Working with interpreters: Guidelines for mental health professionals

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WORKING WITH INTERPRETERS: GUIDELINES FOR MENTAL HEALTH PROFESSIONALS

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There is a variety of views regarding some aspects of working with interpreters (such as whether interpreters should be regarded as cultural informants), and we have tried to highlight the range of views in such circumstances. We emphasise however that the opinions expressed here are those of the authors.

Introduction

These guidelines provide an overview of working with interpreters in the mental health system. They have been developed to assist clinical mental health service providers in the Child and Adolescent, Adult and Psycho-geriatric sectors to improve service delivery to those accessing mental health services from non-English speaking backgrounds, and to assist in the task of working with interpreters as an integral part of clinical practice. It is hoped that this document will encourage the development of local policy and also provide an induction for mental health workers on this topic.

The guidelines provide an overview of systemic and operational issues to be considered in language services. These include the need for policy support, staff training, the role of the interpreter and clinician in the interpreted interview and practical advice for staff in working with interpreters. Of course, the steps described in the guidelines need to be underpinned by a commitment from management to provide the resources necessary.

Practical steps for working with interpreters have been included recognising that staff working in mental health services typically have limited training, and sometimes no training, in how to work effectively with interpreters.

These guidelines are intended to provide suggestions or options available to services in meeting the language needs of clients while recognising that there may be considerable variation in the nature of the work undertaken by age-specific mental health services.

Immigrants and mental health services

The under-utilisation of mental health services by people from non-English speaking backgrounds (NESB) is well documented.

People born in non-English speaking (NES) countries have lower rates of admission to psychiatric inpatient units (as a proportion of the population of each birthplace group) compared to the Australian-born population (Minas, Ziguras, Klimidis, Stuart and Freiden 1995, Stolk 1996a, Trauer 1996, McDonald and Steel 1997). A feature of these data is that people born in NES countries have far lower rates of voluntary admission compared to the Australian-born but roughly similar rates of involuntary admission across all birthplace groups (Trauer 1996, McDonald and Steel 1997).

Several studies have also found that length of stay is significantly longer for people born in NES countries (Falconer and Ziguras 1994, Trauer 1996) although some studies have not confirmed this finding (e.g., Stolk 1996a).

Rates of utilisation of community mental health services are also lower for people born in non-English speaking countries (Minas et al 1995, Stolk 1996a, McDonald and Steel 1997) Studies have also found lower rates of access to allied health professionals (Stolk 1996a) and psychotherapy (Stuart, Minas, Klimidis and O'Connell 1996) and lower average contact duration (Stolk 1996a, Trauer 1996) for NESB compared with ESB clients.

There has been little research into the quality of service provision and outcomes (including client satisfaction) in relation to mental health services. Some indication of quality of service provision comes from a survey of psychiatric services staff (Minas, Stuart and Klimidis 1994). Staff reported that the quality of service provision to NESB groups was inferior to that provided to the Australian-born.

Inadequate communication with people who have limited English proficiency limits their ability to access services, but it also has a profound impact on the quality of treatment they receive when they do gain access. Communication in any clinical relationship is of paramount importance. It is the means by which a clinician can:

- learn what is being experienced by a client
- formulate a diagnosis
- decide, together with the client and his/her family, an appropriate program of treatment
- develop a therapeutic relationship

Where communication between clinician and client is inadequate, the probability of diagnostic and treatment errors is increased (Minas 1991). Misdiagnosis may result from:

- the under-estimation or over-estimation of severity of psychopathology
- the failure to recognise psychopathology
- the diagnosis of psychopathology which is not present

Inappropriate or incorrect treatment may lead to negative outcomes such as the prolongation of the condition, the loss of quality of life or the onset of disability (Minas, 1991). Inadequate communication may also lead the client/patient, family or carers to a limited or distorted understanding of:

- the role of the clinician
- the role of the service
- the nature of the illness
- the purpose of treatment or medication
- side-effects of medication

For those people who do not speak English fluently, communication must take place either with a staff member who speaks their preferred language, or with the assistance of an interpreter. Access to interpreters in public mental health services has been deficient. Two studies have found that the average frequency of interpreter use for psychiatric in-patients who spoke English poorly or not at all was once per week (Falconer and Ziguras 1994). Another study found far less use of interpreters but reported a significant increase in interpreter use after the introduction of a ward policy for interpreter use, training for staff, and greater monitoring of interpreter bookings (Stolk, Ziguras, Saunders, Garlick, Coffey and Stuart 1998).

There is also some question about the use of interpreting services in community mental health services. Working with an interpreter ought to double the amount of time required to conduct a clinical task. If interpreters were being used effectively, it would be expected that consultation times for NESB people would be greater than those for the Australian-born. Trauer (1996) found, though, that average consultation times were lower for NESB people compared to Australian-born in two services. This raises questions about the adequacy of use of interpreting in such settings.

In the Royal Park Ethnic Health Audit, (Royal Park Corporation 1994) clients reported a lack of information, difficulty in communicating with staff and some dissatisfaction with a lack of family involvement in their care whilst in hospital. Some clients with poor English stated that the only person they could communicate freely with was a cook or gardener who spoke their language and they felt that these staff had been more understanding and helpful than any of the mental health professionals.

In relation to Child and Adolescent mental health services, research recently undertaken suggests that an improved awareness of issues confronting families from NESB needs to occur in CAMHS (Luntz, 1998).

Similarly in the area of services for aged people, the risks of misdiagnosis and lack of appropriately qualified bilingual health professionals have been cited as issues confronted by those from diverse cultural backgrounds (Lydall-Smith & Gilchrist, 1996).

Inadequate communication may hamper mental health staff in:

- monitoring symptoms of illness and medication effectively
- understanding the point of view and experience of the client
- understanding the cultural context of behaviour

Moreover, the experience, which may be intimidating and isolating under normal circumstances for a client, becomes more difficult and stressful.

There are legislative and policy requirements to ensure that NESB people are not prevented by barriers of communication or culture from using mental health services.

The Mental Health Act (5 ii) states that mental health services must:

- "take into account the age-related, gender-related, religious, cultural, language and other special needs of people with a mental disorder."

This section applies to all mental health services funded under the Act, including both clinical and psychiatric disability support services.

Department of Human Services policy (1996) also stipulates that services should :

- "provide the best use of language service to enhance communication between their staff, the client and their carers." (p.15)

The National Standards for Mental Health Services (Commonwealth Department of Health and Family Services 1997) also states in Standard 1.7 that:

- "The MHS (mental health service) upholds the right of the consumer and their carers to have access to accredited interpreters." (p.7)

The Department of Human Services has been proactive in implementing a number of initiatives which have prioritised cultural issues within mental health services. An example is the Quality bonus initiative which scrutinised the work of clinical adult mental health services and rewarded good practice in work with cultural diversity with a cash bonus. Another initiative which was designed to impact on mental health services at the systemic level is the Ethnic Mental Health Consultants program whereby consultants working within a particular geographical catchment undertake strategies which impact on the barriers to culturally sensitive practice. Short term projects investigating inroads into culturally sensitive practice in Psychiatric Disability Support Services and the Child and Adolescent Mental Health Services are also underway.

Such policy frameworks and projects improve awareness and skill in working with cultural diversity. As the main focus of these guidelines is to provide information on the issues which arise in working with interpreters, it is hoped that they will contribute to the provision of more effective treatment and care.

Interpreting in mental health services

Interpreting is a highly specialised skill involving accurate and effective translation of information from one language into another. The role of the interpreter is to act as a conduit between clinician and client or carer/guardian, facilitating the exchange of words and concepts. In a mental health setting, this is best done using consecutive interpreting where information is conveyed in short manageable segments. There are several issues which arise when an interpreter is re1quired to interpret for people in a mental health service setting.

1. Stigma

Mental illness is highly stigmatised in all communities, but arguably more so in many non-English speaking communities. Where there is a high degree of stigma, clients may not want to be identified within their community as having a mental illness (or having a family member with a mental illness). This may result in reluctance by the client or carer/guardian to have an interpreter present even if their English language skills are inadequate. It may be that the service knows the interpreter or his/her family and therefore feels uncomfortable in having that person involved in their case. This often occurs in small communities.

2. Confidentiality

It is important to stress to the client/family (and the interpreter) that all information is confidential. Although interpreters are bound by their Code of Ethics to ensure that they maintain confidentiality in their work, many service users are unaware of this. Concern about what happens to information divulged in the presence of an interpreter may be based on past experience: for example, where unqualified staff may have been used to interpret. Failure to maintain confidentiality is relevant for any member of staff (clinical, interpreting or administrative).

3. Technical language

In mental health services, the use of technical language and clinical jargon abounds. It relates to the diagnoses (e.g. schizophrenia, bipolar disorder), symptoms (e.g. delusions, hallucinations, psychosis) and treatment (e.g. counselling, case management, electro-convulsive therapy, psychosocial rehabilitation, supported accommodation, disability support and so on). Names and acronyms for service programs (i.e. Mobile Support Team or MST, Crisis Assessment and Treatment Team or CATT etc) are often confusing. It is important that information about all of these is conveyed as clearly as possible in non-technical language and that the understanding of clients, carers and families is checked.

4. Interpreter attitudes

In the Royal Park Ethnic Health Audit (1994), the negative attitudes of an interpreter towards a person with mental illness and resulting inappropriate behaviour was documented. Staff need to be aware that interpreters may also be affected by stigma, misinformation or lack of training on mental illness.

5. Flexibility

Issues specific to the area of mental health may arise when working with interpreters. For example, the interpreter may need to interpret simultaneously for some situations (eg someone experiencing a manic episode may talk without stopping). It is advisable that the clinician

confers with the interpreter prior to the interview in order to provide information about the case and to establish the mode of interpreting (eg consecutive interpreting). If the interpreter diverts from this, the clinician will understand that the interpreter is responding to the situation at hand. This is also why it is important for the interpreter to be trained in the area of mental health problems.

6. Accuracy of information

It is important that interpreters are aware that they are required to provide as exact an interpretation of the content of an interview as possible. They need to be forewarned that sometimes the information to be conveyed may make no sense as a result of thought disorder, flight of ideas or dysphasia. For the clinician to discern this, it is necessary for the interpreter to interpret exactly what is said without trying to make sense of the client's speech. Clinicians should note that interpreting consists of interpreting meaning as well as individual words, partly because some words or phrases have no direct translation in another language.

7. Continuity

Whenever possible, the same interpreter should be called for a client. Where an interview has progressed well and trust has developed between the client/family and the interpreter, working with the same interpreter is good practice. The onus on the client/family to repeatedly have to re-establish rapport with new interpreters introduces unnecessary and unavoidable difficulties. Feedback from clients/families about their attitude to, or comfort with, a particular interpreter can be gained by telephoning the client using the Telephone Interpreter Service.

8. Trust between Clinician and Interpreter

Where a clinician suspects that information is being wrongly interpreted, it is advisable to inform your client that you need to talk to the interpreter and then clarify with the interpreter whether they have understood the information.

9. Professional Partnerships

We need to acknowledge that interpreters are human beings and professionals whose task is to facilitate an exchange of information and therefore require our respect. Interpreters prefer to be 'worked with' rather than 'used'.

10. Provision of cultural information

There are different views amongst those working in the field and amongst some interpreters themselves about whether interpreters should be seen as a source of information about cultural issues. Interpreters may have considerable knowledge of a particular culture and it may be useful to ask for information from them on religious or cultural practices or historical or political events. In some situations interpreters may even be able to provide information about whether a particular behaviour is common or socially acceptable in their country of origin. This information can also be obtained from bilingual staff in psychiatric services, ethno-specific organisations or ethnic projects in disability support or clinical services.

Some interpreters point out however, that they may know about only one aspect of a community and not be able to comment more broadly especially when the interpreter does not originate from the same country or region as the client. For example an Arabic speaking interpreter born in Egypt may not feel able to comment on Arabic speaking people from other countries. This is obviously the case for bilingual staff as well, so it is useful to keep in mind that each person will have her or his own views about cultural and social issues. For example,

think about the range of responses different Australians might give to a question you are asking an interpreter or bilingual staff member if asked to comment about Australian culture!

Interpreters are not trained mental health professionals and they should not be asked to assess the symptoms of clients.

Note that:

- Interpreters are not trained to interpret behaviour although they may be able to comment on cultural practices
- Bilingual and bicultural clinicians should be sought to assist with secondary clinical consultation
- Be aware of your expectations of the interpreter

10. Block booking

Many health services and some mental health services, organise block booking for an interpreter where there is a high demand for a particular language. This has the advantage of maximising access to an interpreter for each booking and minimising travel costs. There is more than one way in which this might be done. For example, a interpreter can be booked for the same afternoon or morning each week, and clients booked in at this time. Alternatively, some services will try to arrange a new interpreter appointment immediately following one which has already been booked for another staff member.

One reason for promoting block booking is that it is cheaper; generally each interpreter booking is charged for one and a half or two hours regardless how long the interview takes. Multiple appointments for one interpreter booking is obviously more cost-effective than a separate booking for each.

One criticism of block booking has been that it may force clients to come to a service at the same time as others from the same background and that some people would prefer to not to be identified by those from their own community due to stigma or embarrassment. On the other hand, some clients of NESB may enjoy the chance of meeting others who speak the same language and who they can converse with. Needless to say, the preference of clients/families should be taken into account in block booking interpreter appointments as far as possible.

11. Assessment and Accreditation of Interpreters

Assessment of language proficiency and the accreditation of interpreters is undertaken by the National Accreditation Authority for Translators and Interpreters (NAATI). NAATI supervises the accreditation of interpreters according to the following levels of proficiency in Languages Other Than English (LOTE).

NAATI Level 2 - Para-professional interpreter - qualified to interpret in simple, straight-forward situations.
NAATI Level 3 - Interpreter - Preferred level for legal, medical and other specialized work.
NAATI Level 4 - Conference Interpreter - Advanced professional level. These interpreters are qualified to interpret in complex, specialised situations including international conferences.

For rare languages where NAATI does not as yet offer testing, recognition is given once it is proven that interpreters have been practicing in those languages sufficiently to guarantee their ability and skill in interpreting.

It is desirable that interpreters working in the mental health field are familiar with basic psychiatric terms and concepts, have some understanding of mental illness, and have considered their own attitudes to and assumptions about people with a mental illness. Formal training for interpreters in these issues is ad hoc, although some have developed this knowledge and awareness by working with mental health services over a number of years.

Organisational framework

Policy support

A policy supporting and mandating interpreter use is a necessary starting point in beginning the process of implementing language services in an organisation.

The policy should include:

- a statement indicating the commitment of an organisation to respond to cultural diversity by providing professional language services in a timely manner
- that professional, accredited NAATI Level 3 interpreters will be used to facilitate communication in English and that this is for the mutual benefit of the client and the clinician
- that the provision of language services will be according to a Language Services Plan which outlines protocols for staff in using interpreters
- that staff are provided with guidelines and regular training on how to work with interpreters
- that the use of language services by staff is a justifiable expense
- that budgetary provisions for language services are made

Organising a system for interpreter use

A process for booking interpreters should be identified by each service. A designated staff member (eg a Language Services Co-ordinator) with responsibility for the organisational operation of the interpreter service is regarded as an example of best practice.
Preparatory work is necessary to establish a system for interpreters. It is necessary to undertake tasks such as:

- undertaking a process to determine which is the most effective system to be implemented
- organising the development of internal protocols for staff in working with interpreters
- developing and providing resources necessary to support staff in accessing interpreter services (see the section on 'Resources')
- working with administrative staff in the daily running of interpreter services
- organising regular reports from interpreter providers to assist with cost allocation and for quality assurance processes measuring interpreter use

Systems of organising interpreter services include:

- use of hospital interpreter service
- use of external interpreter services such as the Victorian Interpreting and Translation Service, the Central Health Interpreter Service, the Translation and Interpreter Service (TIS)
- use of a central booking system
- use of a block booking systems for languages that are used often enough to justify this on a regular basis

Staff training

Staff require training in how to work with interpreters. This training should include skills in working with telephone interpreters. Training is provided by interpreter services such as Victorian Interpreting and Translating Service or Central Health Interpreter Service on how to work with interpreters. Cross cultural training courses organised by the Victorian Transcultural Psychiatry Unit (VTPU) provide specialised training in working with interpreters in mental health settings from the perspective of practitioners.

Staff Development or Training Units within the organisation should assume responsibility for including, on a regular basis, sessions on how to work with interpreters. Where no such structures exist, organisations need to determine how this will be implemented.

Responsibilities of staff

Staff have some legal responsibilities in relation to communication. For example it is the responsibility of staff to ensure that information about rights is conveyed to clients upon admission "in the language, mode of communication or terms which he or she is most likely to understand." (Mental Health Act, 18 (3)). More generally, the National Mental Health Standards require staff to facilitate the use of accredited interpreting services (e.g. standards 1.7, 7.1, 7.3, 11.3.9).

Staff should inform clients of their rights to utilise language services. This can be done verbally, with a poster or pamphlet on language services, or by telephone, using the Translation and Interpreter Service.

Refusal of interpreter services

Clients and carers/guardians have the right to refuse interpreting services. As discussed earlier, refusal could reflect anxiety about being identified as having a mental health problem or receiving a mental health service. Refusal to accept an interpreter could also be due to concern about confidentiality being maintained or a carer/guardian's belief that his or her English proficiency is sufficient to communicate adequately in English. The clinician should seek out the reason for reluctance to have an interpreter (recognising that communication may prevent this). If possible the provision of information to the client/family about the Code of Ethics which interpreters and clinicians are bound by is also a useful strategy. In some cases, the concern is not with interpreters per se, but some in particular. For example, people from countries with totalitarian governments may believe that some interpreters are spies (this may or not be plausible), and those who have been through the trauma of civil war or ethnic conflict may be very distressed at the presence of an interpreter who comes from a group on the opposing side of the conflict.

Mental health services need to consider the refusal of an interpreter in relation to duty of care responsibilities. Clinicians should work towards achieving the best possible outcome with service users. Options include:

- exploring and dealing with concerns about confidentiality if they exist
- conducting interviews in English and having an interpreter for complex issues which may be beyond the English ability of the service user(s)
- conducting one or two initial interviews in English and then making a judgement about whether this is satisfactory
- asking the client/carer/guardian whether there is a particular interpreter (not a family member) who they trust and would be prepared to have involved, or if there is a specific interpreter they do not want
- checking whether the client/carer/guardian would prefer a bilingual staff member, if available
- requesting that the treating psychiatrist make a decision as to whether an interpreter should/should not be used. NB Where an interpreter is required and not used, the reason for this should be documented in the medical record.

Legal obligations under the Mental Health Act may supersede other considerations, compelling services to call an interpreter against the client's wishes in some situations. Obviously, where there has been client resistance to an interpreter's presence, the information obtained through the interpreter may be incomplete.

When should an interpreter be called?

An interpreter should be called:

- when a client/carer/guardian requests an interpreter
- where the staff member cannot understand the information being conveyed by the client
- when the client/carer/guardian is assessed as needing an interpreter by staff because of difficulty in communicating in English
- when a person prefers to speak and is more fluent in a language other than English

Assessing the need for an interpreter

As well as being influenced by the preferences of service users, staff need to be able to assess the need for an interpreter independently. In order to determine whether an interpreter is required in a clinical situation, an assessment of a person's communication and comprehension in English is necessary. English proficiency can be divided into comprehension and expression in oral and written form. While it is beyond the scope of this document to explore the question of proficiency in any detail, a simple proficiency scale is outlined below:

1. Unable to have an every day conversation (e.g. understands simple greetings and little more).
2. In between 1 and 3.
3. Able to have an every day conversation but not proficient enough to discuss clinical issues or emotional content.
4. In between 3 and 5.
5. Able to communicate well. Can readily discuss clinical information.

If the client falls into categories 1 to 3, an interpreter should be used as these categories indicate a basic level of comprehension in English. If the client is rated at level 4, an interpreter is needed for complex clinical information. While clients with proficiency at Level 5 generally can communicate perfectly adequately in English, they may still need interpreting services in some situations (eg. in discussing deeply emotional or distressing topics, or upon relapse requiring admission to hospital).

The ability to understand clinical information such as that conveyed in a consultation with a mental health worker requires a level of English proficiency comparable to a native speaker. As mentioned earlier, there is a great deal of technical terminology used in relation to symptoms, psychiatric conditions, mental health programs and treatment options which may not be readily understood. While it is preferable to avoid such terms, it may also be useful to explain such terms clearly with an interpreter.

Seeking out information on the level of literacy in English of a service user will further give insight into the level of English proficiency.

Situations when an interpreter should be called

Interpreters should be called in all instances where significant information needs to be conveyed to the client/carer/guardian. An interpreter should be used in the following situations:

- at initial assessment and ongoing treatment
- at intake or admission to the service
- family assessment
- specialist and multi-disciplinary assessments
- during assessment including initial assessment and mental status examination
- for explanation of assessment outcomes, diagnosis, treatment, medication and/or side effects
- to explain legal rights and changes of legal status
- obtaining informed consent for procedures deemed necessary
- risk assessment
- in ongoing reviews whether at service or on home visit
- for the development of an individual service plan and including allied health programs and interventions
- discharge planning
- in monitoring clients who are in inpatient units or receiving intensive treatment. Regular communication with clinical staff reduces isolation and anxiety and helps maintain orientation to reality
- When a client requests one
- Debriefing clients/families/carers following critical incidents

A standard in relation to adult inpatients is that they should be provided with a face to face interpreter at least every second day (e.g. St Vincents Hospital and Community Psychiatric Service *Use of Language Service* 1997; Inner West Area Mental Health Service *Interpreting and Translation Provision 1996*). Use of a telephone interpreter may not be appropriate and clinicians should carefully assess how a client may respond to this

Crisis situations

On site interpreters are often readily available and can be organised within an hour if you indicate:

- that you are from a mental health service **and**
- that you are dealing with a crisis situation.

In many crisis situations, intervention can be delayed until an interpreter is obtained. If absolutely unavoidable, a family member may be used but an interpreter should still be engaged as soon as possible to confirm and clarify the dialogue. A telephone interpreter might be helpful until an on site interpreter can be arranged.

Guidelines for working with interpreters

Preparation

- Identify the appropriate language or dialect (e.g people born in China may speak Mandarin, Cantonese, Hokkien or any of numerous other languages)
- explore client/carer/guardian wishes regarding gender, dialect, country, ethnicity etc.
- allocate additional time for an interpreted interview
- book the same interpreter wherever possible

Booking an interpreter

- specify the language, ethnic group and gender required
- ascertain the length of time the interpreter is available for
- request a NAATI Level 3 interpreter and where this is not possible, ask for a Level 2
- ask for an interpreter with experience or training in mental health issues

Before the interview

- ask the interpreter about his or her training or experience in mental health
- brief the interpreter on the case and the terminology which you may expect to use or any other background information which may be relevant
- discuss how you will conduct the interview

Some interpreters prefer not to be left alone with the client/family prior to or during the interview as they feel it places them in a difficult position (because, for example, some clients choose to divulge information to them that they do not want passed on to a clinician). Check the interpreter's preference.

For the first interview:

- introduce yourself and the interpreter
- explain who you are and your role
- explain the role of the interpreter (eg that they are there to help with communication by interpreting what is said)
- explain that interpreters are bound by their code of ethics to treat everything that is said as confidential (this is a particularly important issue and it may take several sessions before clients are satisfied that confidentiality is maintained)
- explain the purpose of the interview

During the interview

- ensure that the seating is arranged such that a triangle is formed between the client, the clinician and the interpreter. (For hearing impaired clients, seating may be altered so that interpreter is placed on the side of the client's good ear)
- if a carer/guardian is present, they should be seated with the client such that a circle of all parties is formed
- in a large or group meeting situation, seat the interpreter with the clients so they are able to understand the proceedings with minimum disruption to others
- keep your sentences or questions reasonably brief and concise
- pause at the end of each statement to allow the interpreter time to interpret
- explain the need to pause to the client if necessary
- be aware that the interpreter may sometimes have to clarify a statement or answer with the client/carer/guardian
- be aware that it is the responsibility of the mental health worker to maintain the direction of the interview and to intervene if necessary (eg. if the interpreter and client/carer/guardian appear to start having a private conversation or in cases where the interview is not orderly due to the behaviour of a client)
- maintain eye contact with the client/carer/guardian, even when the interpreter is interpreting
- speak to the client directly. Use the first person 'I' and 'you' instead of 'ask him or her' (this limits confusion about who is being referred to and reinforces that the interview is being conducted by the worker with the client)
- avoid jargon or colloquial language which is particularly difficult to translate and explain any concepts or difficult terms. Where technical terms have to be used, it is the responsibility of the mental health professional to explain their meaning, not the interpreter's.
- be aware of the body language of both interpreter and client
- if you need to leave the room, make a telephone call or do anything which is not clear to the other parties, explain your actions prior to doing so

After the interview

- ask the interpreter about any comments they would like to make
- allow the interpreter time to discuss any aspect of the interview they may have found confusing or distressing

Points to remember:

The mental health professional has responsibility for maintaining control of the interview.

- avoid engaging in lengthy discussion with the interpreter during the interview as this may isolate the client/family. If discussing a particular point is unavoidable, explain to the client/family what you are doing and why.
- generally speaking, briefing the interpreter should occur prior to the interview and discussion of any factors the clinician is unsure about after the interview.
- you need to be aware of the information the client/family is receiving and everything said by the client during the interview should be interpreted.
- sometimes clients/family members tell interpreters something and then ask them not to pass this on to mental health staff (you may need to explain the interpreter's role again in such cases).
- avoid using children or family members as interpreters under any circumstances (other than obtaining basic client information such as name and address).
- using an interpreter service via telephone should only be used for obtaining basic information such as registration details. It is not appropriate to use a telephone interpreter service for a clinical consultation.
- try to arrange for the same interpreter in subsequent interviews if all parties are pleased with the interpreter.

Unsatisfactory practices

Some examples of unprofessional practice for an interpreter include:

- not interpreting everything which is said (unless someone is speaking so quickly that this is impossible)
- carrying on a side conversation with the client/carer or clinician during the interview and excluding the other party
- speaking on behalf of the client/carer/guardian
- answering the phone during an interview
- demeaning behaviour or attitude towards the client

What to do:

Discuss any unsatisfactory behaviour with the interpreter after the interview and why you thought it was unacceptable. Assume, in the first instance, that the interpreter was not aware of the problem. For some language groups (especially newly arrived communities) trained interpreters are not available so the person interpreting may not be familiar with some aspects of interpreting.

If the interpreter refuses to acknowledge the problem or if it is repeated, bring this to the attention of the person responsible in the interpreter service who can take the issue up. Ask that this interpreter not be sent again.

Some useful resources

- SBS World Guide.
- Victorian Transcultural Psychiatry Unit (VTPU) Website: http://www.vtpu.org.au - Provides information on publications, newsletters, staff, research and statistics.
- Australian Transcultural Mental Health Network website: http://atmhn.unimelb.edu.au - Provides information on ATMHN programs, translated information and mental health resources.
- Language Card, Translating and Interpreting Service, Department of Immigration and Ethnic Affairs.
- Countries and Language spoken in "Directory of Bilingual Mental Health Professionals" Victorian Transcultural Psychiatry Unit, 2001.
- 'Do you need an interpreter?' poster in 42 languages. Victorian Interpreting and Translating Service, Melbourne 1999. Available from VITS, Tel: (03) 9280 1955.
- 'Knowing your rights is important' poster - North West Health.
- "Directory of Mental Health Information in Community Languages" ADEC, 9383 5566.
- "What is Mental Illness?" pamphlet in 17 languages, ADEC, 9383 5566.
- "Information on Mental Health Problems" audio tapes in 12 languages, ADEC, 9383 5566.

A number of available interpreting services are listed below.

- Translating and Interpreter Service (TIS) (Department of Immigration and Multicultural Affairs) - 131 450
- Victorian Interpreting and Translating Service (VITS)- 9280 1955 (VITS maintains extensive data on a service's interpreter bookings and is able to provide this at short notice.)
- Central Health Interpreter Service (CHIS) - 9370 1222

Private interpreter services can be found in the Yellow Pages under 'Interpreters'.

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Working with Interpreters Guidelines. And the following special circumstances â– mental health assessment, diagnosis and treatment â– counselling â– psychological assessment â– speech pathology â– death of a person and bereavement counselling â– seeking consent for autopsy â– following the birth of a child with disability â– seeking consent for organ donation â– situations involving any suspected abuse, violence or assault2 â– Patient Review and Mental.Â Working with Interpreters Guidelines. It is acknowledged that non-accredited interpreters will be engaged for newer language groups to Queensland where NAATI accreditation or recognition are not available. Mental health professionals can benefit from further training in cross-cultural mental health care and more specifically, in working with interpreters. Another video in this series, â€œPsychiatric Interviewing of Refugee Patients,â€ also provides guidelines for mental health professionals working with interpreters and addresses pertinent cross-cultural issues. Interpreters planning to undertake work in mental health settings, for example on a freelance basis, will require additional training concerning the language of mental health and mental illness and specific aspects of the refugee mental hea... IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC. For feedback or suggestions for the improvement of this publication, please e-mail: IASCmhpss@who.int or IASCmhpss@interaction.org. Foreword.Â Intervention: International Journal of Mental Health, Psychosocial Work and Counselling in Areas of Armed Conflict; Mangrove Psychosocial Support and Coordination Unit; Ministry of Health, Iran; Ministry of Health, Sri Lanka; Psychologists for Social Responsibility; Psychosocial Working Group; Regional Psychosocial Support Initiative for Children Affected by AIDS, Poverty and Conflict (REPSSI); United Nations Educational, Scientific and Cultural Organization (UNESCO); United. Journal of Mental Health 18, 3, 233 - 241. Working with Interpreters in Mental Health. Professor Rachel Tribe. School of Psychology, University of East London, Romford Rd, London E15 4LZ, UK.Â professional interpreters is important, as is the need for clinicians to be trained in working. effectively with interpreters. Language and culture when working in partnership with interpreters.Â Tribe & Thompson (2008) compiled a set of guidelines for the British Psychological Society. on Working with Interpreters in Mental Health in Heath Settings. Preparation and training on. working in collaboration with an interpreter provides essential grounding for clinicians who. have never worked with interpreters before. Different roles for interpreters. Guidelines for working effectively with interpreters in mental health settings. July 2006. Tania Miletic, Marie Piu, Harry Minas, Malina Stankovska, Yvonne Stolk, Steven Klimidis. VTPU. Victorian Transcultural Psychiatry Unit.Â See also: Appendix 2 VTPU Quick Guide to working with interpreters in mental health settings. The interpreterâ€™s role in mental health settings. The interpreter is a crucial member of the professional team in mental health service delivery. There are legislative and policy requirements to ensure that people from culturally and linguistically diverse (CALD) backgrounds are not prevented by barriers of communication or culture from using mental health services.