INforMHAA: Interpreter-mediated Mental Health Act Assessments

Best practices for Approved Mental Health Professionals and Interpreters working together

INforMHAA Project Guidance & Resources

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Disclaimer: This document does not necessarily reflect the opinions of the National Institute for Health and Care Research School for Social Care Research.

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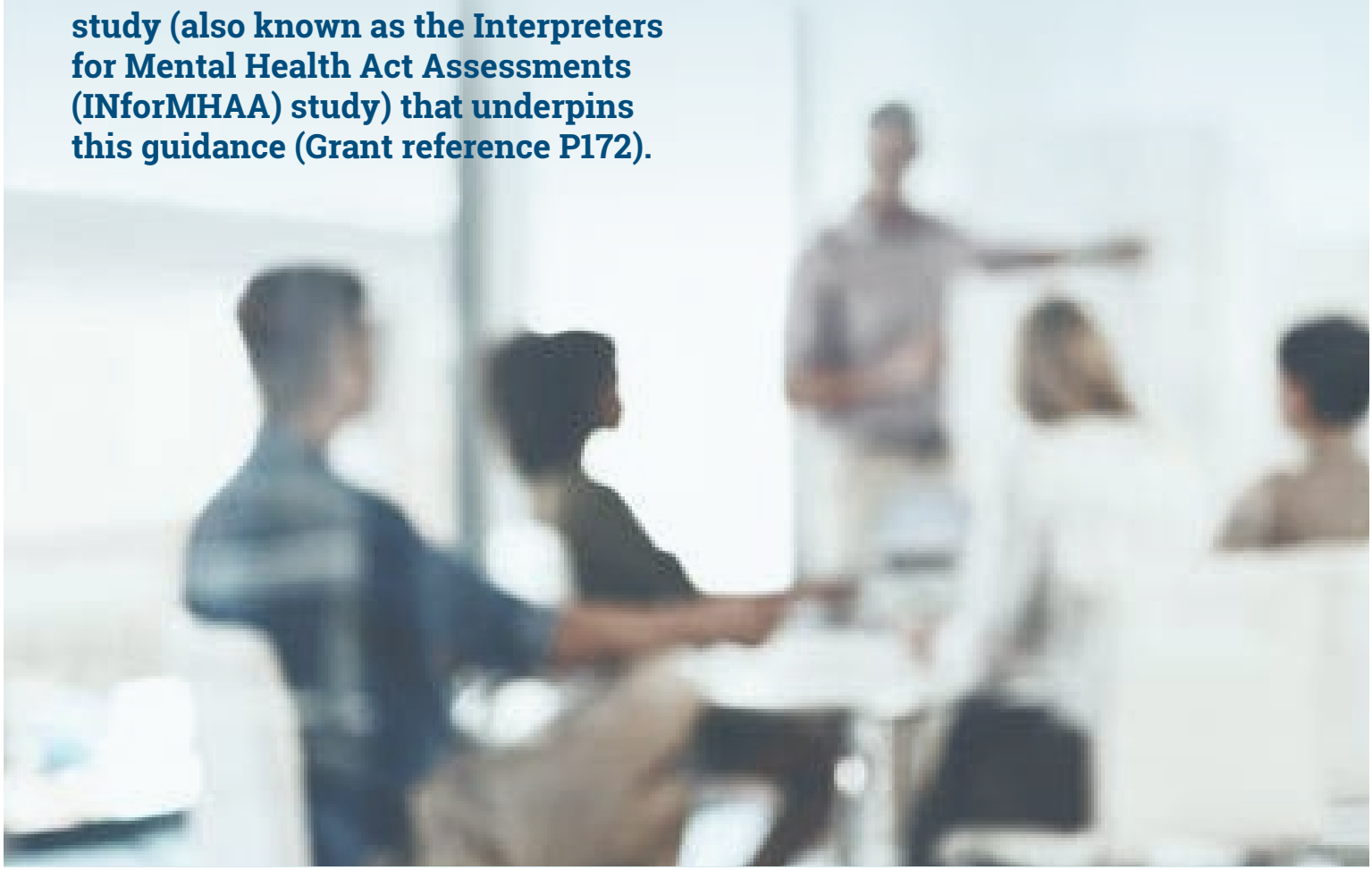

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Introduction and overview

Who is this guidance for?

The guidance is **intended for** AMHPs (Approved Mental Health Professionals) and spoken and/or signed language interpreters who are working together under the Mental Health Act 1983 (MHA).

It is **useful for** AMHP educators offering training leading to approval to practice as an AMHP, subsequent reapproval, and Continuing Professional Development (CPD), as well as for interpreting educators offering initial interpreter training and CPD.

It is **relevant to** others involved in Mental Health Act assessments (MHAAs) such as Section 12 doctors and police personnel, but its primary focus is on AMHPs and interpreters working together in MHAAs.

It may be of interest to people who use services, carers, and people with lived experience of assessment via interpreters whether under the Mental Health Act or other statutory interventions.

It has **some applicability** to professionals working under different jurisdictions, whether in the UK or internationally, in situations where someone may undergo an assessment under the equivalents of the Mental Health Act 1983 and where spoken and/or signed language interpreters are involved.

What is the aim of this guidance?

The aim of this guidance is to enhance the conduct and practice of interpreter-mediated MHAAs with a specific focus on effective inter-professional working practice between interpreters and AMHPs to ensure a fair, supportive, respectful and equitable outcome for people being assessed when language preference dictates the involvement of a spoken or signed language interpreter.

What is the approach of the guidance?

As allied practice professionals, AMHPs and interpreters possess a great many, highly developed skills in communication and understanding human behaviour, alongside a shared commitment to equity, respect, confidentiality seeking the best possible experience and outcomes for people undergoing MHAAs. We use these **shared values**, be they developed through different arenas of practice and education, as a common starting point from which to build more effective joint working across disciplinary knowledge and skills.

The guidance does not provide a list of do's and don'ts and anyone expecting a prescriptive description of exactly what to do in interpreter-mediated MHAAs will be disappointed. This is because the contexts, circumstances and individuality of people involved in a MHAA are highly variable. Any guidance has to be equipped to be useful in the light of diverse practice situations even though there is always a common purpose. Consequently, you will find that the guidance at different point offers **options and recommendations** with a research evidence-based approach to best practice, with support from additional resources developed specifically as part of the Interpreters for Mental Health Act Assessments (INforMHAA) study (2021-23).

The guidance is designed to be easily navigated and for flexible usage depending on what you are looking for and when. It is designed to be dipped in and out of, rather than to be read from end to end. In places we offer suggestions of how different components may be used, but in the end **it is up to you to decide what to use and how to use it**.

That said, we do offer some **clear guidelines** on:

- What underpins best practice between AMHPs and interpreters in MHAAs.
- What ensures that in all instances the person being assessed remains at the centre.
- How AMHPs and interpreters can jointly ensure human rights-oriented practice.
- Ensuring that the duties, powers and responsibilities under legislation and statutory guidance remain central to the process.

How can the content be used?

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Young, A., Tipton, R., Napier, J., Vicary, S., Rodriguez Vicente, N. & Hulme, C. (2023) *Interpreter-mediated Mental Health Act assessments: Best practices for Approved Mental Health Professionals and interpreters working together.* University of Manchester. Online Resource. https://doi.org/10.48420/25634664

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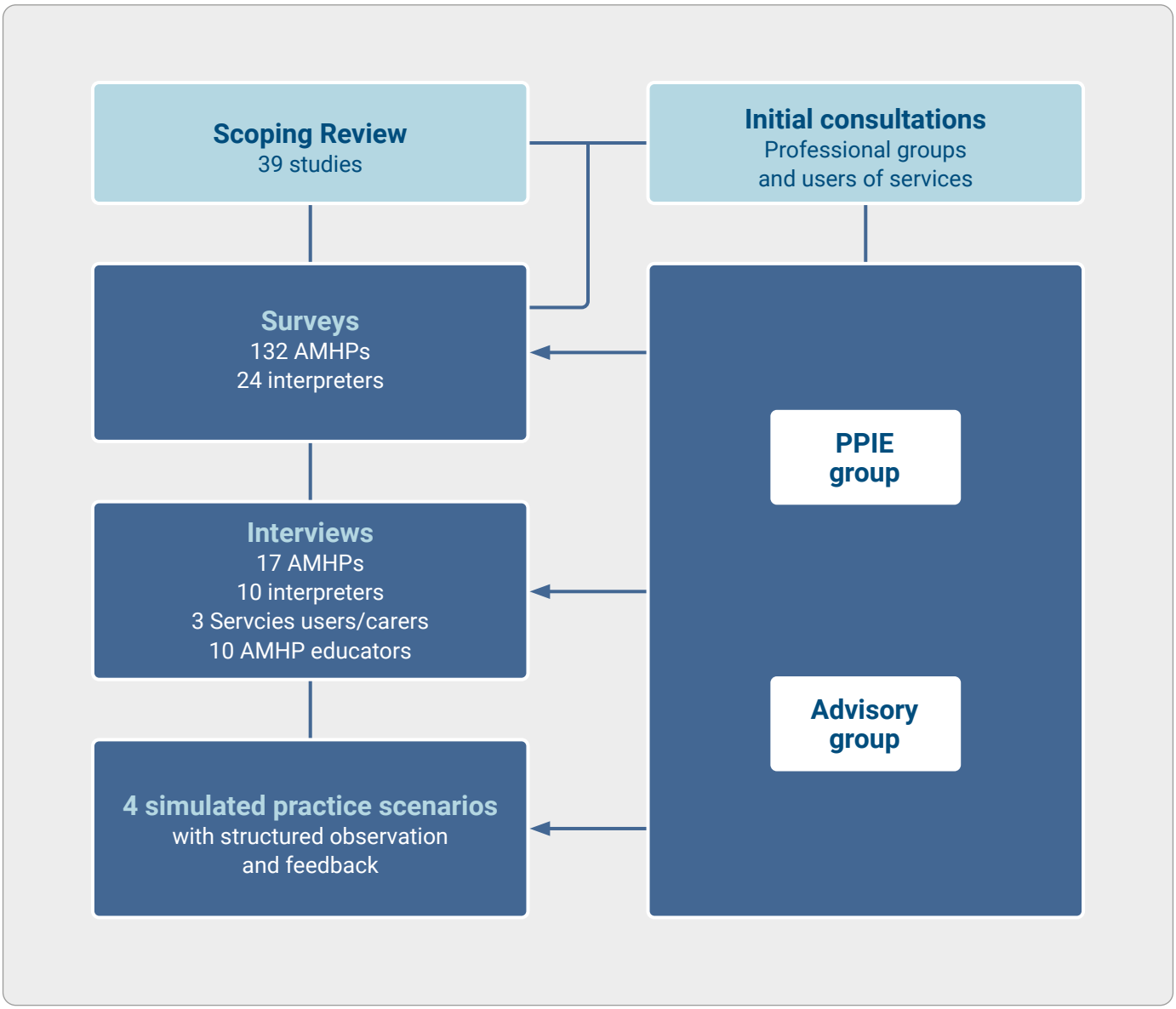
The guidance consists of 13 Parts offering practice-orientated advice that follows the course of a MHAA from the perspective of the role of the AMHP. These Parts are then followed by a series of Resources for training and references to enhance practice and support CPD. Although it is helpful to follow the guidance resource through in order, each Part stands alone enabling it to be dipped into depending on interest and need.

How has this guidance been produced?

The self-guided learning materials, teaching resources, professional practice guidelines, tips, factsheets and practice examples, have been produced following the 3-year 'Interpreting for Mental Health Act Assessments' (INforMHAA) research study funded by the NIHR SSCR (National Institute of Health and Care Research, School for Social Care Research). It is, therefore, a **research evidence-informed resource**. The research study structure is outlined in the chart below.

Further details about the research team, advisors and service users and carers who supported this work can be found in the next chapter.



The Research Team

The research team comprised bilingual and cross-cultural researchers with diverse backgrounds, including members who are deaf and hearing. Each member contributed valuable interdisciplinary expertise, spanning fields such as social work and interpreting.

Professor Alys Young
The University of Manchester

Background: social work (registered social worker) and social research with deaf people

Expertise/Knowledge Contribution: Social Work, health and social care research with deaf people(s), intervention studies.

Researcher profile: ORCID

Professor Jemina Napier
Heriot-Watt University

Background: applied linguistics and interpreting studies

Expertise/Knowledge Contribution: Practicing signed language interpreter (BSL, IS, Auslan), interpreter-mediation, sign language interpreting and brokering, deaf communities.

Researcher profile: ORCID

Dr Rebecca Tipton
The University of Manchester

Background: interpreting and translation studies

Expertise/Knowledge Contribution: French interpreter, spoken language interpreter-mediation within the field of social work, and intercultural communication.

Researcher profile: ORCID

Professor Sarah Vicary
The Open University

Background: social work (registered social worker) and mental health

Expertise/Knowledge Contribution: Social work, Approved Mental Health Professionals , and mental health statutory law, including deprivation of liberty

Researcher profile: ORCID

Dr Natalia Rodríguez Vicente
University of Essex

Background: interpreting studies

Expertise/Knowledge Contribution: Spanish interpreter, mental health interpreting, interactional pragmatics, and clinical communication.

Researcher profile: ORCID

Dr Celia Hulme
The University of Manchester

Background: health sciences researcher

Expertise/Knowledge Contribution: Deaf community, Patient and Public Involvement and Engagement (PPIE), and the lived experience of using interpreters.

Researcher profile: ORCID

To learn more about the project team, visit the INforMHAA Project Team page (INforMHAA Project Team) where you can watch their introductory videos and explore their biographies.

Advisory Board

The advisory board was comprised of invited members representing essential stakeholders in the fields of spoken/signed language interpreting, approved mental health professionals, and programme providers. The group also included representatives from professional associations and regulatory bodies within the domains of social work and interpreting.

Members of the Advisory Board were:

Wendy Anderson, Nahed Arafat, Andy Brammer, Jason Brandon, Sonia Issac-Wilkinson, Robert Lomax, Christine McPherson, Lenka Novakova, Mike Orlov, Paul Peros, Kate Regan, Jane Shears, Martin Stevens, Kevin Stone.

Service Users and Carers (SUC) Patient and Public Involvement and Engagement (PPIE) Group

The SUC PPIE group was composed of individuals who had direct experience with MHAAs involving spoken/ signed language interpreters.

Members of the SUC PPIE group included:

Tania Allen, Richard France, Sue Leschen and Manoj Mistry.

Participants in simulated practice resource creation

As part of the study, a series of video resources were created to simulate aspects of MHAAs.

The participants were:

Actors: Anisa Butt, Bitu Thomas, Mitesh Soni, Zayner Saleh, Pshko Salami, Emily van Zoonen, David Ellington, Christine McPherson, Jemina Napier, Natalia Rodriguez Vicente.

Interpreters: Suhail Umar, Zjiman Khalid and Alex MacDonald.

AMHPs: Julie Dillon, Mark Cooper, Briony Spedding, Richard Nubi.

Tipp theatre company director: Simon Rudding PhD FRSA.

Brief introduction for AMHPs

Preamble

This document is aimed at AMHPs when undertaking a MHAA which requires the need for a spoken or signed language interpreter. It is designed to enhance the training for approval and be a source of training for reapproval and Continuing Professional Development (CPD). It supplies practice guidance and training and reference materials to such ends.

Its specific aim is to support good practice in communication that occurs with an interpreter so that an effective MHAA can take place and to afford transparency in decision making when there is a need to involve an interpreter. It is important for AMHPs to recognise that when an interpreter is involved in a MHAA, the assessment cannot be carried out in the same way as if an interpreter was not present. The presence of the interpreter impacts on the dynamics of the MHAA in many ways. But this is not necessarily an impediment to the MHAA being carried out successfully if AMHPs and interpreters work cooperatively together.

You will gain:

- **Information** on best practice when undertaking a MHAA which involves an interpreter.
- **Support** in understanding interpreter needs prior to, during and after an assessment.
- **Insight** into implications of interpreter-mediated practice for the AMHP role.
- **Sensitisation** about the interpreter's role and strategies for addressing best working practice when an interpreter is involved.
- **Confidence** in understanding the role of language and culture in MHAA.
- **Resources** for practice to refer to in the future.

Brief introduction for interpreters

Preamble

This document, consisting of practice guidance and training and reference materials, is aimed at signed and spoken language interpreters to support effective interprofessional working with AMHPs in MHAAs.

It is underpinned by academic research carried out under the Interpreter-mediated Mental Health Act Assessments (INforMHAA) study (2021-2023) and relevant international research. It is not designed to replace interpreter education and training. It serves to accompany and enhance training where it is available and provides a foundation for understanding MHAAs and their conduct where training is not available.

Although MHAAs may involve several professionals, including doctors and sometimes the police, the practice guidance and accompanying training and reference materials are largely focused on the inter-professional working between AMHPs and interpreters in the interview component of the MHAA. They have the following aims:

- To **support** understanding of MHAAs and legal obligations under the MHA and in particular the role of the AMHP and interpreter involvement.
- To **familiarise** interpreters with the role of the AMHP and best practice in interprofessional working.
- To **outline** common challenges in interpreted MHAAs and provide evidence-informed examples to support interpreter decision-making.
- To **develop** interpreter confidence in handling non-interpreted communications with other professionals during assessments.

Some of the guidance is aimed at interpreter trainers and serves to support initial training and Continuing Professional Development (CPD).

Background and principles

When an interpreter is assigned to interpret at a MHAA, they become part of a wider team of professionals who have various responsibilities under the MHA. Although interpreters themselves do not have clinical or legal responsibilities under the MHA, they play a key role in supporting the core principles of the MHA, in particular helping to maintain the dignity of the person and ensure their wishes, feelings and point of view are clearly represented.

MHAAs involve engaging with individuals who may be very unwell, who may be withdrawn, agitated or in some cases display violent behaviour. These individuals may also be experiencing disordered thoughts and find it difficult to communicate clearly or consistently; they may be very anxious or frightened. Interpreting in such circumstances can therefore look and feel very different to other interpreted encounters in public services, including other types of mental health settings.

Although interpreters, are **not involved** in making any decisions about the outcomes of a person's mental health in a MHAA, the legal implications of assessments and the implications of the outcome for the assessed person mean that interpreters need to be confident in the decision-making their role entails. This role relies on strong interprofessional working foundations and knowledge about the procedures and purpose of MHAAs.

The underlying principles of this guidance with respect to interpreters and their role are:

- Respect for the person and for the process.
- Transparency in interpreters' decision-making.
- Acknowledging the limits of one's knowledge and expertise and taking effective action to address them.
- Adopting a collaborative mindset when working with the assessing team, while maintaining professional impartiality.

What will interpreters gain from this guidance?

- **Information** on key concepts and terms in MHAAs and best practice on how to communicate the concepts and terms effectively and accurately.
- **Support** in communicating interpreter needs to AMHPs prior to an assessment (e.g., need for information, advance planning for possible issues in the assessment itself).
- **Insight** into critical points in the assessment process and implications for interpreter-decision making through evidence-informed examples.
- **Sensitisation** to potential lack of knowledge on the part of AMHPs regarding the interpreter's role and strategies for addressing them.
- **Confidence** in navigating the needs of AMHPs in understanding the role of language and culture in the assessment (e.g., difference between unpacking and explaining, see Part 9 Cultural sensitivities and cultural brokering).

How to use the guidance

The guidance is presented as a series of topics and can be dipped in and out of as needed. Each resource is written to be used in a stand-alone manner, but readers are signposted to supplementary relevant resources where necessary. Some parts are specifically intended more for interpreters than AMHPs, but all is of relevance.

Brief introduction for service users and carers

Preamble

This document is primarily intended for AMHPs and interpreters when undertaking a MHAA. It also supports approval, reapproval and CPD. While it is not specifically intended for service users and carers, their invaluable contributions have played a significant role throughout the research project that underpins this work. We use the term service users and carers to refer to people with lived experience of having been assessed under the MHA, their family, friends, supporters and carers and other users of mental health services.

During the project, service users and carers have identified many key areas that require attention. For example, their insights shared regarding assessment experiences, choices about interpreters and the importance of good communication and mental health knowledge. This guidance however is not written primarily to support services users and carers undergoing a MHAA. This is important. There are other sources of support, information and guidance written specifically to match these needs. See for example:

Rethink: Mental Health Act;

NHS: Easy read Mental Health Act;

MIND: What is the Mental Health Act?;

NHS: MHA Section 2 available in 26 languages;

NHS: MHA Section 3 available in 27 languages;

Young Minds: What do the Mental Health Act sections mean?

Nonetheless, through engagement with this guidance service users and carers may gain:

Improved mental health literacy and gain a deeper understanding of what is best practice for AMHPs and interpreters in MHAAs which may be empowering and important in self-advocacy and holding professional services to the highest standards of practice.

Part 1.
Introduction to the practice guidance

This document offers **specific practice guidance** for AMHPs and interpreters in working together in MHAAs informed by evidence from the research study.

It is divided into 13 topics beginning with overarching considerations then taking a temporal perspective of before the MHAA (preparation), during the MHAA, and after the MHAA. Links to other parts of the guidance and specific resources are also provided. You do not need to review the resource from start to finish in the order the parts are presented; each part stands alone.

Topic	What is covered
OVERARCHING CONSIDERATIONS	
1. **Self-guided learning materials**	• Background to development of the guidance and resources.
2. **The context and key roles**	• Statutory guidance on interpreter use and legal requirements. • How work in MHAAs is outside usual metal health interpreting professional practice. • What does it mean to keep the assessed person at the centre? • Who is responsible for what?
3. **Legal decision making in practice**	• Clarifying the place of the interpreter within legal decision making and the role of the interpreter (not as advocate).

Topic	What is covered
BEFORE THE ASSESSMENT (PREPARATION)	
4. When and why interpreters	• AMHP responsibilities and practicalities in ensuring an interpreter is present. • When might it be acceptable not to have an interpreter? • What kinds of interpreters are required with what ranges of experience?
5. Briefing between interpreters and AMHPs	• Why is briefing important? • What might be negotiated? • What might an AMHP want to ask? • What might an interpreter want to check? • What kinds of content will be included?
6. Key concepts and terms for interpreters (and AMHPs)	• Statutory nature of the language used in MHAAs means some words and intentions may not be fully understood. • Why AMHPs need to know the meanings have been 'properly' conveyed by the interpreter. • Why interpreters can't just translate verbatim.
DURING THE ASSESSMENT	
7. Types of interpreting	• What kinds of interpreting might the AMHP want to ask for and why. • What interpreting approaches the interpreter may seek to offer and why. • Key considerations in the representation of the person being assessed through interpreter mediation.
8. Stopping an interpreter-mediated assessment	• How can AMHPs say if they are not happy with an interpreter mediated MHAA? • When should a MHAA be stopped and why? • Pragmatic considerations in stopping linked to ethics, risk and harm.
9. Cultural sensitivity and cultural brokering	• What role if any does an interpreter have in cultural brokering? • Interpreting and advocacy. • What might be best practice in using cultural and community information and background that an interpreter may have and when this is not ok.
AFTER THE ASSESSMENT	
10. The full patient journey	• Why interpreters are needed for continuity immediately after the MHAA and subsequently.
11. Debriefing and care	• What a good debriefing might look like. • How are interpreters looked after.
12. Issues in recording	• Recording language use and interpreter booking on systems.
13. Governance, accountability and safeguarding	• Important issues in governance and safeguarding when an interpreter is part of the assessment.

Accompanying resources

Topic	What is covered
R1. Purpose of the resource	Description of why the resource has been created, including a disclaimer.
R2. Written interpreter-mediated MHAA scenarios	Four written MHAA scenarios with background of why they have been created and possible uses for training.
R3. Web links	Links to where the resources are hosted with descriptions of languages and formats.
R4. Training ideas	Guidance on how the video scenario versions might be used for training of AMHPs and interpreters.
R5. Developing debriefing skills	Training resource that can be used to follow up on the debriefing good practice.
R6. Curated reference list	A list of useful references with pointers for why they might be useful follow-up reading.
R7. Minimum best practice checklist for interpreters	Focus on specific practice in the MHAA interview.
R8. What to record	Aide memoire linked to the recording guidance section.
R9. Minimum best practice checklist for AMHPs	Focus on specific practice in the MHAA interview.
R10. Related guidance documents	Overview of related guidance documents with an introduction as to why each may be useful with live links.

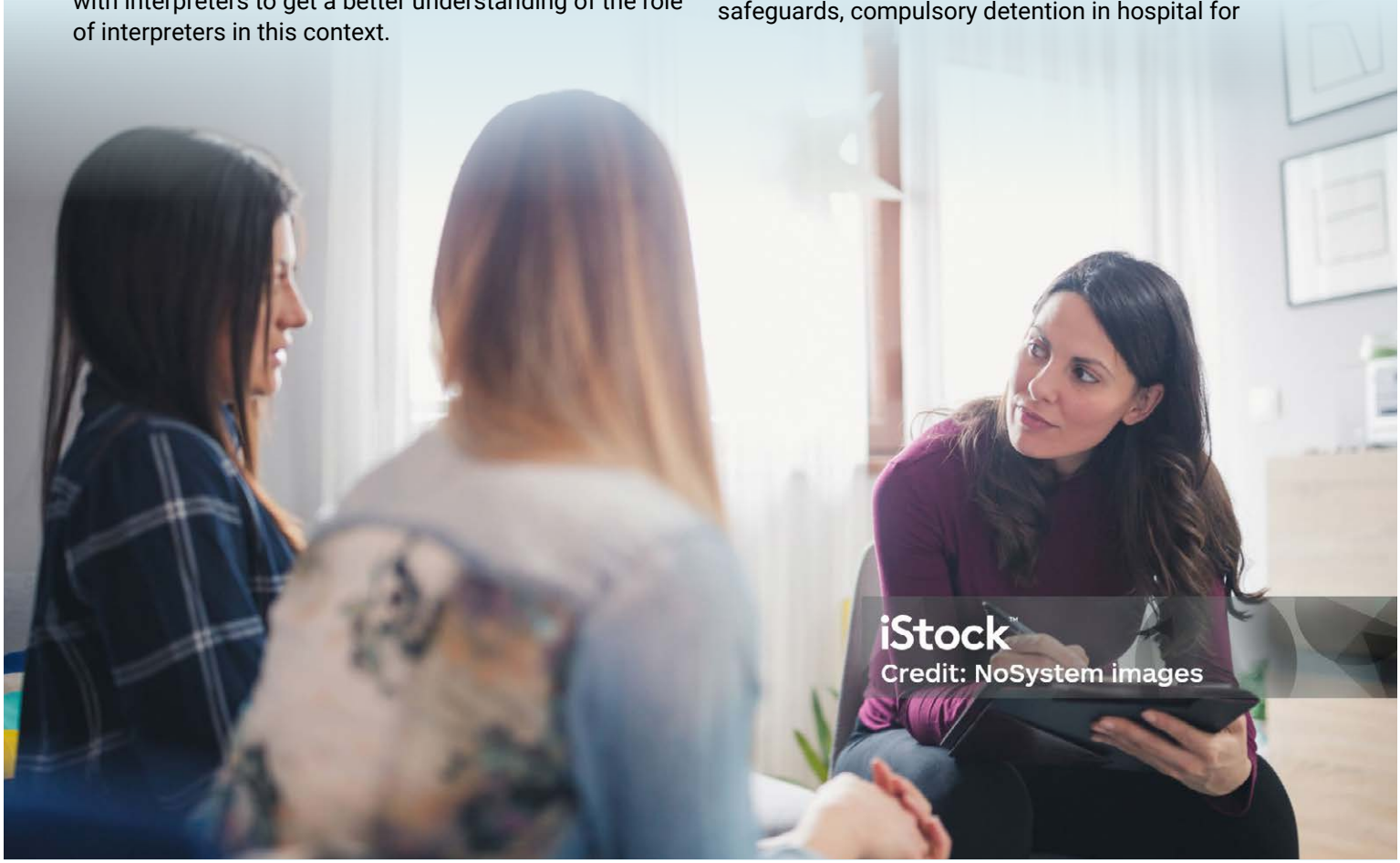
Part 2. Context and key roles

Introduction

Part 2 of the guidance provides a brief overview in lay terms of the context of the Mental Health Act (MHA) 1983, MHA assessments (MHAAs), and roles associated with Approved Mental Health Professionals (AMHPs) and interpreters in conducting a MHAA. **It is particularly intended for interpreters new to working in this context** but may be helpful to AMHPs unfamiliar with working with interpreters to get a better understanding of the role of interpreters in this context.

The MHA and mental health interpreting

Even if an interpreter has experience of working in mental health settings, they may not have experience of working in assessments under the MHA and may not realise the significance of doing so. It is not just another mental health assignment. Rather, the MHA is the piece of legislation that is in place to allow, with appropriate safeguards, compulsory detention in hospital for



assessment and/or treatment if an individual is seriously mentally unwell and poses a risk to themselves or others, as further explained in Part 3. Although it is the AMHP's responsibility to make every effort to check whether the person could be admitted informally the consent of the individual is not required. It is a strong legal power. Consequently, working as an interpreter in this situation is a very serious undertaking as ensuring good communication between all parties will be vital to safeguarding the individual undergoing assessment and upholding both their rights and those of the state. As such, interpreters need to be aware of the weight of their role and familiarise themselves with the fundamentals of the legal framework and the sensitivity needed to work in this context.

Legal provisions, the MHA and interpreter use

The MHA and Code of Practice

The MHA requires that the interview of the individual that forms part of the MHAA is carried out in a "suitable manner" (Section 13(2) MHA, 1983, DoH 2015 para 14.49 p. 121). Guidance that accompanies the MHA, known as a Code of Practice, explicitly highlights the need to ensure appropriate communication for groups who might have difficulties in communicating effectively. There are separate Codes for England and Wales. In England, paragraphs 4.4 p. 36 and 14.42 p. 120 (DoH 2015) safeguards the rights of individuals whose first or preferred language may not be English and to prevent the possibility of unlawful detention based on ineffective communication during the assessment process. Reasons that someone might struggle to understand what is happening in a MHAA might include physical, sensory or cognitive disabilities or simply the fact that they use a different language.

The Equality Act 2010

Language use per se is not a protected characteristic under the Equality Act. However, the Act (see: https://www.gov.uk/guidance/equality-act-2010-guidance) states that it is a legal obligation on all service providers to implement measures or enact "reasonable adjustments" to prevent placing disabled individuals at a significant disadvantage. This is an anticipatory duty, meaning that provision must be made in advance of a need arising. Consequently, AMHPs can access established services that provide interpreters of all languages, when required, in order to fulfil this duty. Race, religion or belief is also a protected characteristic under the Equality Act and will overlap with language provision in some cases.

British Sign Language (Scotland) Act 2015 and British Sign Language Act 2022

British Sign Language (BSL) is a protected language under the BSL (Scotland) Act and the BSL Act in England. Both Acts assert the right for deaf people to have access to services through BSL. AMHPs also have access to professional BSL interpreters when needed, in order to fulfil the obligation to conduct a MHAA in a suitable manner.

The Welsh Language (Wales) Measure (2011)

The Welsh Language (Wales) Measure 2011 states that the Welsh language has equal legal status with English and must not be treated less favourably. A strategic framework in Wales More than just words (gov.wales) published in 2016 provides recognition that use of Welsh language is not just a matter of choice but of need. It proposes the 'Active offer' whereby a service is provided in Welsh without having to ask for it.

Human Rights Act 1998

The Human Rights Act protects all individuals living in the UK including foreign nationals, refugees and asylum seekers and people detained in hospital. This also relates to people who are not English users, including deaf BSL users. Each right is referred to as an article. It is pertinent to the exercise of the MHA and the use of interpreters because, for example, *Article 2: The right to life* places a duty on the state to protect an individual who is at risk of suicide. *Article 5: The right to liberty and security* is superseded by detention under the MHA provided that detention is lawful.

Section 13G of the National Health Service Act 2006 (see: https://www.legislation.gov.uk/ukpga/2006/41/section/13G/2013-10-25) emphasises the need to reduce inequalities in access to health services and the outcomes achieved by those services. Inequalities arising from language use and lack of interpretation are covered by the Health and Social Care Act (2022) and National Health Service Act (2006).

Who is involved in a MHAA?

All MHAAs are coordinated by an AMHP and will usually involve two medical practitioners (sometimes referred to as Section 12 doctors after the part of the MHA that specifies their role and accredits them to perform it). An AMHP is also required to consult a Nearest Relative. In some instances, an assessment may be an emergency and the Police are involved too (See Part 3 Legal decision making). The MHA allows for the involvement of spoken and/or signed language interpreters to enable appropriate communication. It is a common error for AMHPs and other professionals to refer to interpreters as 'translators'. Interpreters generally deal with real-time communication, making on-the-spot decisions about how best to convey information between parties and represent each to the other (see Part 7 Types of interpreting). Translators generally work asynchronously having time to consider and edit their translations and typically work between written texts or written and signed texts, as opposed to between spoken languages, a spoken and a signed language, or between two signed languages.

The specific role and legal responsibilities of the AMHP and others is set out in the Brief introduction for interpreters and the Brief introduction for AMHPs. Here we emphasise:

- The role, responsibility and duties of the AMHP are prescribed under law. Consequently, the interpreter will be working with AMHPs to fulfil these to the best of their abilities.
- The rights, protections and safeguards of someone being assessed are prescribed under law. Consequently, the interpreter has a key role in ensuring these are fulfilled through ensuring good quality communication between all parties.
- The interpreter does not have a role in decision making within the assessment but can be very helpful to AMHPs in their decision making.
- Good quality interpreting within MHAAs and particularly within the interview component is a vital contributor to best outcome for the person being assessed.
- There should be parity in assessment under the MHA for people being assessed with the support of an interpreter and people for whom this is not required.

Interpreter's role in MHAAs

Interpreters facilitate communication between an AMHP (and other professionals), and a person assessed when they do not share a language. They must ensure that all information discussed is conveyed between all parties involved. Interpreters should minimise their input to the assessment and avoid influencing the conversation, focusing only on mediating the interaction between the AMHP and the service user. The interpreter monitors understanding and might interrupt a speaker/signer if clarifications are needed to support understanding. They do not advocate for the person being assessed. An AMHP may engage the interpreter to clarify points about the character of a person's communication or issues of cultural understanding. The interpreter may also advise the AMHP if they feel the person being assessed does not understand. This is discussed in Part 9 (Cultural sensitivies and cultural brokering).

Person-centredness in MHAAs

AMHPs often refer to the notion of 'the person at the centre' when undertaking their role and in particular the interview component of the MHAA. In interpreting, it is more common to refer to person-centredness which includes an emphasis on consent and lack of coercion, bias or undue influence. This does not apply in the same way in MHAAs which are statutory and can commonly include the detention of someone on a formal basis. Nonetheless, an individual's needs and preferences are at the forefront of an assessment, and it is within the interpreter's role to ensure that this occurs through providing good quality communication between parties.

Of particular note, is the role of the interpreter to ensure the 'voice' of the person being assessed remains clear throughout. This refers to their capacity to express themselves and their ability to communicate their thoughts, feelings, preferences, and wishes during the assessment process. The person assessed might feel like their 'voice' is diminished in these assessments, particularly if experiencing mental distress. The interpreter can play their part alongside the AMHP in ensuring they have every opportunity to be seen and heard during the assessment.

Part 3.
Legal decision making in practice

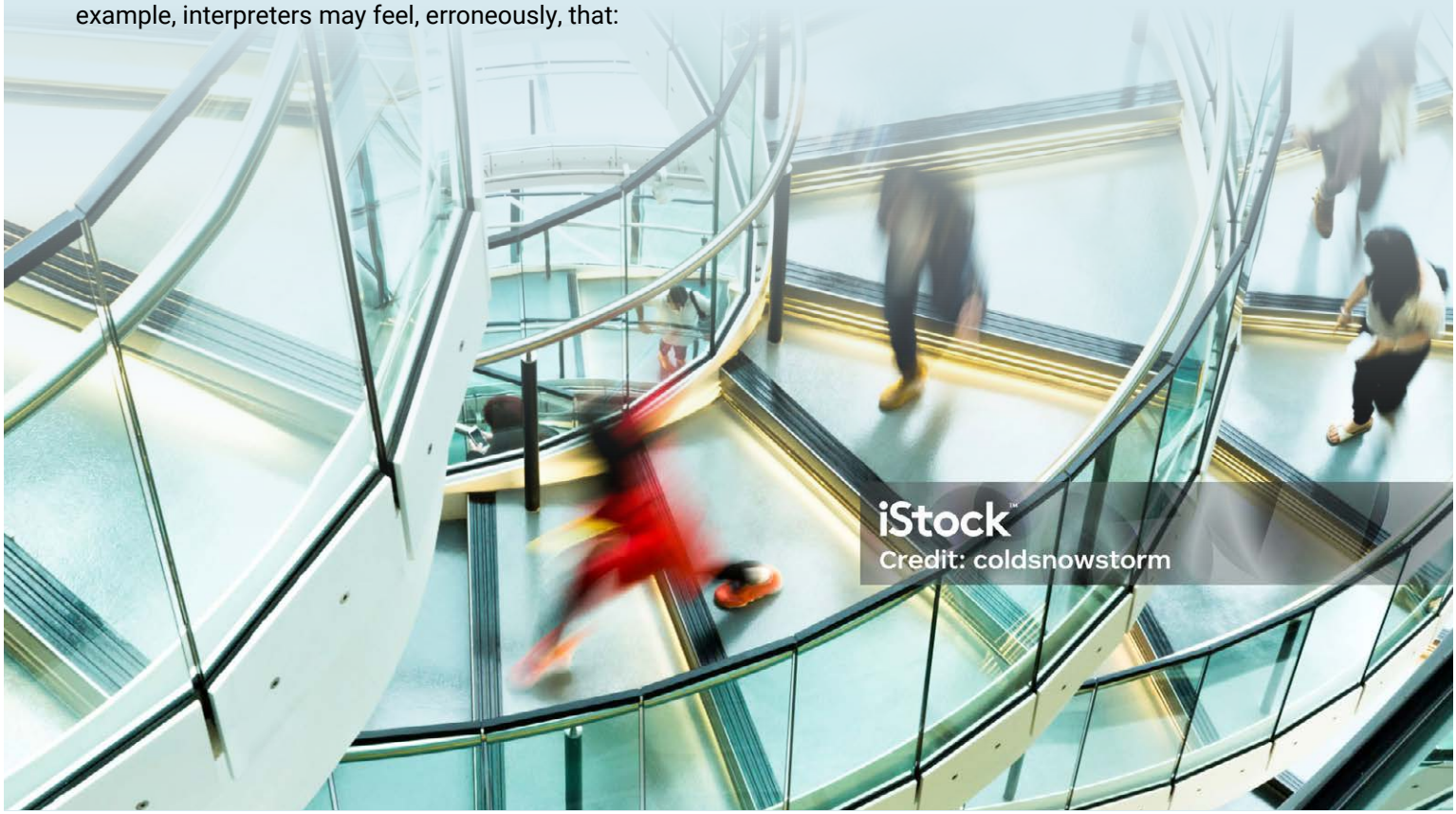
Introduction

In any Mental Health Act assessment (MHAA) it is the Approved Mental Health Professional (AMHP) who is ultimately responsible for making the decision about its outcome. That said, where there is a need for interpreter mediation, interpreters contribute to the making of the most appropriate decision as it is their role to mediate communication. To navigate this process successfully, both parties should be aware of their respective roles and responsibilities and in this process, there are practice matters that need to be considered. For example, interpreters may feel, erroneously, that:

- their role is to advocate on behalf of the person;
- their input is to enable the person to consent to what is happening.

In addition, AMHPs may:

- be unaware that many interpreters have received little or no training in understanding key legal or mental health concepts;
- be reluctant to rely on another person to help them communicate in a decision for which they are ultimately responsible.



What is good practice in these circumstances?

Be clear about the responsible decision maker. AMHPs need to consider that the interpreter may not be aware of the AMHP's decision-making responsibility and check this with them at the outset.

Be clear about the process of decision making. It is recognised that AMHPs will make their decision based partly on what is said at interview. It is therefore helpful for the interpreter to understand that they should convey what is being asked by the AMHP and in turn convey to the AMHP what the person is saying, however unusual the utterances may seem. The AMHP and interpreter will each need to discuss and agree how this interaction should take place and what to do if the interview needs to stop (see Part 5 Briefing and Part 8 Stopping an assessment).

Be clear that interpreters may have contributions to support decision making. AMHPs should clarify that although the ultimate decision-making lies with them, they can also welcome the interpreter's input in relevant areas such as:

- Interpreters may have suggestions about how to better convey key terms or concepts to ensure cultural equivalence. (See Part 6 Key concepts and terms)
- Interpreters might notice nuances in language (e.g. unusual word choice, sentence construction), tone, or nonverbal cues that could provide further insights into the individual's mental state. (See Part 7 Different types of interpreting)
- Interpreters may have cultural knowledge of meanings behind or specific associations with what the assessed person has said that may be missed without additional comment. (See Part 9 Cultural sensitivies and cultural brokering)

Be clear about possible seriousness of the outcome. It is possible that an interpreter may not understand the consequences of the outcome of a MHAA. It is therefore helpful if the AMHP makes this clear at the outset and agrees with the interpreter that they understand concepts such as consent and objection, alongside the legal nature of them. Part 6 Key concepts and terms indicates key ones to discuss.

Part 4.
When and why is an interpreter needed?

Introduction

As part of a MHAA, AMHPs have a duty to interview "in a suitable manner", a legal provision that includes paying attention to a person's language requirements. Our research indicates that the current guidance for AMHPs as to when and why an interpreter may be needed tends to focus on what is recommended and not the how. It is also aspirational, lacking a true reflection of the practical complexities encountered in the professional field. For example, in the MHA Code of Practice it is recommended that registered, qualified interpreters be sought with expertise in mental health interpreting and appropriate in terms of sex, religion or belief, dialect, cultural background, and age (see https://assets.publishing.service.gov.uk/media/5a80a774e5274a2e87dbb0f0/MHA_Code_of_Practice.PDF). It is also suggested that relatives and friends or untrained interpreters should only be used exceptionally. We do not disagree with such recommendations but are aware that on occasion there are difficulties in sourcing the right interpreter and that arrangements will need careful consideration. This part of the guidance will consider when to use an interpreter, what kind of interpreters are required, including how to discern their experience, and what compromises might be involved. The issue of when remote interpreting may be appropriate is covered in Part 13 Governance, accountability and safeguarding.

When is an interpreter required?

Beyond the relevant sections of the MHA Code of Practice (DoH 2016 para 4.6, 8.35, 14.42, 14.116, 14.117), in practice, it may not always be apparent that an interpreter is warranted. For example, an AMHP may be told in advance that a person's spoken English is fluent although their home language is different, or that a deaf person manages well with lipreading and spoken language. In reality, these assumptions may not be correct, or an individual's linguistic fluency in a second language is being affected by their mental condition, or that a person's language preference has not been honoured (see Part 3 Legal decision making). A multi-lingual individual may also have fluctuating fluency in languages by context or subject.

- If there is any doubt about whether an interpreter might be required, good practice dictates that one should be provided regardless.

Who is a suitable interpreter?

The choice of an interpreter in a MHAA is the responsibility of the AMHP who is also responsible for finding one, booking them usually through an agency and making any arrangements required for them to be present. By liaising with the interpreting agency in advance, the AMHP can communicate specific requirements, thus enabling the agency to identify an interpreter whose qualifications and profile align with the demands of each specific assessment. For example, consideration should be given to matching language, the level of experience, training and expertise in mental health and cultural considerations as explained below:

Language match. Clearly the interpreter must use the language of the person being assessed. However:

- It is not always clear what language an individual is using. One good practice idea is to have a pre-prepared card with different languages written on it so that an individual might point to the right one (See for example the Language Identification Chart produced by the National Register of Public Service Interpreters: https://www.nrpsi.org.uk/news-posts/Language-Identification-Chart.html). This does not always work because of barriers to literacy but it is worth having the resource just in case.

Also:

- The same language can have different forms that are regional ('dialects') or social ('sociolects') within a country. For example, Arabic is not spoken the same way in all Arabic-speaking countries. Ascertaining where an individual is from or the community they are part of in the UK is also important in ensuring a good language match.

In addition:

- Dialects exist within languages. Just because someone is fluent in one dialect of a language does not mean they are fluent in another dialect of the same language. The dialect that is used can betray other features of an interpreter including class, political, religious or cultural affiliation. This can create difficulties in the acceptability of the interpreter for the person being assessed. See Part 9 for further discussion on cultural sensitivity and cultural brokerage.
- Efforts should be made to try to ascertain the dialect in advance or if this is not possible to be sensitive to the impact and acceptability of a clash of dialects in considering whether the interpreter is a suitable match.

Qualifications and experience of the interpreter. Most AMHPs in our research assumed that all interpreters who might be on the books of an agency or on a local authority/health Trust list have specific qualifications in being an interpreter. This is not true. A large percentage of spoken language interpreters who work formally as such, do not have any specific qualification in interpreting, only fluency in the languages and some experience. Language ability does not necessarily equip a person to be an interpreter as specific skills and techniques are required (and taught) for effective work as an interpreter. Sign language interpreters generally have much higher qualifications as interpreters because formal registration as a sign language interpreter requires the completion of an interpreting course equivalent to British Sign Language Level 6 in the National Vocational Qualifications. There are scarcely any specialist spoken language interpreting courses in the UK that focus on mental health. CPD in sign language interpreting in mental health does exist but not as a formal qualification.

To overcome some of these difficulties, good practice might be:

- regional cooperation between AMHP teams and local interpreter agencies to provide joint and reciprocal training aimed at enhancing interpreters' awareness of working under the MHA and enhancing AMHPs awareness of the skills, requirements and contributions of interpreters. This guidance and the resources supplied are offered to enable and enhance such co-operative joint learning.

We suggest that in requesting an interpreter and making clear what the assignment is, the AMHP includes the following information to ensure the best fit possible:

- The assignment does not concern mental health in a general sense, but one that ideally requires experience of interpreting within a MHAA context.
- If an interpreter does not have this experience, ideally a more experienced interpreter is required who is used to complex assignments.
- If an interpreter is used who proves to be very good for MHAAs that AMHPs keep a note of them and share this information in their network and encourage agencies to mark their profiles as suitable for this kind of work.

Booking an interpreter

Our research has shown that systems to support sourcing interpreters and booking them vary on a regional basis with some AMHPs having good online access to comprehensive lists of interpreters and agencies, and others having more ad hoc local arrangements. This can be particularly challenging for out of hours MHAAs. In some cases, agencies will not provide interpreters unless the clear method of payment has been established with approval for any specific booking. In other regions in which interpreting demand has traditionally been higher, the system may be more well established.

- It is good practice for AMHPs to be familiar with sourcing and booking interpreters well in advance of when they might need to do so for any given case.
- In the case of BSL interpreters, the duty to provide language access for deaf people falls under the **anticipatory duty** of the Equality Act 2010 meaning there is a legal responsibility to ensure such arrangements in are in place in advance of them being required. Reasonable adjustments in relation to disabled people is the only anticipatory duty in the Equality Act.

What kind of interpreter and interpreting?

Part 7 of the guidance considers different interpreting modalities that are available and also focusses on key points to consider when engaging a remote rather than in person interpreter.

Compromises and pragmatism in practice

Despite following good practice in ensuring an appropriate interpreter is present, there remain compromises that might have to be made and advantages and disadvantages carefully considered on an individual basis whilst upholding the responsibilities and duties of interpreter provision. Circumstances such as those outlined below are a real challenge for AMHPs to weigh up within their role. For example:

- That to secure a suitable interpreter may cause undue delay and distress to the person being assessed.
- That only an interpreter who has no mental health training or experience is available.
- That an interpreter can only be secured remotely because of an uncommon language when in person interpreting is preferable.

If an interpreter cannot be secured in a timely manner, someone who is not officially an interpreter such as a relative, another professional or an advocate can be used as a last resort, but this must be exceptional and justified because having no interpreter outweighs the risk of involving an ad-hoc interpreter. On such occasions care must be taken regarding ethical principles such as confidentiality, power or family dynamics (See also Part 8 on Stopping a MHAA).

If an interpreter has little or no training in mental health a briefing should take place (see Part 5) with reference to key mental health and legal concepts and terms (see Part 6).

If an interpreter is only available via telephone or another remote video device, careful consideration needs to be given to the physical management of this MHAA. For example, where is the device to be placed or is a speaker phone to be used. Moreover, where a person may be hearing voices as one possible manifestation of their mental health problem careful attention needs to be given to the impact a disembodied voice may have.

Part 5.
Briefing between interpreters and AMHPs

Introduction

A briefing refers to a **preparatory session** that takes place between an AMHP and an interpreter before conducting a MHAA. It sets the foundation for developing shared **understanding** and **effective collaboration** between the AMHP and the interpreter during the actual assessment. Our research shows the benefits of a pre-assessment briefing between an AMHP and an interpreter in pre-empting common misunderstandings about respective professional roles and reflecting on preferred strategies to address common practice challenges. (See Part 2 Context and key roles and Part 7 Types of interpreting).

This guidance outlines key considerations and practices for AMHPs and interpreters to conduct effective briefings.

What might an AMHP want to ask or check in a briefing?

- Establish the interpreter's level of experience with the MHA and wider mental health settings.
- Ascertain the interpreter's familiarity with MHAAs and reinforce their purpose and potential outcomes if required.
- Ascertain the interpreter's familiarity with the AMHP's role in the assessment, reminding them where necessary of key statutory duties they play (e.g., consultation with Nearest Relative; consideration of the least restrictive alternative) and key responsibilities including e.g., the co-ordination of the assessment.
- Discuss the interpreter's confidence in handling commonly used terms in MHAAs, particularly legal ones. Advise on terms you are likely to use in the assessment and discuss how these might be best explained.
- Ascertain the interpreter's preferred ways of working (e.g., how they handle certain features of talk like disordered speech, overlapping talk, seating arrangements, and disclosures about whether they know the assessed person, etc).
- Find out whether the interpreter will have time at the end for a short debrief.
- Ask about the interpreter's level of exposure to situations that can be emotionally disturbing. Remind them to be mindful of their own reactions.
- Invite reflection on the interpreter's experience of how questions are asked in the assessment. Remind them that sometimes questions might sound hard, but they should not be afraid to replicate the tone.
- Agree with the interpreter how they will communicate with you during an assessment if they are struggling and what action you will take (e.g., stopping the assessment and booking a different interpreter, if it is safe to do so).
- Establish whether a deaf intralingual/ relay interpreter is needed for a deaf person being assessed (e.g., if they do not know British Sign Language or have disordered sign language production).
- Discuss any potential risks and concerns associated with the physical environment and how to maximise the safety of all involved.
- Provide the interpreter with any key points about the mental state of the person being assessed that are relevant (e.g., whether they are experiencing hallucinations or are very withdrawn).

What might an interpreter want to ask or check in a briefing?

- Request a short overview of the situation you are about to enter into.
- Disclose whether you have interpreted in MHAAs before and share any concerns you might have based on these experiences.
- Request overview of any key terms that might be used, especially terms that have legal significance and check your understanding of them to aid explanation. In particular, be alert for 'false friends' – terms that in lay language have one meaning but in this context have a highly specific meaning e.g. Nearest Relative. (See Part 6 Key concepts and terms).
- Agree with the AMHP what action you will take if you have met the assessed person before and how this will be handled in the assessment. Be mindful of the issues arising from the often limited pool of interpreters working with certain language combinations, and the potential anxieties triggered for service users if you have worked with them in another non-mental health related setting.
- Establish whether the AMHP has worked with an interpreter before. Be prepared to provide a basic overview of your role, your interactional preferences (e.g., first or third person interpreting) and what they can do to work effectively with you.
- Establish whether any particular safety precautions could be needed (e.g., in relation to clothes, jewellery, note-taking, seating arrangements).

In all matters the goal is to promote effective interpreter-AMHP working to ensure that the best possible conditions are created for the person who is at the centre of the assessment and their family members.

Part 6.
Key terms and concepts

Introduction

We have included this information in this guidance because our research has shown that many interpreters may not be fully aware of the meaning and implications of some key mental health legal terms and concepts that are particular to MHAAs. This can create unnecessary difficulties in preparing for and during a MHAA when terms and concepts drawn from the law and mental health have certain meanings or implications. Sometimes terms may seem intelligible across languages because in different contexts they can be commonly used so the highly specific meaning in the terms of the law and mental health, especially in a MHAA, is lost. The following is a list of key legal and mental health concepts in lay language by way of explanations rather than formal definitions.

Mental Health Act 1983 (the MHA)

The MHA is the current mental health legislation for England and Wales. It applies to both children and adults but is more commonly used with respect to adults. It came into effect in 1983 and at the time this guidance document was produced in 2023-24 the MHA was under formal review. The Government's response published in March 2024 to the Joint Consultative Committees' report was to reject most of its recommendations. Reforms to the MHA are likely to be at discretion of the new government. As law or statute, it contains specific duties, powers, and responsibilities which are invoked when an individual has a defined mental illness AND poses a risk to themselves or others and is unable to receive the assessment and/or treatment they require on a voluntary or informal basis (see below).

Code of Practice

A Code of Practice is published for the MHA and provides statutory guidance to all professionals in its use. It cannot be departed from unless there is cogent reason to do so; a standard that was made clear through case law. Until 2008 one Code covered both England and Wales, but separate ones are now published. Each Code contains principles and gives direction about the way in which the MHA should be carried out. This includes when interpreters should be used (see also Part 2).

Approved Mental Health Professional (AMHP)

An AMHP is a professional who has undertaken specialist training and has been approved by a local authority to carry out certain duties under the MHA. AMHPs are usually social workers but other allied health professionals are eligible to undertake the work once approved. These other professionals are mental health nurses, occupational therapists, or clinical psychologists.

Mental Health Act Assessments (MHAAs)

AMHPs are responsible for coordinating MHAAs, which is the whole process through which a decision is made as to whether the person being assessed should be admitted to a mental hospital or not. The AMHP is responsible for making this decision including whether the admission should be formal (compulsory admission) or informal (with the person being willing to go) (see below). Sometimes this process is more commonly referred to as being "sectioned".

A MHAA is not an assessment carried out with regard to psychological functioning or testing an ability/disability but has a legal basis through which the State enacts powers for the good of individuals who are experiencing extreme mental distress.

A MHAA is carried out by an AMHP and, usually two doctors, one who knows the person such as their GP and one a specialist doctor, a registered medical practitioner known as a Section 12 doctor. Doctors make a medical recommendation concerning the person's mental health. The AMHP then decides what is the best outcome in all circumstances of the situation, a decision they base on the medical recommendations, an assessment of the social circumstances and an interview with the person.

Interpreter

An interpreter is someone who mediates communication between two or more people that do not use the same language. This can be between two spoken languages, a spoken and a signed language or two signed languages. Professional interpreters have met national occupational standards by completing recognised training courses and /or assessments. In the UK interpreting is not a statutory regulated profession, but interpreters can voluntarily register with professional registration bodies in order to illustrate their commitment to best practices. Interpreting is carried out live, in real time in either consecutive (where one person speaks or signs at a time) or simultaneous mode (when the interpreter renders the interpretation just a few seconds after the original speaker/ signer; for spoken language interpreters this is done in some situations with the assistance of specialist equipment or through whispering to avoid auditory language clash). This is different from translation, which allows time for preparation, recording and editing before finalising the end signed or written translation product. So, AMHPs work with interpreters not translators in MHAAs. In the context of MHAAs, spoken language community interpreters tend to work consecutively and due to the fact that there is no clash between two languages being spoken at the same time, sign language interpreters typically work simultaneously. In the UK public service interpreting context, interpreters are only expected to mediate communication; they are

expected to remain impartial and not undertake any type of advocacy activity. In public service settings, and specifically in MHAAs, professional interpreters should always be used. Bilingual family members, friends or acquaintances should not be called upon to do any interpreting because they may not have the interpreting skills required or the specialist knowledge, and may also have a conflict of interest.

Interviews

MHAAs typically involve an interview with the person being assessed and significant others including family and where possible other professionals. Interviews are likely to include questions about a person's thoughts and feelings, lifestyle and daily routine, medication, use of drugs and alcohol and plans a person may have to harm themselves or others. It is also an opportunity for the AMHP to explore whether any option other than hospital admission might be viable – sometimes referred to as the least restrictive alterative.

Key mental health concepts

Concepts associated with mental health are based around usual understandings of 'normal' behaviours as they are understood for the purposes of this practice guide in a British context. Different mental health terms can arise during a MHAA:

- **Delusion.** Some people may believe they are someone they are not. This can include royalty or religious figures. Delusions may also take the form of false beliefs about others including assumptions about who might be harming them.
- **Disordered thought.** A person's apparent inability to make sense of what they are thinking or to explain this in a way which makes sense to another. It can result in expression in spoken or signed language that is unusual, hard to follow or nonsensical.
- **Flight of ideas.** A person may be having lots of thoughts not necessarily connected with each other or based on ideas that may not be making sense to an observer. This too can affect the form of expression someone uses such as fast speech/signing or repetitive words.
- **Hallucination.** A person may be seeing, hearing, feeling, tasting or smelling something not apparent to anyone else at that time. This can sometimes be referred to as hearing voices. It may result in a person having a conversation with someone they are hallucinating.
- **Psychosis.** A severe mental condition usually implying that contact with reality has been lost.

Whilst concepts relating to mental health are fluid and can change over time, there are key legal concepts which underpin a MHAA, that are fundamental to the process and significant.

Key legal concepts

- **Formal admission** or detention is where a person is admitted to hospital against their will. It is also referred to as involuntary admission, compulsory admission or being sectioned; a phrase that refers to the section of the MHA under which the person is admitted.
- **Informal admission** is where a person is admitted to hospital with their agreement. It is sometimes referred to as **voluntary admission**.
- **Section 2** can be for a period of up to 28 days and is for assessment. **Section 3** is for a period of up to 6 months and is for assessment and treatment. Other sections exist such as **Section 4** used in an emergency when the two medical recommendations are not available and to delay might cause undue harm and **Section 136** which allows for the police to take a person in a public place who may be behaving strangely and threatening harm to themselves or others to a place of safety, so that a MHAA can be done.
- **Nearest Relative.** The MHA introduces formal safeguards to act as a check when decisions about formal admission or detention are being considered. One such safeguard is a Nearest Relative who must be consulted by the AMHP wherever practicable. Nearest Relative does not mean next of kin. The definition of who is the Nearest Relative is given in order of rank in **Section 26** of the MHA. A Nearest Relative must agree to an admission especially in the case of a Section 3. The formal legal requirement is that the AMHP must ensure that the Nearest Relative does not object. This is not the same as the Nearest Relative being required to consent.
- **Statutory.** Refers to any action that is guided by law. An AMHP has a statutory duty as defined in the MHA to coordinate a MHAA including interviewing the person in a suitable manner.

Part 7. Types of interpreting

Introduction

Accurate interpretation is crucial to ensure that the person's thoughts and concerns are understood, allowing AMHPs to make informed decisions. Skilled interpreters not only capture the meaning of words but also the unspoken subtext – the pauses, affect, hesitations, emphases – all of which contribute to an understanding of the individual's mental state. In becoming 'the voice' of the person, interpreters portray the individual's inner world and how they present themselves. This is known as 'representation'. It is relevant both to the person being assessed and to the AMHP who is also interpreted and represented through the interpreter. From an AMHP's point of view, *how* an individual communicates, not just *what* they say, is helpful to gauging an individual's mental state, their ability to engage in discussion about their circumstances and the potential outcomes of the assessment and what these may imply. AMHPs also must assure themselves that key points they are required to say are conveyed by the interpreter with precision in order to fulfil the statutory duties entailed in the AMHPs' role.

AMHPs may not be aware that interpreters have at their disposal different approaches to interpreting that they are taught and may be deployed as appropriate to the situation; for example, 'consecutive' or 'simultaneous' interpreting. Our research has shown that most AMHPs regard interpreters as neutral conduits of information exchange and do not realise that there are choices to be made about types of interpreting nor have considered the complexities of representation. To explain: interpreters do more than 'just translate' words/signs between languages, they seek equivalency of meaning between languages that in some cases means they might use different words or expressions than those of a literal translation. This can be both beneficial and a problem in statutory work (see below).

Types of interpreting

Representation through interpreting may vary depending on the type of interpreting employed (i.e. which modality). Interpreting in signed languages tends to happen in real-time (simultaneous) due to the visual channel of the language. Interpreters can provide different interpreting modalities:

- **Bilateral** (also known as '**short consecutive**') **interpreting** means conveying the message after the speaker finishes each utterance. This can be used by both spoken and signed language interpreters.
- **Simultaneous interpreting** means providing real-time interpretation while the speaker is talking. For this, spoken language interpreters might use a whispered voice (whispered interpreting) but sign language interpreters do not need to whisper as one of the languages is silent.

An AMHP might request different interpreting modalities depending on situational needs. In sensitive encounters like MHAAs, bilateral interpreting might be preferred for thorough and accurate communication. AMHPs need to assure themselves that key points have been conveyed concerning what is happening, why, and what the outcome might be for example. Simultaneous mode is very cognitively demanding for interpreters meaning they might not maintain it for long, however it is typical practice in sign language interpreting. Times when the interpreter might need to resort to simultaneous interpreting include:

- **Crisis interventions** in which swift and accurate exchange of information is vital for example as a distressed individual shares their thoughts.
- **Preserving language fluency or memory flow:** For individuals recounting intricate details, the pauses in consecutive interpreting can disrupt the train of thought and compromise the thread of memory. Simultaneous interpreting provides a continuous and fluid channel of communication.
- **Disordered language:** to clearly represent how the individual is expressing themselves (e.g., in their choice of words, speed of expression, hesitation, gaps and non-sensical sentence structures).

Good practice

- In situations involving individuals experiencing psychosis, it becomes crucial to explain that simultaneous interpreting is happening. This can help prevent any potential confusion between the interpreter's voice and auditory hallucinations.
- AMHPs should agree in advance with interpreters any preferences concerning approaches to interpreting and also during the assessment the AMHP should feel confident to ask an interpreter to switch to simultaneous for example, or to maintain consecutive.
- AMHPs and interpreters should agree in advance that it is all right for an interpreter to suggest a change in interpreting style if they feel it is more helpful at a given moment.

Representing mental illness in communication and language

It is vital that interpreters understand that their role in MHAAs might carry a heavier weight than in other settings. They are representing the severity of the person's mental illness within a statutory decision-making framework that has serious consequences concerning an individual's liberty but also serious responsibilities to safeguard that person and prevent the risk of harm to themselves or others. Aspects of mental illness might be expressed through language use which it is vital that the AMHP is fully aware of to build up a picture of the person at the centre of the assessment. Examples of this include:

- Vocabulary choice – an individual might use an incorrect term, or an archaic version of a word or sign.
- Disordered expression – this might manifest in nonsensical sentences or missing words.
- Prosody – e.g., the tone of communication, speed of expression.
- Withdrawal – silences and gaps in the communication as words are searched for or just not expressed.
- Lack of understanding – e.g., someone is unable to understand the communication even if the language is clear and either masks this, does not acknowledge it, or is repeatedly asking for clarifications.
- Reduced language – e.g., few words, repeated words, unelaborated expression.

The non-verbal component of communication is also important to represent in interpreted communication particularly for someone experiencing mental distress to build up a full picture of their communication. Examples include:

- Inability to concentrate – sometimes manifested through movement and erratic behaviour.
- Impaired ability to interaction within a conversation – e.g., does not turn take, interrupts inappropriately, withdraws and does not participate.
- Unusual eye contact – e.g., lack of eye contact, wandering or more intense than usual.
- Withdrawal – as shown by body position and gaze.
- In the case of BSL users, expected patterns of eye gaze and turn taking are different from those usually seen with hearing people because vision is a vital component of comprehension. Changes in them are of great significance in a non-verbal language.

Good practice

- Interpreters might be tempted to make sense of, or tidy up, a person's language if it is disordered or different to ensure clarity of communication. They should not do this, and it is helpful if AMHPs reinforce the importance of this in their pre-briefing (See Part 5 Briefing). It is helpful for interpreters to be aware that an AMHP will not misconstrue an unusual or non-fluent interpretation as evidence of an interpreter's lack of competency or professionalism.
- AMHPs should give consideration to explicitly suggesting to interpreters in advance of an assessment that they are permitted to offer comments on the language use of the person assessed (See Part 9 Cultural sensitivities and brokering). This gives an opportunity to point out non-verbal aspects that are of significance. Whether this is done at the end of an assessment interview, or if necessary during, should be negotiated between them. This is usually referred to as interpreters using a 'meta-description' of language use and guidelines are available to them on how best to do this (see R10 Resource with reference to various guidelines).
- Interpreters should work to match the tone of voice and style of delivery to match that of the person being assessed to reinforce aspects of their communication that might be helpful for the AMHP to be aware of.

Literal and verbatim translation

In our research, AMHPs discussed occasions when they had told the interpreter to 'just translate what I said' or 'do a literal translation' or 'translate verbatim'. Usually this arose because the AMHP was concerned that the exact nature of what they were communicating to the assessed person had not been rendered accurately enough. This is of importance to the AMHP who has to assure themselves that certain specific matters have been explained. They have a statutory duty to do this. Therefore, if the interpretation is more informal or loose, AMHPs were concerned that their duties had not been fulfilled and the right of the assessed individual and their families had not been upheld (see Part 13 on Governance, accountability and safeguarding for examples). In other instances, AMHPs were concerned that the interpreter was presenting a summary of what the assessed person was saying rather than comprehensively representing them in the assessment.

Interpreters in our research said that the language used by AMHPs in assessments was sometimes very difficult to interpret, especially if instructed to do this 'verbatim' which could make it harder for the person being assessed to understand. Examples include:

- Sentences might be too long with numerous clauses which is especially challenging in consecutive interpreting.

- An AMHP might use passive rather than active language, which is harder to render directly.
- Specific terms are not explained adequately by the AMHP leaving the interpreter to make decisions about their meaning that might not be correct.
- The AMHP uses metaphors that do not translate easily across languages/cultures.
- The AMHP attempts to soften language by using generalised terms that then make it harder to interpret.

Good practice

- An instruction to translate 'verbatim' or 'literally' should be very rarely used as it does not ensure good understanding by all parties.
- It is better to agree in advance with the interpreter what key points the AMHP feels must be conveyed during the MHAA interview, so the interpreter is fully aware of the significance of some of the AMHPs language/ expression. This is best done via a pre-briefing. (See Part 5 Briefing and Resource R7 Minimum best practice check list for interpreters).
- The AMHP should try to adopt good practice in their communication style and approach to avoid additional burden in interpretation and comprehension. (See Resource R9 – Minimum best practice check list for AMHPs).

Implications for rights of the person being assessed

The role of the interpreter in representing the person being assessed has profound implications for safeguarding the rights of individuals undergoing MHAAs. The way they represent the person being assessed carries serious weight, steering the course of their entire journey within the mental health system, even shaping the potential for detention. An inadequate interpretation might lead to misunderstandings, misdiagnoses and resulting misguided decisions, potentially affecting the person's liberty and treatment journey. So, in essence, interpreters safeguard the person's right to be understood. (See Part 13 Governance, accountability and safeguarding).

Part 8.
Deciding to stop a MHAA interview

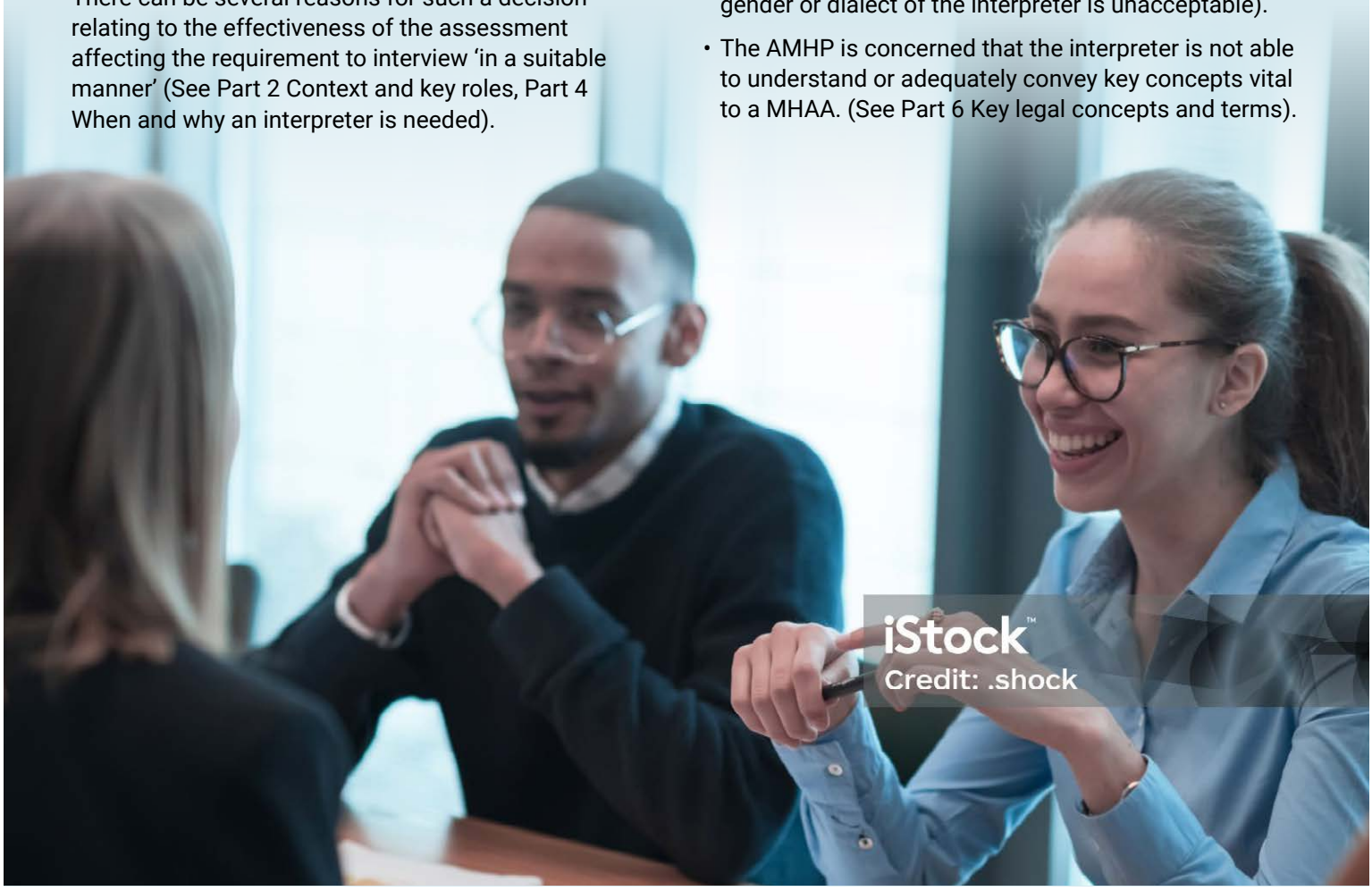
Introduction

There are occasions when serious consideration should be given to whether an interpreter-mediated interview during a MHAA should not go ahead or be stopped. It is the responsibility of the AMHP to make such a decision.

There can be several reasons for such a decision relating to the effectiveness of the assessment affecting the requirement to interview 'in a suitable manner' (See Part 2 Context and key roles, Part 4 When and why an interpreter is needed).

For example:

- The person being assessed appears unwilling for the interpreter to be present, the reasons for this may be unclear or specific to the individual interpreter perhaps because of unwelcome familiarity (the person and the interpreter may be from the same community and are known to each other) or cultural requirements (e.g., the gender or dialect of the interpreter is unacceptable).
- The AMHP is concerned that the interpreter is not able to understand or adequately convey key concepts vital to a MHAA. (See Part 6 Key legal concepts and terms).



- The interpreter appears unsure, hesitant or distressed to an extent that it is interfering with good communication during the assessment.
- The time the interpreter has available is very limited which may impede a fair assessment process.
- Issues connected with the circumstances of the interpreting and/or interpreter are creating risks that are not manageable.

In circumstances such as these, serious consideration should be given to whether the MHAA should be stopped and/or a different interpreter sourced. Our research indicates that AMHPs may be very reluctant to stop an assessment because of practicalities associated with sourcing interpreters and time required. AMHPs may not have considered fully that the implications of interviewing in a suitable manner also includes stopping that interview if the communication skills or practice of the interpreter is not good enough. The decision to stop must be balanced against the needs of the person who may be distressed, and a delay could add to this.

What is good practice in these circumstances?

It is important to reflect on what can be done to prevent getting to the point where stopping an assessment interview becomes a consideration. Therefore:

- Briefing an interpreter beforehand should take place wherever practicable. The briefing allows an AMHP to relay appropriate information to the interpreter and should also be an opportunity to decide if the interpreter understands what is required of them, including the need to understand and convey key concepts and pragmatic matters such as what time the interpreter has. Parts 5 and 6 and resources R7 and R9 in this document provide some helpful background to this.
- If the AMHP has concerns, then consideration should be given to not going ahead with the interview.
- There may also be a need to stop an interview if matters arise whilst the interview is taking place.
- In both instances the AMHP should make this known to the person being assessed, to the interpreter and to anyone else, explain what is to happen next and this decision must be recorded in the AMHP report form.
- The AMHP should ensure that the person being assessed is safe and arrange for a replacement interpreter as soon as is possible.

Part 9.
The role and responsibilities of interpreters: cultural sensitivities and cultural brokering

Introduction

Part 7 of this guidance on different types of interpreting focused on the technical aspects of interpreting in terms of how an interpreter does their job, and what AMHPs need to be mindful of in working with an interpreter in relation to the language they use. In this part of the guidance, we consider the role and responsibilities of an interpreter with respect to the transmission of cultural information within the assessment process by unpacking what would typically be expected of interpreters generally and how things might be different in the context of a MHAA.

Para 4.4 and 4.6 page 36 of the Code of Practice (DoH 2015) specifies that due attention must be made to the culture of a person being assessed and the potential consequences of cultural identity and background for that assessment. This encompasses respect for cultural preferences and norms of interaction as well as a recognition of culturally embedded forms of understanding and expression. In the proposed revisions to the MHA, the role of the Independent Mental Health Advocate is being expanded to include specific provision for a cultural advocate who is involved in all stages of the MHAA and subsequent treatment and review. Interpreters would not typically see themselves as cultural advocates. In some instances, the roles may have to overlap if there is no one else available to provide cultural support, and this may make interpreters feel uncomfortable.

An interpreter's understanding of their role and responsibilities is informed by the nature of the training they have received, but there are core ethical principles that interpreters adhere to when mediating interactions. These principles are informed by professional interpreter association codes of conduct. Spoken and signed language interpreters are expected to adopt the same principles, regardless of their working language combination(s). Although the phrasing of the principles may vary slightly across different codes, the essential elements are the same.

Our research confirms previous research findings in other domains that AMHPs (alongside other professionals, in for example, healthcare and the legal system) have varied perspectives on the role of interpreters and may not be clear on how much they can ask the interpreter to do with respect to providing cultural explanation or context. Some have a very narrow focus on what an interpreter's role should be that might exclude all culturally explanatory information. Others see the cultural insights that an interpreter might bring as part of their role in ensuring full understanding of all parties. Likewise, our data and initial training reveals that interpreters themselves are also not sure about how much cultural information they should provide in MHAAs.

Core ethical principles of the role and responsibilities of an interpreter

- Professional judgement
- Linguistic competence
- Subject competence
- Professional competence
- Responsibilities to professionals they work with or alongside
- Responsibilities to other interpreters
- Continuing Professional Development

Essentially this means that interpreters:

- Judge whether they have the appropriate and relevant skills and knowledge before they accept an assignment.
- Are there to interpret for both parties – it is not a one-sided transaction. They are neutral in terms of their role, but this does not mean they are merely a conduit. They need to work cooperatively with both parties to ensure the interaction flows both ways.
- Transfer message from one person to another across two different languages to the best of their ability.
- Seek to be as accurate as possible in the message transfer.
- Take into account not only linguistic differences, but also cultural differences in order to convey equivalent meaning in the message transfer.
- Remain impartial in the interaction, not inserting their own opinion or guiding the discussion in any way.
- Retain confidentiality of content of discussion and do not disclose to anyone outside the interaction.
- Behave professionally and respectfully towards other interpreters and other professionals that they are working with.
- Behave with professional integrity to uphold ethical practices in representing their profession.
- Commit to maintaining and developing their professional skills on an on-going basis.

Examples of Interpreter Codes of Conduct

- National Registers for Communication Professionals working with Deaf & Deafblind People
- National Register of Public Service Interpreters
- Chartered Institute of Linguists

Nuances to these principles: Interpreter as cultural and linguistic expert

Interpreters are typically perceived as bilingual or multilingual linguistic experts. But they are also bi- or multi-cultural experts. The above core principles that are considered essential as part of the interpreter role and responsibilities focus primarily on message transfer and the role of the interpreter to remain impartial as a linguistic expert. However, there may be times – especially in MHAAs – when the interpreter can be asked their opinion with respect to any cultural sensitivities, and anything in particular that the AMHP feels they need to know. The interpreter may also feel that they need to offer information to the AMHP based on something they observe that they feel the AMHP needs to know. There is a fine line, however, for interpreters to tread in relation to providing information and advocating for the person being assessed. The nuance comes from not only the professional responsibility that interpreters have, but also their moral responsibility in potentially being the only person in the room that understands both languages and cultures and where there may be a mismatch, and the potential risks – especially in a MHAA.

Interpreters are responsible for mediating communication, but they also have a responsibility to make interpreting decisions according to what feels right as a linguistic and cultural expert. In the context of MHAAs, this requires interpreters to work collaboratively with AMHPs to ensure that the assessment is delivered in a suitable manner (see Part 2 Context and key roles and Part 4 When and why interpreters are booked) and the safety of the person being assessed is assured (see Part 13 Governance, accountability and safeguarding). Interpreters have a responsibility to the message, but as noted earlier under the requirements of the MHA, they also have a responsibility to the cultural aspects of identity that might be relevant to the outcome of a MHAA. Thus, interpreters and AMHPs need to work together as allied practice professionals.

Good practice for AMHPs

- Talk to the interpreter before the interview to prepare them (see Part 5 Briefing).
- Ask the interpreter if there are any cultural sensitivities that they should be aware of – for example in terms of religious practices, or what would be considered 'typical' behaviour in some cultures. This could include the way honorifics are used, or whether it is appropriate to make direct eye contact.
- Check if the interpreter notices anything unusual in the way the patient is speaking/signing (see Part 7 on Types of interpreting) that might impact on how they are able to assess them.
- Check with the interpreter if the phrasing of particular questions will make sense culturally or how best to re-phrase. For example, asking if a deaf person can hear voices in their head.
- Do not ask the interpreter what they think the outcome of the assessment should be – but do ask them if there is anything about their language use or cultural background that might contribute to the AMHP's decision making.
- Do not ask the interpreter to contribute to discussion about decisions to be made as a consequence of the assessment (see Part 3 Legal decision making). The interpreter should not offer an opinion on the mental health of the patient. They should only offer opinion on linguistic/cultural issues that may influence the assessment decision/outcome. If you would like the interpreter to comment on any language or cultural issues, be specific in your question.

Good practice for interpreters

- Talk to the AMHP about their expectations of the MHAA prior to the interview (see Part 5 Briefing).
- If possible before the interview, offer a brief explanation of any cultural sensitivities that the AMHP should be aware of.
- If you notice anything unusual about the way the patient is talking, let the AMHP know so that they can take it into account in their assessment.
- Let the AMHP know if you have any doubts that the person being assessed understands what is going on. Especially if it is because of any cultural mismatch between British and other cultural expectations.
- Do not offer an opinion on the person's mental health status or contribute to the discussion about outcomes of a MHAA. But do offer advice on any specific language or cultural issues that the AMHP should be aware of that might influence the assessment.
- Discuss with the AMHP when it might be better to proceed with a cultural advocate, legal intermediary or deaf (relay) interpreter present.

Part 10. The full patient journey

Introduction

The majority of this guidance is focused on AMHPs and interpreters working together during the interview component of the MHAA. However, the requirement for interpreter mediation may extend beyond that. There are implications involved in stopping a MHAA interview for the AMHP, whose role is to secure interpreters, and for interpreters themselves. The research underpinning this guidance has demonstrated that there can be constraints on the amount of time that an interpreter is booked for and/or lack of consideration of other aspects of interpreter requirements across the full journey of the person being assessed. In this Part we outline some additional considerations that may not apply in all cases but at least need to be thought about.

Consultation with the Nearest Relative

Even if an assessment is carried out in English, the required consultation with the Nearest Relative (see Part 6 Key legal concepts and terms) may be with someone for whom spoken English is not a first or preferred language. The AMHP would need to book an interpreter for this consultation even if not for the MHAA itself. Ascertaining the preferred language of the Nearest Relative in advance is important in this regard because subject to the normal considerations of patient confidentiality, the AMHP has to inform the Nearest Relative of the outcome of the assessment give their decision and reasons for it (DoH 2015 para 14.111, p. 130).

Transportation and arrival at hospital

The decision for someone to go into hospital is a serious one and potentially very distressing to the patient. Ensuring that there is a continuity of communication and linguistic access after the decision has been made is, therefore, an important consideration. Often interpreters are only booked for the assessment itself, rather than booked to assist with communication as the person is transported and arrives in the hospital environment. Although it is the hospital itself that should provide communication/language provision for inpatients, the transition process from home to hospital arrival is perhaps best facilitated through an interpreter who is already known to the patient and has taken part in the assessment. If this is not possible, ensuring that an interpreter is available to assist with immediate communication needs on arrival at hospital would be good practice. Practically, the easiest way to do that would be to book the same interpreter for the additional hours required to cover that. In situations where the transport to convey (usually an ambulance) is delayed, make arrangements to contact that same interpreter if possible, when timescales are known. For specialist psychiatric units for deaf people there is usually on site means of communication in British Sign Language (BSL) as part of the ward culture and because deaf staff are employed too. For other hospital environments it would be highly unusual that staff have fluency in a range of spoken languages.

Provision of language-appropriate materials for people who have been detained

Although there are many helpful resources available in multiple written languages and in BSL that explain the rights of people who are detained (see Resource R6 Curated reference list), literacy is an important consideration. Not all spoken languages have a written form but also not all users of spoken language have good written literacy. Furthermore, not all deaf people feel comfortable reading English. Whilst it falls outside of the AMHP's immediate responsibilities to advise on access to materials on patient rights in a variety of spoken/written/signed languages, it may be helpful for the AMHP to be aware that these materials exist to be able to advise if required.

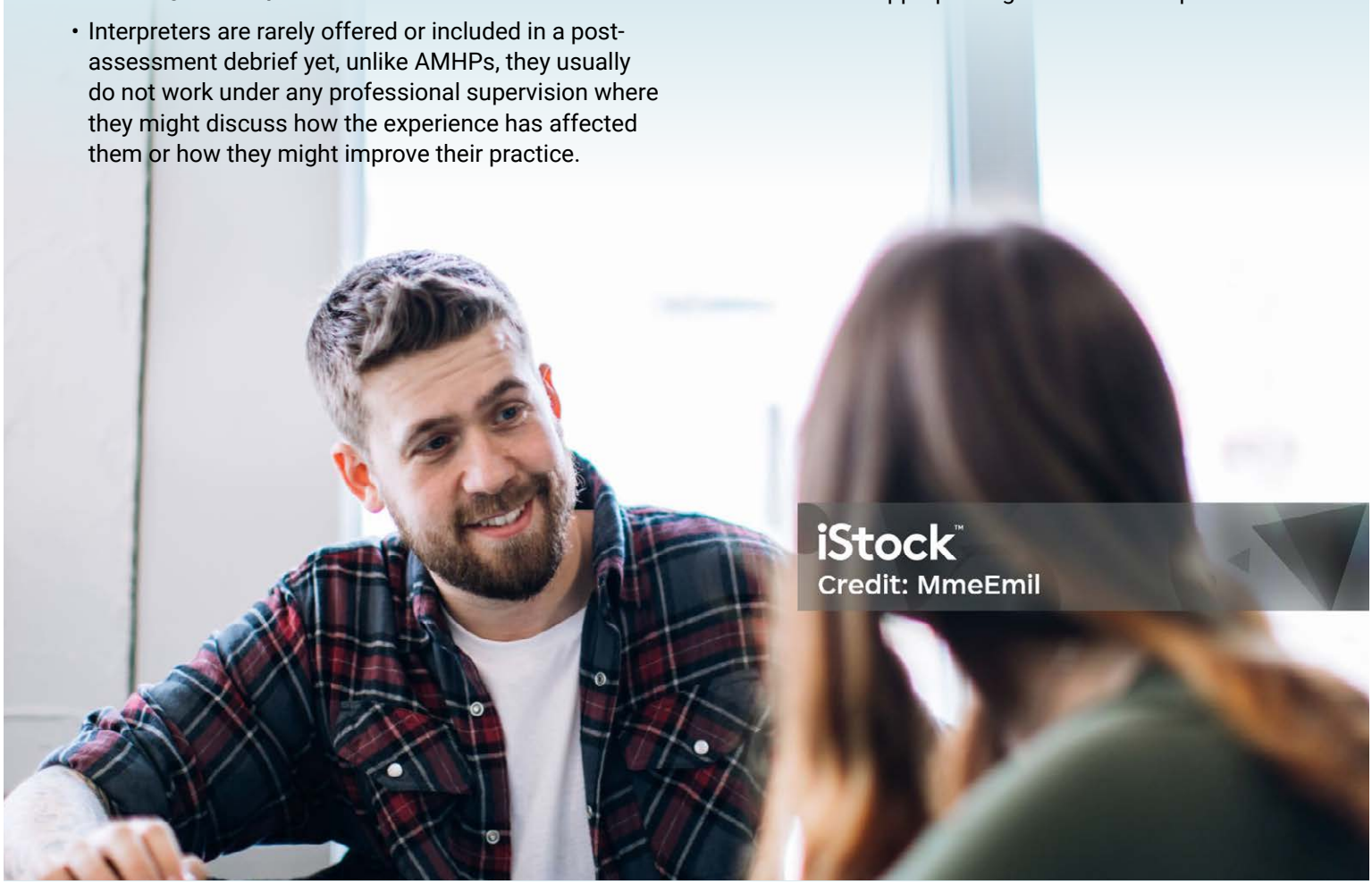
Part 11. Debriefing

Introduction

Debriefing is a short, informal conversation between professionals and occurs after a MHAA has taken place and the outcome has been communicated to the assessed person. The purpose of a debrief is to create a space for reflection on the overall MHAA process, the effectiveness of interprofessional working, the specific language and cultural challenges presented by the encounter, and any issues impacting on the well-being of the professionals involved.

Debriefings are important because:

- Interpreters are rarely offered or included in a post-assessment debrief yet, unlike AMHPs, they usually do not work under any professional supervision where they might discuss how the experience has affected them or how they might improve their practice.
- AMHPs' overall co-ordinating role during MHAAs should involve checking the well-being of interpreters.
- Information from the debrief can inform AMHP report writing and improve future joint working practice.
- Debriefing allows interpreters to share insights they might not have had the chance to convey during the assessment, such as observations about disordered language. This enriches the overall understanding of the individual's linguistic output.
- Even in a short debriefing AMHPs can provide support, validation and appropriate guidance to interpreters.



What is good practice in debriefing?

Time

Debriefing does not have to take long and should be viewed as an integral part of the interpreter-mediated assessment process from the outset. AMHPs can make this clear at the start of working together with an interpreter at the start of a MHAA.

Interpreter adjustments

Most interpreter codes of ethics instruct interpreters not to comment on any aspect of interpreter-mediated encounters. The statutory nature of MHAAs, however, may require an adjustment to interpreter practice in this regard (see Part 9 Cultural sensitivities and cultural brokering). The debrief is an opportunity for interpreters to describe critical points in the MHAA in which decision making about meaning, tone, etc. was a particular challenge and why for the record.

Interpreter well-being

Interpreters do not have routine access to supervision (although it is becoming increasingly popular among British Sign Language interpreters), which means that it is important that AMHPs check in with them, particularly after a challenging MHAA. Evidence from our research suggests that this seldom happens. Even in a short debrief, AMHPs can create a safe space for interpreters to express their needs, offer them coping strategies, and address any outstanding needs to help with closure ('containment').

AMHP reporting

Our research shows it is helpful in completing the AMHP report form if any challenges associated with the any aspect of the interpreting process are noted. These can be discussed in the debrief. This is helpful for future practice too.

Interprofessional working effectiveness

Being honest about what went well, areas of improvement and potential adjustments to enhance collaboration in the future ensures that the debrief is a point of shared learning.

Part 12. Issues in recording

Introduction

Local recording following a MHAA (the AMHP's report form) varies regionally/nationally with no uniform template or requirements. Drawing on the information from these report forms, information is collated and a minimum data set is uploaded to NHS Digital which provides the basis for annual published reporting (Mental Health Act Statistics, Annual Figures, 2021-22 - NHS Digital). Currently, ethnic identity as well as gender information is recorded, but this is not the case with linguistic characteristics and language use preferences of the person assessed.

There is no requirement in the minimum data set to include:

- the first or preferred language of the person being assessed;
- the language or languages in which the assessment took place;
- whether an interpreter was used at any point;
- whether an interpreter was requested but not used or was not available;
- the language or languages used by the AMHP, Section 12 doctor or any other professional involved in the assessment.

The absence of this information makes it very difficult to identify where any disparities may exist in assessment or outcome related to language use or the conditions of interpreter-mediation during assessments. Differences in disposal highlighted in relation to ethnicity are not synonymous with potential differences that might arise through language use. Our research has shown that on a local level, information about preferred interpreters, difficulties that might have arisen in the assessment related to interpreting/language use, and good practice are sometimes recorded but not consistently. The following are suggested good recording practices to support people undergoing assessment and to promote professional practices in interpreter-mediated assessments. The headings are summarised on a template in Resource R8 – What to record.

The language of the person assessed

A person's choice of language is a fundamental part of who they are and should be documented accordingly, rather than solely inferring from choice of interpreter. Furthermore, a language label is not sufficient to characterise a person's language use. For example, during an assessment some may communicate entirely through an interpreter whereas others may blend languages – their home language and English for example. Some may understand spoken English but prefer to express themselves in a different language. Some may find their fluency in a first or second language is impaired as a result of their mental health. Trauma may cause them to favour one language rather than another within their repertoire. It is helpful to record such issues of language use within the assessment for future reference.

The language(s) of the professionals involved

Some doctors and AMHPs have fluency in multiple languages. If these are used in the assessment to communicate directly with someone being assessed this should be recorded. The professional's language skills may mean they are able to follow the interpreted communication and to some degree monitor that. This should be noted as part of creating a record of the adequacy of available communication for all parties.

The language for which an interpreter was requested

Some standardised AMHP report forms have drop down boxes to specify the language for which an interpreter was requested, some only say interpreter – yes/no. In that case, it is good practice to record separately in open comments the language for which an interpreter was requested.

The name and contact details of the interpreter

For purposes of continuity should the person need to be re-assessed or require ongoing treatment/support it is helpful to record the name and contact details of the interpreter used, if the individual assessed was happy with that interpreter. The knowledge they bring of the individual to future related assignments supports high quality language access. We note, however, that some interpreting agencies insist that the name of the interpreter and their contact details explicitly requires their individual consent and/or the consent of the agency for whom they work. The AMHP may wish to negotiate this after the assessment.

Concerns expressed about the interpreting or interpreter

On an individual basis, some interpreters may not be acceptable to a person being assessed/patient for personal reasons. For example, they are known to the person socially and they do not want them to be associated in this personal capacity. Or in a professional capacity, maybe the interpreter has worked for this person in a service other than mental health. Or the interpreter's cultural/political background is unacceptable to them in the case of historical conflicts in nations. There may also be more general cultural reasons why a given interpreter is not acceptable, for example, on grounds of gender, age, unmarried status in some instances. This is helpful information to record on the form for future use should interpreters be required. The wishes of the person being assessed with regards to their preferred interpreter should be met if at all possible.

Any concerns raised by the AMHP or other professional involved should also be noted about the capability or suitability of the interpreter for a MHA specific assignment. Our research has also highlighted rare but more serious concerns where the situation revealed pre-existing relationships between interpreters and people being assessed that gave rise to safeguarding referrals. In such instances, usual protocols of reporting and escalation should be used.

Difficulties in meeting interpreter requirements

We suggest it is helpful to record any difficulties in meeting the requirement to provide a suitable interpreter. This may cover: identification of a suitable interpreter (which can be especially difficult with uncommon/rare languages in the UK context); problems in interpreter provision in a timely manner (e.g., delays in availability that may have affected the timeliness of an assessment); provision of only remote interpreting when face to face is preferred and why; failure to provide suitable interpreting provision which resulted in an escalation of distress/illness leading to emergency or alternative provisions (see Part 13 – Governance, accountability and safeguarding). Such recording assists in the identification of gaps in provision and problems of process that require attention in any given locality. They may also be important in relation to any future MHAA s or Mental Health Tribunals.

Part 13.
Governance, accountability and safeguarding

Introduction

Several issues concerning governance have arisen through our research. What follows is a consideration of four key themes: regulation, confidentiality, safeguarding and remote assessment, with suggestions for good practice associated with each theme.

Regulation

It is usually thought that interpreters are a regulated profession in the same way as social workers, doctors and allied health professionals and that their practice is overseen nationally by a regulatory body responsible for the register of suitably qualified interpreters, the maintenance of professional standards and a formal process of debarment when justified. This is not so.

In the case of spoken language interpreters, the *National Register of Public Service Interpreters (NRPSI)* is an independent, but voluntary regulator for interpreters working in public services and runs the largest open access national register of accredited interpreters. NRPSI-registered interpreters abide by the NRPSI Code of Professional Conduct which outlines good practice and ethics. Not all interpreters who work for agencies that health/social work/social care use will be members of NRPSI nor necessarily required to be. Most spoken language interpreters work without any formal training in interpreting, relying on multilingual fluency and experience alone without having been taught professional skills. In the case of British Sign Language (BSL) interpreters, a UK-wide register of interpreters does exist: *National Registers of Communication Professionals working with Deaf and Deafblind People (NRCPD)* and formal qualification is required to enter the register. Although BSL interpreting is not a statutory regulated profession like social work, there is an established Code of Practice, a means of removal from the NRCPD register and several ways to search for registered, qualified and experienced interpreters working in specific fields of practice. Furthermore, there is a strong expectation that BSL interpreters will voluntarily be registered to be deemed safe to practice. (See Part 7 Types of interpreting and Resource R7 Minimum best practice checklist for interpreters).

To be an AMHP first requires registration as a regulated professional whether social worker, nurse, psychologist or occupational therapist. All AMHPs then require a formal training for approval to practice that statutory role. The specification for the training follows statutory guidance. There are specific guidelines governing maintenance of knowledge and experience to continue to practice and any complaints concerning practice are dealt with via the regulatory body, Social Work England.

What is good practice?

- It is important to be aware of the variety of training and development that interpreters receive. This is explained more in Part 7 Types of interpreting.
- Should there be any concerns about an interpreter's practice before or during a MHAA then consideration should be given to not going ahead (see Part 8 Stopping an assessment). Any concerns should be raised with the interpreter themselves and in turn the agency. Both the NRCPD and NRPSI have complaints mechanisms (see https://www.nrcpd.org.uk/make-a-complaint and https://www.nrpsi.org.uk/for-clients-of-interpreters/complaints-about-interpreters.html) and interpreter boking agencies should also have their own internal complaints process.
- If an interpreter has any concerns about the practice of the MHAA or any professional involved, these should, in the first instance, be discussed with AMHP directly or if this is not possible advice should be taken from the employing interpreter agency or the formal regulator for AMHPs, Social Work England, from whom advice could be sought.

Confidentiality and information sharing

Sharing of information covers two aspects in interpreter-mediated assessments. The first concerns what information is shared with the agency and interpreter about the person being assessed to secure the most appropriate interpreter. The second concerns what information is shared with the agency regarding the performance of the interpreter, good and bad.

What is good practice?

- Sharing of information about the person being assessed must be done on a need-to-know basis and their privacy and confidentiality respected. However, it is important to convey some issues to ensure safety and good practice within the assessment.
- Sharing the medical history of the person being assessed is not appropriate, but it is important to outline in general terms the seriousness of the person's mental state that has meant a MHAA is required. Some inexperienced interpreters may not understand this issue of severity and assume it is a routine kind of assignment concerning mental health.
- It is helpful for the AMHP to share specific aspects of the person's behaviour that are of concern that might impact interpreting practice. This might include, for example, unusual or odd remarks that are being made, or evidence of hallucinations or states of extreme withdrawal.
- A discussion should occur about any aspects that are considered high risk including behaviour that could cause harm either to the person themselves or others involved in the MHAA, including the interpreter.

Safeguarding

With regard to safeguarding, all professionals involved in the MHAA have a professional responsibility to raise any concerns about safeguarding including evidence of abuse, harm, neglect or exploitation with respect to the person being assessed. It may be, in rare cases, that safeguarding concerns become evident concerning one or more professional involved during the assessment itself. It is the responsibility of the NHS and Local Authorities to ensure that interpreters have undergone checks and clearance in line with the Disclosure and Barring Service. This is commonly viewed as a delegated responsibility of the agencies supplying the interpreters. It is more problematic if an interpreter is working independently and because spoken and signed language interpreters are not regulated professions.

Good practice

- The AMHP is able to check records held on the person being assessed to see whether safeguarding concerns have been raised in the past and what has/is happening, or to make a new referral for investigation if appropriate.
- Confidentiality will mean the details of any past history/current procedures concerning safeguarding cannot be shared with the interpreter, but reassurance should be given that it is being recognised and attended to if an interpreter raises a concern.
- If it is a new concern meeting referral/investigation, the interpreter will be required to provide information that can be recorded by the AMHP.
- Where an interpreter's input in the MHAA has raised a safeguarding concern the reason for this should be shared with the interpreter and in turn the agency. Depending on the concern, the feedback may also include a discussion about future involvement, or in more serious instances such as unprofessional behaviour, that a note is made on the record of the MHAA and followed up with whoever has commissioned the interpreter service.

Remote assessment

MHAAs can be complex and may involve safeguarding concerns. Communication needs and the potential for harm add to this complexity. In addition to language, a person's mental health may also add a layer of complexity in understanding or being understood (See Part 7 Types of interpreting). Remote, rather than in person interaction can make this situation even more challenging for everyone concerned, including the person being assessed. Whilst MHAAs conducted remotely during the pandemic are now deemed unlawful, it nonetheless remains the case that the use of remote interpreters is not unlawful and continues. Not all AMHPs are comfortable with this practice and governance issues concerning the adequacy and quality of remote interpreting remain largely unaddressed. However, the Institute of Translation and Interpreting Position statement on remote interpreting asserts that it is important to maintain identical requirements for interpreters in terms of qualifications whether they are working on site or remotely.

Our research has shown that 'remote interpreting' covers a range of practices including: the interpreter is on the telephone and the phone is passed between individuals as someone speaks; the interpreter makes a video call so that s/he can see the behaviour of all parties as well as hear the communication and the person being assessed and professionals involved can see him/her; a professional remote video interpreting services is used in the case of BSL interpreters with a good quality interface meaning that all parties can see the interpreter and the interpreter can see them. Each of these communication adaptations can pose difficulties in a MHAA situation. For example, non-verbal cues are a vital part of understanding disordered communication and this is not possible to observe in telephone interpreting; a disembodied voice may be confusing or confronting for a person experience auditory hallucinations.

What is good practice?

- Every effort should be made to secure an interpreter in person. A MHAA is a complex matter which should enable appropriate communication so that the best decision can be reached.
- Although remote interpreting brings pragmatic benefits in cases where an interpreter is difficult to source or travel is unrealistic, it should be regarded as complementary to in person interpreting, not the first choice.
- An emergency or crisis may mean that remote interpreting is the only choice because of the time priority but these situations are rare, even within MHAA.
- Where in person attendance by the interpreter is not possible, consideration must be given to the practicalities of how the MHAA is to take place. This will involve agreeing with the person being assessed and the interpreter how the interview is to be conducted, for example, where the technology will be placed to permit the remote interpreting, a clear sequencing of communication to promote intelligibility, whether video or sound only will be used and why.
- If at any time the remote attendance is causing upset such as the person who is being assessed showing confusion or there are practical difficulties in communicating such as an unclear telephone line or internet connect then the interview should be stopped (see Part 8 Stopping an assessment).
- The circumstances of the remote interpreting should be recorded in the AMHP report form with any comments on its quality/adequacy.

Resources

RESOURCE R1: Introduction to the simulation videos

Introduction

As part of the project four simulations of Mental Health Act assessments (MHAAs) were filmed. These were filmed for three purposes:

1) To visually illustrate examples of good practice and not so good practice in AMHP and interpreter behaviours during an MHAA.
2) To use the simulations as part of further data collection by running online focus groups with AMHPs, interpreters and service users as a stimulant for discussion on what constitutes good and not so good practice.
3) To have a freely available training resource to be used in initial, reapproval and CPD training for AMHPs and interpreters.

Each video simulation was created using a scenario developed by the INforMHAA research team, drawing on our own experiences as AMHP and interpreter practitioners, as well as authentic experiences reported to us by AMHPs, interpreters and service users through our surveys and interviews.

Each video features professional actors playing the role of patient or parent, and a real AMHP. Three of the scenarios include a real professional interpreter. In three of the scenarios there was also a member of the INforMHAA research team or advisory group playing the role of an additional medical professional.

In each video the AMHP and Interpreter were both directed specifically to ask questions/ make decisions or interpret in such a way that highlights key issues that can arise in these assessments. This is not a reflection of the quality of their skills as AMHPs or interpreters in real practice. We are grateful to the AMHPs and interpreters for being prepared on occasions not to demonstrate their usual excellent practice (!)

The goal in creating the scenarios to illustrate examples of good and not so good practice was to stimulate discussion about best practices for AMHPs and interpreters in working together.

Two ways to use the simulated practice work

We are using the scenarios in two different ways:

- In the first, the focus is more on the practice of interpreting with close attention to the interactions between the interpreter, the AMHP and the person being assessed. The videos we made are available to download from the INforMHAA website and details of where to find them can be found in Resource R3. Resource R4 provides guidance on how the videos might be used in interpreter training or joint interpreter/ AMHP training.
- The second uses only the written information we created that supported the improvisation of the actors in the films because in their own right these semi-scripted scenarios are useful for training purposes. There is more detail in this version of the background and legal issues. They are suitable for initial AMHP training as well as for joint AMHP/interpreter (CPD). These can be found in Resource R2, with a background to each scenario and how they may be used in training.

RESOURCE R2: Written case studies for discussion

Introduction

During the research project we created four short videos to illustrate practice-based issues in interpreter-mediated MHAAs, which were then used to prompt exploration and discussion amongst a group of AMHPs, interpreters, services users and carers. The short films were made with actors playing the person being assessed and using real AMHPs and interpreters. These films are available in Resource R3. We are using them in two different ways. In the first, the focus is more on the practice of interpreting with close attention to the interactions between the interpreter, the AMHP and the person being assessed. Details of viewing the video along with some structured questions suitable for interpreter and joint interpreter/AMHP training are available in Resource R4.

Here we are using the original information we created that supported the improvisation of the actors in the films because in their own right these semi-scripted scenarios are useful for training purposes without reference to the filmed versions. The following can be used as written case studies and are suitable for AMHP training as well as joint AMHP/interpreter training.

The contexts, practice issues and dilemmas within them were drawn from the project's data collection but are fictional; they are amalgams of several real-life situations in order to maintain confidentiality.

How might the written scenarios be used?

- As stand-alone case studies or to accompany the videos to prompt and support discussion to explore aspects of AMHP-interpreter professional practice whether in qualifying programmes or for reapproval or CPD purposes.
- They are suitable for use in profession-specific groups (AMHPs or interpreters) as well as in multi-disciplinary groups
- They raise issues and discussion points that are highly relevant to uses of services and their families as well and might be used in groups that are involving experts by experience.
- They illustrate examples of good and not so good practice which allow for reflections on what best practice should look like.

The case studies contain:

- A background scene setting part of the scenario.
- A further description of the action as it unfolds.
- Some suggested discussion questions to structure a group discussion. These can be raised between 'background' and 'unfolding action' settings or all left to the end.
- Links to the relevant good practice guidance sections to support the discussion.
- Suggested other publications/texts/resources to consult.

As in all group work that concerns sensitive topics we would recommend:

- A suitably qualified and experienced group facilitator (ideally an AMHP or interpreter) undertakes the discussion work.
- A means of debriefing and individual support is available to group participants should the scenarios or discussion raise concerns or be upsetting.

Scenario One: the time-limited interpreter and the unsure AMHP

Background. This is not a planned assessment but one that has arisen as an emergency response to the patient's health and behaviour. The Dutch speaker has already been seen by the Section 12 doctor who was able to carry out their assessment directly (as they speak the language of the person being assessed) and the doctor has left her notes and signed forms and gone. We join the situation after the AMHP has been waiting for over 2 hours for an interpreter to arrive. The AMHP has had real problems finding a suitable interpreter. This is because the AMHP would prefer to have an interpreter in person, rather than a spoken language interpreter via the telephone because that could be potentially more confusing for the person being assessed who is experiencing some auditory hallucinations. The agency has explained that the interpreter will only be available for 45 minutes after which they will have to leave for another booking. The AMHP has decided this is better than nothing as the person has been waiting so long and does not wish to create further potential distress.

Potential discussion points concerning the background information:

- Do you agree with the AMHPs view that it is better to have an in–person interpreter even though this is adding to the delay for the person being assessed?
- In your experience, do you think there are differences between interpreter-mediated assessments that involve a remote interpreter and ones involving an in-person interpreter and does this matter?

Unfolding action: On arrival the interpreter says she wants to spend 5 minutes alone with the person being assessed to introduce herself, gauge her language use and tune in to her. The AMHP remains present for this discussion as he does not think it advisable to leave them alone but does not understand the conversation that is going on.

Judging by body language, the AMHP is not sure the woman is comfortable with the interpreter but unsure why. He asks the interpreter to check with her whether he is happy to have her as the interpreter. The interpreter says something which provokes an angry response but the interpreter tells the AMHP not to be concerned. The woman being assessed gets up and starts to pace and move around the room including passing behind the back of where the interpreter is sitting. The AMHP encourages with hand gestures for her to sit down again in a calming manner. When this does not work, he asks the interpreter to encourage her to sit down. The interpreter does so but it is clear from her tone of voice that she has been very direct. The AMHP starts to wonder if the interpreter is interpreting everything he is saying and whether the woman is understanding everything. The interpreter admits that she is familiar with the woman and her family from 'back home' The interview continues…

Potential discussion points:

- Could the AMHP have done anything differently to ensure the start of this interview went better?
- Is the interpreter behaving professionally or would you have wanted to intervene in some way?
- Are the patient's rights and needs and safety being attended to adequately through the interpreted communication?

Parts of the guidance that can be drawn on when debating these and other talking points:

- Booking interpreters and being booked as an interpreter (Part 4)
- Briefing between interpreters and AMHPs (Part 5)
- Different types of interpreting, linguistic decision making and representation (Part 7)
- Stopping an interpreter-mediated assessment to protect the rights of the individual (Part 8)

Scenario Two: the sign language interpreter and modifying terms to support understanding

Background. This scenario takes place at the point when the AMHP is coming to the decision about the outcome and will have to convey that to the patient. The doctor, the AMHP, the person being assessed and the interpreter are all present. The person being assessed is Deaf and the languages of interpretation are BSL (British Sign Language) and English.

Potential discussion points concerning the background information:

- Is there any specific statutory guidance relevant to when a Deaf person who uses sign language is undergoing assessment?
- Is there anything different relevant to AMHP practice when a sign language interpreter is involved rather than a spoken language interpreter?

Unfolding action: The AMHP thanks the person who has been assessed for their patience and all they have shared and explains that she and the doctor will now leave the room for about 5 minutes to have a chat about what to do next. She turns to the interpreter and says it would be helpful if he could join them because as an interpreter working with Deaf people he may contribute some issues of context and culture that it would be helpful to know about. The interpreter translates this comment to the Deaf person but then explains to the AMHP that he would prefer to stay as he is the only one the Deaf person can communicate with directly and he wants to offer him some reassurance and support. The AMHP agrees but feels she is losing important additional information that the interpreter might have been able to contribute. The AMHP returns and starts to explain to the Deaf person that they have decided that he needs to go to hospital and be assessed further there and receive treatment. She starts to explain some of his rights. The interpreter interrupts the AMHP several times saying that the language she is using would be very hard for the person to understand and wants to explain it differently in lay language and using simpler terms. The AMHP is concerned that that the interpreter may not be using strong enough language to emphasise that this decision is a legal one and it is to protect the patient as well. The AMHP wants to ask the interpreter to back translate exactly (verbatim rendition) how he has put things but is very mindful that to do so might be even more confusing for the Deaf person being assessed.

Potential discussion points concerning the unfolding action:

- Is it appropriate for the interpreter to be part of the discussion with professionals prior to making a decision?
- What do you think about the interpreter acting as the assessed person's emotional support?
- Is the AMHP's request for a verbatim back translation a good solution in that context?
- What do you think the interpreter meant when he suggested the AMHP was using language that the Deaf person would not understand? He seemed to be implying more than a problem of finding the right signs for the words used.

Parts of the guidance that can be drawn on when debating these and other talking points:

- Legal decision making in practice (Part 3)
- Briefing between interpreters and AMHPs (Part 5)
- Key concepts and terms for interpreters (and AMHPs) (Part 6)
- Different types of interpreting, linguistic decision making and representation (Part 7)
- Cultural sensitivity and cultural brokering (Part 9)

Scenario Three: the relative is the interpreter in exceptional circumstances

Background. This assessment takes place in a hospital setting. It is a planned assessment as the person is on Section 2 and a referral has been made for a possible Section 3. All the required people are in place: the doctor, the patient, the AMHP and the interpreter is booked to be there in person. The patient's father happens to be visiting at the same time and is aware the assessment is taking place. The Kurdish speaking interpreter who has been booked is familiar to the patient and the AMHP and has been used before. At the last minute the interpreter calls to say she has to attend an emergency so cannot be there and there is no immediately available replacement in person or by phone. However, a Section 2 lasts up to 28 days and this is the last day. It had been hoped that the person would improve enough to agree to remain informally but the patient's team are unsure, hence the request for a further MHAA. Hence, there is some urgency to complete the assessment that day.

Potential discussion points concerning the background:

- What precautions, if any, could have been taken to avoid this situation?

Unfolding action: The patient since being on the ward has shown some degree of English comprehension and sometimes inter-mixes English words with his own language. Over the past month he has become more used to being on the ward and staff say he has a reasonable understanding of why he is there. He has a good relationship with his father who is very supportive and when the father realised the problem he offers to act as the interpreter. The father checks with his son if he is ok with this and the son looks relieved. The doctor feels it is a good solution and the AMHP on reflection decides it is ok to go ahead because the person is already under Section in any case and does understand some English. The AMHP explains to the patient that they are wanting to renew the Section, but this will mean that the patient will have to some treatment that perhaps they are reluctant to have and will likely stay longer in hospital. The father explains all this, but the AMHP is aware that he has no way of knowing exactly how this is being put by the father. The patient does not visually appear to be distressed and nods his head a lot. When asked if he has any questions he says 'no'. The assessment concludes. As the AMHP is leaving, the father checks what sort of 'treatment' might be required for his son. He says he told him it would just be a few more pills. Was that right? Later the AMHP starts to wonder about the legality of the Section because a nearest relative was used as the interpreter. On the other hand, it avoided some distress and difficulty for the patient and minimised any problems around the patient's ongoing treatment.

Potential discussion points from the unfolding action:

- Do you agree with the AMHP's pragmatic approach to using a relative as an interpreter in this situation?
- Could the AMHP have done anything differently to improve the process given that he had to use the father as the interpreter?
- Is the Section legal?

Parts of the guidance that can be drawn on when debating these and other talking points:

- When and why interpreters (Part 4)
- Different types of interpreting, linguistic decision making and representation (Part 7)
- Governance, accountability and safeguarding (Part 13)

Scenario Four: interpreter mediation and nearest relative

Background. An 18-year-old British woman from a family of South-Asian heritage has been receiving input from mental health services for the last year. Over the last three weeks her mental health has deteriorated and, following a Mental Health Act Assessment, it has been decided to admit her to hospital under Section 3. She ordinarily lives with her parents of whom the mother is the older. This means that under the Mental Health Act the AMHP has to consult with the mother as the Nearest Relative. The mother speaks Hindi but very little English and, in any case, always defers to her husband who also has a much stronger understanding of the English language. The AMHP knows that she is required to consult with the Nearest Relative to check whether there is any reasonable objection to the admission. The interpreter has already been in the house for a number of hours and will need to leave soon. Meanwhile the young woman who is now liable for detention is becoming agitated. The mother and father are both trying to calm their daughter.

Potential discussion points from the background:

- Is there anything in particular that the AMHP should have briefed the interpreter about given this situation?

Unfolding action: The AMHP explains to the mother through the interpreter that she has to ascertain whether she objects to her daughter being admitted under Section 3. The mother replies that she "wants her husband to make the decision". The interpreter tells the AMHP that it is ok because the mother has consented anyway. The AMHP realises that there is a problem with the translation and the interpreter has perhaps substituted consent for objection and does not understand exactly what the AMHP has asked and why. She tries again using a different form of words and asks the interpreter to tell her exactly how he is interpreting the term 'objection'. During the conversation the daughter who has been assessed interrupts a few times and talks directly with her parents and the mother and father converse about their understanding of what is being asked.

Potential discussion points from the unfolding action:

- How could the AMHP have prepared the interpreter better?
- Should the interpreter have been more assertive and explained what the family were finding hard to understand or just kept finding a different way to say it until they did?
- What strategies could the AMHP have used in that situation to ensure that Nearest Relative rights were fulfilled?

Parts of the guidance that can be drawn on when debating these and other talking points:

- Briefing between interpreters and AMHPs (Part 5)
- Key concepts and terms for interpreters (and AMHPs) (Part 6)
- The full patient journey (Part 10)
- Debriefing and care (Part 11)

RESOURCE R3: Details of the simulation videos

Introduction

Four videos simulating various phases of interview stage of interpreted Mental Health Act assessments (MHAAs) are available through this project website. Note that several versions are available of each video:

1) with spoken English only

2) with subtitles of spoken English only; and

3) with subtitles of spoken English and back-translation into English of the other spoken/signed language (which appear in a different colour in the subtitles)

4) English subtitles including subtitles of the translations from other spoken languages plus BSL interpretation throughout.

The videos last around 8 minutes each.

Disclaimer:

Please note that these interpreter-mediated Mental Health Act assessment videos are simulations. They have been created using a scenario developed by the INforMHAA research team. They feature professional actors playing the role of patients, members of the INforMHAA advisory group or research team playing the role of a medical professional, and real Approved Mental Health Professionals (AMHPs) and real professional interpreters. It should be noted that these are scenarios and the AMHPs and interpreters were both directed specifically to ask questions/ make decisions or interpret in such a way that highlights key issues that can arise in these assessments. This is not a reflection of the quality of their skills as AMHPs or interpreters in real practice.

Scenario A: Dutch speaking patient

In the hospital

This is not a planned assessment but one that has arisen as an emergency response to the patient's health and behaviour. The person has already been seen by the Section 12 doctor who was able to carry out their assessment directly as they speak the language of the person and the doctor has left their notes and signed forms and gone. We join the situation after the AMHP and person have been waiting for over 2 hours for an interpreter to arrive. The AMHP has had real problems finding a suitable interpreter and booking them and they have had to settle for a bilingual translator. It is a spoken language interpreter booked via an interpreter agency. The agency has explained that the interpreter will only be available for 45 minutes after which they will have to leave for another booking. The AMHP has decided this is better than nothing as the person t has been waiting so long and does not wish to create further potential distress. The person being assessed has lost contact with their family and is experiencing some auditory hallucinations therefore the AMHP would prefer to have an interpreter in person, rather than a spoken language interpreter via the telephone that could be potentially more confusing for the person being assessed given their symptoms.

- **Dutch videos**

Scenario B: British Sign Language (BSL) using patient

In the patient's home

This scenario takes place at the point when the AMHP is coming to the decision about the outcome after an MHA assessment has been carried out and will have to convey that to the patient about the need to take him to hospital for treatment. The doctor, the AMHP, the person being assessed and the interpreter are all initially present. The person being assessed is deaf and the languages of interpretation are BSL and English.

- **BSL videos**

Scenario C: Kurdish speaking patient

In the hospital

It is a planned assessment as the person is on Section 2 and a referral has been made for a MHA assessment with a view to detain them under Section 3. All the required people are in place: the doctor, the young patient, the AMHP and the interpreter is booked to be there in person. A room has been found off the ward for the assessment, but it is quite noisy. The patient's father happens to be visiting at the same time and is aware the assessment is taking place. The interpreter who has been booked is familiar to the patient and the AMHP and has been used before. At the last minute the interpreter calls to say she has to attend an emergency so cannot be there and there is no immediately available replacement in person or by phone. As a planned assessment this would not have been a problem except that the ward staff have waited until the last minute to run the Section down so they have a better sense of the person's condition and whether they would accept treatment voluntarily. This is not the case. So there is some urgency to complete the assessment that day. The father offers to interpret for his son who is the patient.

- **Kurdish videos**

Scenario D: Hindi speaking patient

At the patient's home

An 18-year old person from an Asian family has been receiving input from mental health services for the last year during which time she had been under a Section 2. Over the last three weeks she has been distressed and, following a Mental Health Act Assessment, it has been decided to admit her to hospital under a Section 3, an assessment that has taken place in the family home that afternoon. The woman ordinarily lives with her parents of whom the mother is the older. This means that under the Mental Health Act the AMHP has to consult with the mother as the Nearest Relative. The mother speaks very little English and, in any case, always defers to her husband who also has a much stronger understanding of the English language. The AMHP knows that she is required to consult with the Nearest Relative in order to check whether there is any objection to the admission. The interpreter has already been in the house for a number of hours and will need to leave soon.

- **Hindi videos**

RESOURCE R4: Guidance on using the simulation videos for training

Introduction

Four videos simulating various phases of interview stage of interpreted Mental Health Act assessments are available through the project website. Note that several version are available of each video: 1) with spoken English only 2) with subtitles of spoken English only 3) with subtitles of spoken English and a back-translation into English of the spoken/signed language (which appear in a different colour in the subtitles) 4) English subtitles including subtitles of the translation from other spoken languages plus BSL interpreting throughout.

Depending on the learning aims of your session, you may or may not wish learners to have access to everything that is being said (e.g., you might deliberately not show the subtitles in order to simulate real-life experience of AMHPs being reliant on an interpreter). You may also show different versions of the same video within a single session to illustrate particular points. The BSL interpreted videos are intended to be fully accessible to Deaf learners.

The video resources can be used for interpreter/AMHP-specific training and joint training. Wherever possible – and based on the INforMHAA team's experience of trialling the resources – joint AMHP-interpreter training will optimise knowledge exchange and learning.

Getting started

Before using any of the video materials, please make it clear to your group that these are learning scenarios and the professionals involved (both AMHPs and interpreters) may not be demonstrating best practice as deliberately instructed at the design stage in order to provide stimulus for discussion.

This document provides a set of discussion prompts and supplementary information in the form of references to the evidenced-based guidance produced by the INforMHAA study and other relevant guidance. The discussion prompts are starting points only and can be adapted to the needs of the learners and reflect local contexts of practice.

Brief Overview of the Four Videos

Video 1
Post-assessment conversation between an AMHP and an assessed person (a Kurdish speaker) with father offering to help with the interpreting in a hospital setting.

This video concerns situations where the AMHP may pragmatically choose to use a relative for interpreting whilst being aware this is not best practice and some of the difficulties that nonetheless may result because of it.

Please note that this video is better suited for AMHP training and is of limited benefit in interpreter training, other than in initial training to illustrate the problems that can arise from using non-professional interpreters.

Video 2
Start of an assessment in a hospital setting with a Dutch speaking person.

This is useful in focussing on the very first stages of the interview where the AMHP, interpreter and person to be assessed are meeting for the first time. In this scenario, the interpreter is not very experienced at participating in MHA assessments and the person to be assessed is experiencing positive symptoms of psychosis.

Video 3
Post-assessment conversation between an AMHP and two Hindi-speaking family members whose daughter (the assessed person) is also in the family home with a spoken language interpreter.

Here the issue of focus concerns interpreting with respect to a nearest relative who does not speak English but whose husband does but is not the nearest relative in legal terms. It focusses in on what the AMHP really requires ensuring her duties are fulfilled and the interpreter who may not be aware of the full significance of this communication and the exactness it requires and why.

Video 4
BSL interpreted conversation in the assessed person's home.

This scenario concerns the issue of voluntary or informal detention as a possible outcome and the AMHP's concern to ensure that this has been adequately explored rather than concluding that a formal section is required. It focusses on levels of comprehension that may be conceptual rather than linguistic and what happens to a complex decision-making process like this if there are deletions in the interpreted message and/or other features of interaction and response that the interpreter or AMHP may be unaware of but are relevant and not communicated.

For a fuller description of each video, please refer to Resource 3.

Using the video resources

The videos last around 8 minutes each. You can decide whether to play them in full or pause for discussion after intervals of several minutes. The INforMHAA team have adopted both approaches to good effect.

Video 1

Discussion prompts

1. General

- Do you think the AMHP is getting what he needs in this scenario?
- Was the AMHP able to fully discharge his legal responsibilities in this scenario?

2. Non-professional interpreting

- What challenges are faced by a family member who serves as an interpreter in such circumstances (emotional, practical, relational)?
- What risks arise for the assessed person when a family member serves as an interpreter? (think about the potential for miscommunication especially with regard to the concept of 'treatment')

3. Handling language repertoire

- It is clear that the assessed person knows some English due to his reactions to the AMHP, but is he at the centre of the discussion throughout?
- What actions could the AMHP take to feel more in control of the communication in this situation? (e.g. think about the need to check English language comprehension of the father in this specialised scenario and how this might be achieved)

4. What happens next?

- The AMHP expresses serious doubts about the meeting at the end of the scenario. What options are open to him to ensure all relevant information is conveyed to the assessed person?

Developing the discussion: supplementary information and guidance for Video 1

Mental Health Act 1983: Code of Practice

Paragraph 4.6 "Where an interpreter is needed, every effort should be made to identify an interpreter who is appropriate to the patient, given the patient's sex, religion or belief, dialect, cultural background and age. Interpreters need to be skilled and experienced in medical or health-related interpreting. Using the patient's relatives and friends as intermediaries or interpreters is not good practice, and should only exceptionally be used, including when the patient is a child or a young person. Interpreters (both professional and non-professional) must respect the confidentiality of any personal information they learn about the patient through their involvement."

Paragraph 14.116: "Unless different arrangements have been agreed locally, the AMHP involved in the assessment should be responsible for booking and using registered qualified interpreters with expertise in mental health interpreting, bearing in mind that the interpretation of thought-disordered language requires particular expertise."

The **INforMHAA** Guidance on **When and why interpreters?** (see Part 4) suggests that:

- It is good practice for AMHPs to be familiar with sourcing and booking interpreters well in advance of when they might need to do so for any given case.
- In the case of BSL interpreters, the duty to provide language access for deaf people falls under the anticipatory duty of the Equality Act 2010 meaning there is a legal responsibility to ensure such arrangements in are in place in advance of them being required. Reasonable adjustments in relation to disabled people is the only anticipatory duty in the Equality Act.

Video 2

Discussion prompts

1. General

- Do you think the AMHP is getting what he needs in this scenario to fulfil his role and responsibilities?
- What do you think about the style of interpreting that is being used?

2. Conflicts of interest

- Do you think the familiarity between the interpreter and the person assessed is having any consequences? (e.g. relational) [NB this question will require learners to have viewed the video with the English subtitles of the spoken Dutch]
- Reflect on the interpreter's decision to ask the patient about her family name: does this raise any ethical issues?
- How can AMHPs navigate potential conflicts of interest or familiarity when working with interpreters who have personal connections to people assessed?

3. Time pressure

- Do you think that (1) the emergency nature of the assessment and (2) the interpreter's limited availability is impacting the approach taken by the AMHP and the interpreter?
- What options are open to the AMHP to take action in mitigation?

4. Safety and safeguarding issues

- Are there any safety issues worth noting in this scenario?
- Was the initial seating arrangement with the interpreter in the middle optimum from the AMHP's perspective?
- What can the interpreter themselves do to prepare themselves and keep safe?

5. Practice enhancements

- What could the AMHP/interpreter do to enhance their practice in this scenario?
- What information might the AMHP prioritise in a pre-brief to support the interpreter and vice-versa?
- How can the assessed person be kept at the centre? Think about the implications of this interpreted assessment for issues of ethics, dignity, respect, and (human) rights.

Developing the discussion: supplementary information and guidance for Video 2

The **INforMHAA** Guidance on **Pre-/Debriefing**: (See Part 5 on pre-briefing and Part 11 on debriefing) suggests:

What might an interpreter want to ask or check in a briefing (examples)?

- Request a short overview of the situation you are about to enter into.
- Disclose whether you have interpreted in MHAs before and share any concerns you might have based on these experiences.
- Agree with the AMHP what action you will take if you have met the assessed person before and how this will be handled in the assessment. Be mindful of the issues arising from the often limited pool of interpreters working with certain language combinations (particularly involving languages of lesser diffusion) and the potential anxieties triggered for service users if you have worked with them in a non-mental health related setting.
- Establish whether any particular safety precautions could be needed (e.g., in relation to clothes, jewellery, note-taking, seating arrangements).

What might an AMHP want to ask or check in a briefing? (examples):

- Establish the interpreter's level of experience in MHA assessments and wider mental health settings.
- Ascertain the interpreter's familiarity with MHA assessments and reinforce their purpose and potential outcomes if required.
- Ascertain the interpreter's familiarity with the AMHP's role in the assessment, reminding them where necessary of key statutory duties they play (e.g. consultation with Nearest Relative; consideration of the least restrictive alternative) and key responsibilities including e.g. the co-ordination of the assessment.

- Discuss the interpreter's confidence in handling commonly used terms in MHA assessments, particularly legal ones. Advise on terms you are likely to use in the assessment and discuss how these might be best explained.
- Ascertain the interpreter's preferred ways of working (e.g., how they handle certain features of talk like disordered speech, seating arrangements, and disclosures about whether they know the assessed person, etc).
- Ask about the interpreter's level of exposure to situations that can be emotionally disturbing. Remind them to be mindful of their own reactions.
- Provide the interpreter with any key points about the mental state of the person being assessed that are relevant e.g., whether they are experiencing hallucinations or are very withdrawn.

The INforMHAA Guidance on Stopping an interpreter-mediated assessment (see Part 8) suggests:

- the time the interpreter has available in this scenario is very limited, to the extent that this may impede a fair assessment process

Good practice:

  - If the AMHP has concerns, then consideration should be given to not going ahead with the interview
  - There may also be a need to stop an interview if matters arise whilst the interview is taking place.
  - The AMHP should ensure that the person being assessed is safe and arrange for a replacement interpreter as soon as is possible.

Video 3

Discussion prompts

1. General

- What elements of good practice are you seeing here with respect to the person who has undergone the assessment?

2. Working relationships

- How would you describe the working relationship between the AMHP and Interpreter in this scenario? Are there ways in which it could be enhanced?
- What sort of topics might the AMHP and Interpreter usefully discuss in a briefing prior to the assessment in this case?

3. Enhancing communication

- What else might the interpreter have done to make the interaction clearer and to support the AMHP in getting across what they needed to?
- Could the AMHP in any way have modified her language/approach in this scenario?
- Do you think the AMHP/interpreter handled the issue of overlapping talk effectively?
- Do you think the AMHP's request for the interpreter to back translate the information conveyed about 'objection' was effective?

Developing the discussion: supplementary information and guidance for Video 3

The INforMHAA guidance on Legal Decision Making in Practice (see Part 3) suggests that:

- AMHPs should clarify that although the ultimate decision-making lies with them, they can also welcome the interpreter's input in relevant areas.
- It is possible that an interpreter may not understand the consequences of the outcome of a MHA assessment. It is therefore helpful if the AMHP makes this clear at the outset and agrees with the interpreter that they understand concepts such as Nearest Relative, consultation and objection, alongside the legal nature of them.

What is very important here is that the threshold requirement concerns 'objection' and NOT that the Nearest Relative 'consents'. These are legally different matters. 'Displace' is a formal legal term that an AMHP seeks to do if the Nearest Relative is objecting unreasonably, so is not appropriate in this situation as it is the mother who, according to Section 26 is the Nearest Relative because of her age but is wishing to defer to the father for cultural and language reasons.

The **INforMHAA** guidance on **Briefing** (see Part 5) suggests that good practice means that AMHPs:

- Invite reflection on the interpreter's experience of how questions are asked in the assessment.
- Remind interpreters that sometimes questions might sound hard but they should not be afraid to replicate the tone.
- Agree with the interpreter how they will communicate during an assessment if the see the interpreter is struggling and what action they will take (e.g. stopping the assessment and booking a different interpreter, if it is safe to do so as discussed in Part 8 Stopping an interpreter-mediated assessment).

The **INforMHAA** guidance on **Types of Interpreting** (see Part 7) states that for good practice:

- An instruction to translate 'verbatim' or 'literally' should be very rarely used as it does not ensure good understanding by all parties.
- It is better to agree in advance with the interpreter key points that must be conveyed during the assessment interview from the perspective of the AMHP so they are fully aware of the significance of some of the AMHP's language/expression. This is best done via a briefing before the assessment.
- The AMHP should try to adopt good practice in their communication style and approach to avoid additional burden in interpretation and comprehension.

The **INforMHAA** guidance on **Safeguarding** (see Part 13) states that for good practice:

- Sharing of information about the person being assessed must be done on a need-to-know basis and their privacy and confidentiality respected. However, it is important to convey some issues to ensure safety and good practice within the assessment.
- Every effort should be made to secure an interpreter in person. A MHA assessment is a complex matter which should enable appropriate communication so that the best decision can be reached.

Video 4

Discussion prompts

1. General

- what evidence (if any) is there that the AMHP in this scenario has good Deaf awareness?
- how effective do you think the seating arrangements are in this scenario?

2. Interpreter decision-making

What are your views on the interpreter's decision not to accept the invitation to be part of the assessment team discussion, opting instead to stay with the Deaf person?

- Is this appropriate? Does it align with their role? (Consider cultural affiliation)
- What are the power dynamics in this? (Should there be power dynamics if it is a team approach?)
- What factors could be driving the AMHP's preference to include the interpreter in the discussion? (For example, potential linguistic/ cultural nuances that might have been missed).

3. AMHP-interpreter interaction

The AMHP expressed concerns regarding the interpreter's choice of language, believing that it is not forceful enough considering the legal context. For example, the interpreter said, 'I told him he should go to the hospital'. Do you think the interpreter accurately reported the conversation between him and the Deaf person? If not, why not?

- Do you think it was justified that the AMHP asked for a back translation or a verbatim account of the interpreter's conversation with the patient?
- What motivated her to make this request?
- How can interpreters ensure both the Deaf person's comprehension and AMHP's satisfaction in this scenario?

4. Handling information that can support AMHP decision-making

During the interview the Deaf person keeps referring to, and interacting with, the picture on the wall, which is relayed by the interpreter.

- Do you think that the interpreter sufficiently conveyed the fact that the Deaf person was suggesting that the picture on the wall was telling him to go to the hospital?
- Did the interpreter understand the significance of the Deaf person repeatedly referring to the picture on the wall?
- What are the implications for an assessment if the AMHP does not pick up that the service user is referring to the picture on the wall?

5. Conveying uncertainty

Towards the end, the Deaf person said they would go to the hospital voluntarily. However, the interpreter told the AMHP they were not sure if the Deaf person fully understood and thought he might be agreeing just to stop the assessment. Should the interpreter have brought up this uncertainty earlier?

- Do you think it was a wise choice for the interpreter to address these uncertainties?
- What ethical and legal considerations arise when deciding when to disclose or not disclose such uncertainties? What could be the consequence of either choice?

Developing the discussion: supplementary information and guidance for Video 4

Regarding Question 1

The **NRCPD Code of Conduct**:

- "You must act in the best interests of the people and organisations that use your services".
- "You must work within the limits of your training, skills and experience".

The **Code of Practice to the Mental Health Act**

- Paragraph 4.2 focuses on effective communication (meeting the assessed person's linguistic and cultural needs). Interpreters must be skilled and experienced in medical/health interpreting.
- Paragraph 14.115 focuses on patients who are deaf and stresses:
  - AMHPs and doctors assessing a deaf person should receive deaf awareness training that includes mental health.

- AMHPs are responsible for booking BSL interpreters

The **INforMHAA** Guidance on **Key roles / Cultural sensitivity and cultural brokering** (see Parts 2 and 9)

- Interpreters' role in MHA is to facilitate communication and minimise their input; however, they can interrupt for clarification and monitor understanding.
- Interpreters are not advocates for the persons being assessed – BUT there is a fine line between advocating and providing information. This is based on moral responsibility being the only person in the room that understands both languages.
- AMHPs can ask interpreters about the character of the person's communication or issues of cultural understanding.
- Interpreters can advise the AMHP if they feel the person being assessed does not understand.
- AMHPs should not ask the interpreter to leave the room to discuss the case with them nor should they offer an opinion on the mental health of the patient.

Regarding Question 2

The **NRCPD Code of Conduct (see weblink above)** states:

6. You must behave with professionalism and integrity.
   - 6.1 You must make sure your behaviour justifies public trust and confidence in you and your profession.
7. You must provide important information about conduct and competence
   - 7.2. You must take appropriate action if you have concerns about the conduct or competence of a communication and language professional you work with.
   - 7.3. must give a constructive and honest response to anyone who complains to you about your services.

The **INforMHAA** guidance on **Types of interpreting** (see Part 7) discusses 'literal and verbatim translation':

- Our research showed AMHPs often ask the interpreters to 'do a literal translation' or 'translate verbatim' and they were concerned that interpreters were presenting a summary version rather than a comprehensive version.

- What is good practice?
  - Agree in advance with the interpreter the key points that must be to get across.
  - AMHPs should adjust their communication style and approach to reduce the additional burden of comprehension on the interpreter.

Regarding Question 3

The **Code of Practice to the Mental Health Act**

- Paragraph 14.118 states that people carrying out assessments under the Act should be aware of how mental health problems present in deaf people.
- Paragraph 14.119 highlights the importance of understanding how signing is presented (to people who are not familiar who could see some signing as aggressive).

The **INforMHAA** guidance on **Cultural Sensitivity and Cultural Brokering** (see Part 9) suggests

- Interpreters can offer information to the AMHP based on something they observed that they feel the AMHP needs to know.
- Work with AMHP to come to a consensus on professional, legal and moral responsibilities to ensure each of their own responsibilities are upheld.

- Good practice
  - Pre and post debriefing (explain potential cultural sensitivities, check how to phrase questions).
  - Report to the AMHP if see anything unusual in the way patient is speaking/signing.
  - Do not offer opinion on person's mental health status but do offer to signpost to appropriate services that could assist with decision making.

Regarding Question 4

The **NRCPD Code of Conduct** (see weblink above) is based on the ethical principles that you should:

- do no harm or, in rare circumstances where causing harm is unavoidable, the least amount of harm;
- strive to do good;
- act justly and fairly;
- be honest;
- keep your word; and
- respect the personal choices of service users.

The **INforMHAA** guidance on **Cultural Sensitivity and Cultural Brokering** (see Part 9) suggests:

  - o Interpreter can offer information to the AMHP based on something they observed that they feel the AMHP needs to know.
  - o Agree with the AMHP before the assessment when to bring up uncertainty.
  - o Work with AMHP to come to a consensus on professional, legal and moral responsibilities to ensure each of their own responsibilities are upheld.

The **INforMHAA** guidance on **Types of interpreting** (see Part 7) suggests:

  - o Our research showed AMHPs often ask the interpreters to 'do a literal translation' or 'translate verbatim' and they were concerned that interpreters were presenting a summary version rather than a comprehensive version.

- What is good practice?
  - o Agree in advance with the interpreter the key points that must be to get across.
  - o AMHPs should adjust their communication style and approach to reduce the additional burden of comprehension on the interpreter.

RESOURCE R5: Developing debriefing skills

Length of session

50 minutes

Method of delivery

in-person or online

Learning Aim

- Familiarise Approved Mental Health Professionals (AMHPs) and Interpreters with the concept of debriefing after a Mental Health Act assessment (MHAA)
- Support good practice in structuring and prioritising topics in a debrief

Learning Outcomes

- Define a debrief and its purpose in interpreter-mediated MHAAs
- Articulate the benefits of debriefing
- Identify what to include in a debrief and how to prioritise topics if time is short

Resource needs

Copies of the debrief scenario / access to a whiteboard or flipchart

Available guidance to support the delivery of the session:

Debrief good practice guidance in associated Part 11 of the guidance document

Evidence from the INforMHAA research paper:

- Young, A., Vicary, S., Napier, J., Tipton, R., Rodriguez Vicente, N., Hulme, C. (2023). Mental Health Professionals (AMHPs) perspectives on interpreter-mediated Mental Health Act assessments. *Journal of Social Work*. **DOI: 10.1177/14680173231197987**

Centre for Culture, Ethnicity and Health (Australia): **Debriefing with an Interpreter (Tip sheet)**.

1. Welcome and outline learning aims

2. Whole group discussion [5 mins]
Define a 'debrief' based on general understanding and experience.

3. Teacher-led contextualisation [3 mins]
Group are alerted to academic research (INforMHAA study) that shows debriefing between AMHPs and Interpreters seldom happens.

4. Whole group discussion [5 mins]
Brainstorming for potential barriers to a debrief.

[possible responses / ideas to include]: lack of time, perception (by interpreters and AMHPs) it is unnecessary, AMHP overlooks role in checking interpreter wellbeing…

3. Small group activity [15 mins discussion]

Groups are given the following scenario:

This has been a very volatile assessment. The person being assessed was experiencing psychosis and has been very loud and physically moving around a lot that has meant the interpreter has not felt safe and also has experienced the person being assessed as aggressive. The details discussed in the assessment have been also very distressing as they concern events in the past that the person has experienced as a refugee. The interpreter's family were also in the past asylum seekers in the UK before settling permanently.

Questions:

1. If you are an AMHP, how would you introduce the idea of a debrief following this scenario?
2. What do you think it should cover – i) from the AMHP perspective and ii) from the interpreter's perspective?
3. If either the AMHP and/or the Interpreter have limited time between appointments, what do you think should be prioritised in the debrief in this case?

4. Whole group plenary [15 mins]

A spokesperson from each group summarises and presents the main discussion points.

Facilitator: Introduce the idea of information from the debrief supporting the AMHPs report writing and creating a record (trace) of issues and discussions that could be useful in the event of an appeal.

5. Whole group discussion prompts [5 mins]

Has this activity changed your mind about the purpose and importance of a debrief?

Do you feel confident in requesting a debrief and knowing what to prioritise in the conversation?

What should be avoided in a debrief?

6. Wrap up [5 mins]

Point participants to guidance on debriefing available on the INforMHAA website and additional resources as a further point of reference.

RESOURCE R6: Further reading

Introduction

To complement our guidance and expand your understanding of the topics covered, this curated list of references serves as a resource to help guide your supplementary reading. It also provides references to the documents internally cited in our guidance. The aim of this annotated reading list is to offer advice to individuals in the field, and organisations engaged in the commissioning of interpreting services, across a spectrum of contexts that may benefit from extrapolating learning about interpreted Mental Health Act (1983) assessments (MHAAs). Whether you are based in the United Kingdom or elsewhere, this collection of references has been designed to enhance your knowledge base.

Each reference within this list signposts to an open-source downloadable document and can be used as a standalone document, providing you with practical, actionable guidance for your unique context. To provide clarity and accessibility, this list is organised into different thematic areas so that individuals and organisations can locate the references that best align with their interests and needs.

MHAA concepts explained

In this section, there is a compilation of resources that are specifically geared toward explaining complex concepts related to MHAAs in an easy-to-understand, "easy read" format.

- **MIND's Easy Read Resources on the Mental Health Act:** MIND is a charity in the UK, dedicated to promoting better mental health by raising awareness. On MIND's website, you can find a dedicated section or resources that explain MHAAs in plain language including patient rights. Here is a selection:
  - Nearest Relative – what powers and rights they have
  - Sectioning – rights that you have if you are sectioned under the MHA (1983)
    The most relevant parts of this guidance are Sections 2,3,4 and 7. Also Section 136 should involve an AMHP (and hence may require interpreters).
- **MHA terminology in different languages** in the resource library of the NHS Cumbria, Northumberland, Tyne and Wear Foundation Trust. This website offers leaflets for information for people who may be undergoing a MHAA, and for their families or other interested parties. They provide leaflets in different languages, here is a selection:
  - Section 2 – Admission to hospital for assessment – in multiple languages
  - Section 3 – Admission to hospital for treatment – in multiple languages

  - o Section 4 – Detention in hospital for assessment in an emergency (in English only)
  - o Section 7 – Guardianship – in multiple languages
  - o Section 136 – Assessment of mental health via a police contact (in English only)
- **MHA terminology and explanations in British Sign Language**

The University of Swansea School of Social Care has created a brief video on introduction to mental health awareness in BSL, which includes an explanation of Section 3

The organisation Sign Health has a BSL health video library, which explain various health conditions, some of which related to mental health

Legislation and Statutory Guidance

In this part we have gathered a toolbox of resources that help unpack the legal side of interpreted MHA assessments. Think of it as your guide to understanding the rules and regulations that govern these assessments mostly from the mental health legislation but also the interpreter provision angle.

These relate to the duties and responsibilities attendant on public services in light of the legal status of British Sign Language and of Welsh.

- British Sign Language (England) Act 2022
- British Sign Language (Scotland) Act 2015
- The Welsh Language (Wales) Measure 2011 – this states that the Welsh language has equal legal status with English and must not be treated less favourably. A strategic framework in Wales More than just words (gov.wales) published in 2016 provides recognition that use of Welsh language is not just a matter of choice but of need. It proposes the 'Active offer' whereby a service is provided in Welsh without having to ask for it.
- Department of Health and Social Care (DHSC) (2018). Modernising the Mental Health Act – final report from the independent review. GOV.UK

Independent Review of the Mental Health Act 1983 this report contains the main conclusions from a review of the current Mental Health Act with recommendations for its reform. To date no reforms have taken place although a draft bill has been passing through Parliament. Suggested reform of the current MHA1983 began in 2017 culminating in a draft mental health bill in June 2022. The pre-legislative Joint Consultative Committee reported in January 2023 and a Government response is awaited.

- Draft Mental Health Bill 2022
- Joint Select Parliamentary Committee on the Draft Mental Health Bill
- Equality Act 2010 – this is the unifying equalities legislation in the UK and professional services must comply with it in the fulfilling of their duties and responsibilities including those under the Mental Health Act

Human rights legislation also guides the fulfilment of duties and responsibilities under the Mental Health Act.

- Human Rights Act 1998
- European Convention on Human Rights

The United Nations Convention of the Rights of People with Disabilities (UNCRPD) – this Convention aims to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities.

Statutory guidance is available to AMHPs and other professionals with powers, responsibilities and duties under the Mental Health Act. It includes information about the provision of interpreting and cultural advocacy.

- Mental Health Act (1983) - Code of Practice
- Mental Health Act (1983) Code of Practice for Wales (revised 2016)
- A separate Code of Practice for Wales was published in 2016 Mental Health Act 1983 – Code of Practice (gov.wales). Paragraphs 1.17, 4.7 to 4.10 and 14.3, 14.107 to 14.109 concern use of interpreters.

Data and statistics

In this part there is a set of data-driven resources that encompass different aspects directly or indirectly linked to interpreter-mediated MHA assessments including the composition of the AMHP workforce, statistics on outcomes and detentions under the Mental health Act according to some protected characteristics (but not by language) as well as general statistics on migration and language use.

- Approved Mental Health Professional (AMHP) workforce produced annually by Skills for Care and Department of Health and Social Care

Data on outcomes and detentions include:

- Mental Health Act Statistics, Annual Figures, 2021-22
- NHS Digital Mental Health Act Statistics, Annual Figures - 2022-23

Migration data includes:

- Migration Observatory at Oxford University. (2024). English language use and proficiency of migrants in the UK
- Immigration statistics – input immigration statistics in the search box – UK government- GOV.UK (www.gov.uk)
- Net migration to the UK, latest statistics by the Migration Observatory

Data on language use in the UK includes:

- Office of National Statistics (ONS) (2022) Language, England and Wales: Census 2021. Statistical bulletin available in ONS website.

Interpreting organisations and Codes of Conduct

In this part we provide links to several interpreting organisations in the UK, the directories to find interpreters linked to such organisations, and codes of conduct that outline the ethical frameworks that interpreters adhere to.

- National Register for Communication Professionals working with Deaf & Deafblind People – Code of conduct
- National Register of Public Service Interpreters (NRPSI) - Code of Conduct
- UK Chartered Institute of Linguists (CIoL) directory 'Find-a-Linguist'
- UK Institute of Translation & Interpreting (ITI) directory 'Find a Professional'

Other practical resources

In this part you can find links to websites that offer practical aspects about working with interpreters that can be helpful to MHA assessments or similar contexts.

- Assessing the need for an interpreter by Centre for Culture, Ethnicity & Health
- Debriefing with an interpreter – by Centre for Culture, Ethnicity & Health
- Good practice guide to interpreting in multiple languages produced by Migrants Organise
- Guide for Clinicians Working with Interpreters in Healthcare Settings developed by the Migrant and Refugee Health Partnership in Australia
- Interpreters: an introduction – by Centre for Culture, Ethnicity & Health
- Language Identification Chart produced by National Register of Public Service Interpreters
- Language Identification Chart produced by Refugee Council
- NHS Inform resources in other languages

Open-source academic references

In this part, you will find a range of open-source academic references, spanning various dimensions of interpreter-mediated MHA assessments and offering scholarly perspectives

- Abbott, S (2022) **A Study Exploring How Social Work AMHPs Experience Assessment under Mental Health Law: Implications for Human Rights-Oriented Social Work Practice**, The British Journal of Social Work, Volume 52, Issue 3 Pages 1362–1379
- Tipton, R. (2016). **Perceptions of the 'Occupational Other': Interpreters, Social Workers and Intercultures**. The British Journal of Social Work, 46(2), 463–479
- Tribe, R., & Lane, P. (2009). **Working with interpreters across language and culture in mental health**. Journal of Mental Health, 18(3), 233–241
- Tribe, R. and Thompson, K. (2022). **Working with interpreters in mental health**. International Review of Psychiatry
- Young, A., et al., (2023). **Mental health professionals' (AMHPs) perspectives on interpreter-mediated mental health act assessments**. Journal of Social Work, 0(0)

INforMHAA – further resources

- Project website **sites.manchester.ac.uk/informhaa**
- Other relevant guidance documents are available through the INforMHAA website: **sites.manchester.ac.uk/informhaa/resources-support**

RESOURCE R7:
Minimum best practice checklist for interpreters in MHA assessments

This checklist has been created to focus on specific practice in the MHAA and aims to assist interpreters when mediating an interview between an AMHP and a person who uses a language other than English. It is a summary of the information available in the previous parts of the guidance. For a full explanation of why these headings are important and what should be included, see relevant parts as indicated.

Heading/topic	Brief explanation	Relevant part of this guidance
Things to check when job request to interpret MHAA is received.	MHAAs are highly sensitive situations so think carefully about whether you have the right skills and experience. Confirm language combination and if you have the appropriate combination/ dialects. Request any information that might indicate a potential conflict of interest. Check the amount of time that has been allocated and whether you would be able to stay longer as complex assessments sometimes need more time. Information can be requested under GDPR guidelines that are essential to the job, but information received must be destroyed as soon as the job is complete. Minority language communities are small, so it could be uncomfortable for the person being assessed if they are familiar with you.	Part 2: Context and key roles Part 3: Legal decision making Part 4: When and why interpreters are booked Part 7: Types of interpreting
Booking confirmed	Establish whether attendance is in person or remote and consider interpreting strategies accordingly.	Part 4: When and why interpreters are booked Part 12: Issues in recording Part 13: Governance, accountability and safeguarding

Heading/topic	Brief explanation	Relevant part of this guidance
Request a briefing with the AMHP	To ensure best joint working practice - check AMHP understanding of role of interpreter, how best to work with an interpreter and any other information they can share so that you understand the nature of interview to come and any aspects of the person's behaviour that you should be aware of.	Part 5: Briefing Part 6: Key concepts and terms Part 7: Types of interpreting
Address any safety concerns	For example, you may need to check seating arrangements, what to do if you feel uncomfortable or distressed at any time.	Part 13: Governance, accountability and safeguarding
Check language understanding	Ask the AMHP if you can check that you understand the language of the person being assessed (and vice versa) before the interview commences. Communicate with the AMHP why this is necessary due to potential dialectical variation.	Part 5: Briefing Part 6: Key concepts and terms Part 7: Types of interpreting
Disclose familiarity	As soon as any familiarity between interpreter and person being assessed is identified, inform the AMHP and then a discussion can be had about whether to continue with the assessment.	Part 9: Cultural sensitivities and cultural brokering
Interpret the interview	It may be necessary to consider stopping the interview if you do not feel comfortable or changing the approach to interpreting – especially if you think that the person being assessed does not understand you. For sign language interpreters simultaneous interpreting is standard practice but due to the sensitivities of MHAAs it may be appropriate to switch to consecutive mode at times to help manage the flow of information. Alternatively, spoken language interpreters should work consecutively as standard practice in this context. Simultaneous interpreting may not be appropriate, but whispered simultaneous could be considered if there is a time pressure and it will not create more distress for the person being assessed.	Part 8: Stopping the assessment
Linguistic and cultural sensitivities	Consider sharing any information with the AMHP about linguistic or cultural information that might be helpful to them in conducting the assessment.	Part 9: Cultural sensitivities and cultural brokering
Request a debrief with the AMHP	So that you can discuss your role as interpreter in the assessment (but not the assessment itself) and to learn for future joint practice.	Part 11: Debriefing
Request a debrief with the AMHP	So that you can discuss your role as interpreter in the assessment (but not the assessment itself) and to learn for future joint practice.	Part 11: Debriefing
Note issues of good practice and/or concerns	Lessons learned and shared.	Part 10: The patient journey

RESOURCE R8:

Reminder to AMHPs of what to include when recording information about an interpreter-mediated MHAA

For a full explanation of why these headings are important and what should be included, see Part 12 of the guidance: Issues in recording.

Heading/topic	Brief explanation
Interpreter used	Yes/No
Which language was the interpreter booked for	May be drop down list or open text
Language preference of the person assessed	Record in own right as a characteristic of the person, not just consequence of interpreter booking
Person's use of language(s) in the assessment	Multiple languages? Differences in expressive and receptive communication Full or partial use of interpreter Only through an interpreter Impairment in fluency in language? Any issues with interpreter or client understanding each other
Professionals' use of languages	Any direct communication in languages other than English? Any competence in comprehension/monitoring of the interpretation?
Name and contact details of the interpreter	For continuity purposes With their consent/consent of the agency

RESOURCE R8: Reminder to AMHPs of what to include when recording information about an interpreter-mediated MHAA

Heading/topic	Brief explanation
Any concerns about the interpreter or interpreting?	Concerns/objections raised by the person being assessed Observations of competency from the professionals involved Concerns raised by the interpreter themselves about the conditions in which they are working Concerns about the legality of the assessment because of interpreting issues
Good practice	Any notes of good practice in the interpreter's working with AMHPs and others
Difficulties encountered in meeting the requirement to provide an interpreter	Practical issues of identification, booking, in person/ remote; timing
Any issues of good practice	Including lessons learned

RESOURCE R9:

Minimum best practice checklist for AMHPs in an interpreter-mediated MHAA

This checklist has been created to focus on specific practice in the MHAA and aims to assist AMHPs when undertaking a MHAA when an interpreter is involved. It is a summary of the information available in the previous parts of the guidance. For a full explanation of why these headings are important and what should be included, see relevant parts of the guidance as indicated.

Heading/topic	Brief explanation	Relevant part of this guidance
The need for an interpreter has been established and language preference of the person being assessed established	If any doubt over whether an interpreter is required err on the side of booking one. Language preference is not necessarily straightforward.	Part 2: Context and key roles Part 4: When and why booking interpreters Part 13: Governance, accountability and safeguarding
Interpreter sourced	Establish whether attendance is in person or remote and consider impact on person accordingly.	Part 4: When and why booking interpreters Part 12: Issues in recording Part 13: Governance, accountability and safeguarding
Inform the person being assessed who the interpreter is	This is courtesy but it also serves to establish whether the given interpreter is acceptable or whether there might be a conflict of interest or pre-existing familiarity that is not helpful.	Part 4: When and why booking interpreters
Interpreter briefed	To ensure best joint working practice.	Part 5: Briefing Part 6: Key legal concepts and terms

Heading/topic	Brief explanation	Relevant part of this guidance
Check understanding	Check that the interpreter understands the person being assessed and vice versa, as there are many language variants and dialects so although an interpreter may be professionally qualified in a particular language it does not guarantee understanding on both sides.	Part 7: Types of interpreting
Interview undertaken	It may be necessary to consider stopping the interview or changing the approach to interpreting	Part 8: Stopping an assessment
Decision making	Consider input of interpreter in clear information sharing.	Part 3: Legal decision making Part 9: Cultural sensitivities and cultural brokering
Interpreter debriefed	To support the interpreter and to learn for future joint practice	Part 11: Debriefing
Record of interview to include use of interpreter and language preference of the person	To include details of interpreter involvement, details of the language, remarks on process/interview.	Part 12: Issues in recording
Note issues of good practice and/or concerns.	Lessons learned and shared.	Part 10: The patient full journey

RESOURCE R10:
Guidance on commissioning interpreting services and working with interpreters in related areas of practice

Introduction

This resource signposts people to written guidance on commissioning interpreting services and working with interpreters in relevant related situations in the UK and internationally. Each resource can be used as a stand-alone document in relation to the relevant activity, but also serves as a useful comparison with, and companion to, the INforMHAA evidence-based guidance for gaining a better understanding for the specific characteristics of interpreter-mediated MHAAs.

All of the resources are free to download and all links were checked on 25.09.2023. They are arranged thematically according to subject area and also professional role.

A. Guidance on interpreting in general mental health settings

For service providers:

Best Practice Guide for Mental Health Practitioners Working with BSL/English Interpreters
(created by Esther Rose Bevan for ASLI 2018)

Good Practice Guide: Working with an Interpreter
(created by Heriot Watt University, revised 2018)

Good Practice in Action Fact Sheet
(created by British Association for Counselling)

Guidelines for Working effectively with interpreters in mental health settings
(Created by the Victorian Transcultural Psychiatry Unit, Melbourne Australia 2006)

For Interpreters:

Mental Health Interpreting Guidelines for Interpreters
(created by Dr Jim Hlavac, Monash University, Melbourne, 2017)

Best Practice Guide for BSL/English Interpreters Working in Mental Health
(created by Esther Rose Bevan for ASLI 2018)

B. Guidance on interpreting for Domestic Abuse victims

For Service Providers:

Guide for Staff at Women's Aid on Working with Interpreters
(created by Rebecca Tipton 2020)

Tips for police on working with sign language interpreters
(created as part of the Justisigns 2 project)

Toolkit and factsheets for service providers and interpreters in domestic abuse settings
(created as part of the Justisigns 2 project)

A Guide for Spoken Language Interpreters Working with Adult Survivors of Domestic Abuse
(created by Rebecca Tipton 2020)

Interpreting in Situations of Sexual Violence and Other Trauma
(Dublin Rape Crisis Centre, Ireland)

SOS VICS: Resources and guidance for Spanish-speaking interpreters
(created by the University of Vigo, Spain)

C. NHS guidelines

For Service Providers:

Guidelines for Working with British Sign Language / English Interpreters in Mental Health Settings (2017)

Guidance for Commissioners of Interpreting and Translation Services in Primary Care (2018)
(Based on a research project co-led by SORD, University of Manchester)

For Interpreters:

Interpreting Guidelines for Psychiatric Assessments
(Sylheti)

D. Guidelines for psychologists

Working with interpreters: Guidelines for psychologists
(created by the British Psychological Association 2017)

E. Guidelines for social care settings

Best Practice Guide for BSL/English Interpreters Working in Social Care Settings
(created by Caron Wolfenden for ASLI 2020)

F. Guidelines for police

ASLI Legal Interpreting Best Practice
(edited by Karen Newby and Jason Weald for ASLI 2015 with input from Heriot-Watt University and Justisigns project)

If you are viewing a printed version of this Guidance, there is a digital version available by scanning the QR code.

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