpreter can see that the client is using a lot of words that do not form a sentence: phone, house, spy, phone, watch. The interpreter cannot see a 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 how to interpret in this situation. If appropriate the interpreter may interpret consecutively, use communication aids such as pictures or role-play. If the interpreter has doubts that they have

been understood, they can ask the client to repeat back to them what has been said/signed. The client may benefit more from working with an interpreter who is Deaf.

3.3. **Deaf Interpreters** – Some clients may use a non-standard form of sign language, which could be a result of their mental ill health and/or socio-linguistic factors. They may have a language disorder, visual difficulties, communication problems, or use sign languages other than BSL. For these clients it is useful to have Deaf interpreter. The Deaf interpreter is an experienced working interpreter. The Deaf Interpreter is not just a member of the clinical team who takes on an additional communication facilitation role. The Deaf interpreter will interpret between BSL and other signed communication or written English. There are many ways of co-working with a Deaf interpreter and it is important to discuss the method with them before the session.

3.4. **Foreign language interpreters** – In some circumstances the interpreter will be co-working with a non-English language interpreter. It is important to meet with them before the session to arrange how you will work together, e.g. to agree how information will be "chunked".

3.5. **Keeping the clinician informed –** The interpreter should inform the clinician when it is believed the client does not understand the interpretation of the clinician's communication and may offer suggestions for repair. It is also important to inform the clinician when the client's communication is changing, e.g. speech/signing has accelerated, or the client's affect seems to have altered, e.g. has become muted/flat.

It is important to inform the clinician when the interpreter needs to use examples or different approaches in order to convey a concept. It may be useful to have two interpreters; one modifying their language so that the client understands; the other providing the clinician with a discreet interpretation of what those modifications are.

3.6. **Professional humility**- the interpreter should accept that professionals and others in the session might have a better understanding of what the client is signing/saying. The interpreter should not feel threatened by their contribution, provided it is given in a supportive and professional manner. The interpreter needs to accept this as part of an effective communication process.

3.7. **Breaks** – To allow the interpreter and client to communicate effectively, it is essential they have regular breaks, e.g. 5 minutes break per 30 minutes interpreting. The interpreter should leave the room if possible. Negotiations should be made to avoid breaks occurring at inappropriate times.

3.8. **Jargon** –Jargon and abbreviations may be used and people may assume that the interpreter will modify the language to make it accessible for the client. The interpreter should make the professionals aware that it is their responsibility to use accessible language, and that extensive use of jargon may make it difficult or impossible for the client to understand.

4. Confidentiality

(ASLI CoPC 4.1) *"Maintain confidentiality at all times and treat any information which may come in the course of your work, as privileged information, not to be communicated to any third party, without authority."*

4.1. **Client sessions** - It is imperative that any information about client sessions and their mental health is fully confidential. It is also important to be aware of the confidentiality policy within the service the interpreter is working in.

4.2. **Sharing information**

4.2.1. The interpreter can share details of the assignment in a confidential supervision session in order to improve their practice

4.2.2. The interpreter may discuss the assignment with other members of the interpreting and clinical team. They may provide feedback to clinical meetings, if appropriate. The interpreter should only comment on language and communication.

4.2.3. If a client seeks to contact the interpreter in person or in written form, it may be appropriate to pass the communication on to the clinical team.

4.2.4. Any records of idiosyncratic signs or sign names used, or specific recommendations on communication with patients should be kept in a secure place to maintain patient confidentiality.

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

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

4.5. **Risk of harm** – If outside a session, the interpreter is exposed to information about a client that suggests severe risk of harm to themselves or others, the 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 seek advice from other more experienced interpreters.

5. **Competence**

(ASLI CoPC 5.2) *"Refuse work which is known to be beyond your competence, either linguistically or because of a lack of specialised knowledge"*

It is recommended that the interpreter be a LASLI (Licensed ASLI member) or MRSLI (Member of the Register for SLI's). Associate SLI's or TI/JTI (Trainee/Junior) should only undertake mental health interpreting under close supervision/ observation.

5.1. **Supervision –**It is vital that interpreters regularly reflect on their work practices, and the impact the content can have on their interpreting and their wellbeing. This should include different forms of supervision and support. See Appendix 1.

5.2. **Training/Shadowing -** The interpreter is responsible for his/her continuing professional development, in both generic interpreting skills and issues relevant to mental health. It is strongly recommended that the interpreter shadows more experienced colleagues and receives training in this field. There are several Deaf mental health services within the UK that may provide shadowing opportunities and information about training.

Appendix 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.

1. **Supervision of interpreting skill**
   a. Regularly film and observe your work
   b. Find a mentor to discuss work practice and dilemmas with.
   c. Find observation and shadowing opportunities in MH settings
   d. Arrange supervision with an experienced MH interpreter.
2. **Group supervision –** A group of interpreters can meet to discuss strategies for self-care, whilst providing supportive feedback, emotional support and the opportunity to debrief. It may be possible to arrange for a facilitator with clinical experience.
3. **Peer supervision –** An unaffiliated group or pair of interpreters meeting regularly to discuss issues and offer support.
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 triggers 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. **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.

Appendix 2

Types of assignments

Different meetings often have their own jargon. MH interpreters should try to familiarise themselves with this jargon. Some examples of assignments in the mental health field are:

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.

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

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.

Mental Health Tribunals – These tribunals involve multi-disciplinary and multi-agency professionals, as well as the client. The Tribunal is a major event in the client's life and offers them the opportunity to challenge their diagnosis and Section.

Sectioning under the Mental Health Act – a hospital or police may retain a client if their mental ill health is seen as a risk. The law they use to enforce this is called the "Mental Health Act". Each "Section" within the MH Act is different, so it is essential to be familiar with the various sections within the Act.

Care Programme Approach (CPA) Meetings/Ward Round/Network meetings etc – These meetings usually involve multidisciplinary and multi-agency 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.

Business meetings – These meetings usually raise staffing, financial, policy and service planning issues.