‘Just interpret’

Problematising demands and controls for effective interprofessional working in statutory mental health assessments

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This article explores the lived experience of signed and spoken language interpreters in the context of Mental Health Act (1983) assessments (MHAAs) in England, based principally on data from 10 interviews from a wider corpus of the Interpreters for Mental Health Act assessments (INforMHAA) study (2021–2024). Informed by Braun and Clarke’s (2022) reflexive thematic analysis and Dean and Pollard’s (2001) Demand Control Schema, the present study investigated the interpersonal demands arising in interpreted MHAAs and the way in which controls are articulated and navigated interprofessionally. The findings reveal adjustments to their practice among a group of experienced interpreters in order to accommodate the interpersonal demands specific to MHAAs, the frames of reference that motivate such adjustments and the extent to which they are consistent with the objectives and practices of assessments under the Mental Health Act 1983. In particular, they help to problematise the principle of the ‘person at the centre’ when language mediation is required and support targeted interventions to enhance interprofessional working prior to, during and after assessments.

Keywords: controls, demands, interprofessional working, Mental Health Act assessments, signed and spoken-language interpreting

1. Introduction

This article focuses on interpreter-mediated Mental Health Act 1983 (MHA) assessments (MHAAs) that are carried out in a community or hospital setting

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as an emergency response to a mental health crisis or as a planned review of an individual who is already being assessed or receiving treatment in hospital, in this case under the MHA in England and Wales. Individuals who are assessed under the MHA experience a unique set of circumstances. In part, these arise from the nature of the severe mental illness they experience and its manifestations in behaviour, thinking, feeling and communication. These manifestations are partially moderated by social, cultural, linguistic and contextual characteristics that are unique to the individual and their circumstances; these characteristics are expressed through a potentially wide range of verbal and non-verbal behaviours. Signed and spoken language interpreters are used to working in a largely predictable participation framework (Goffman 1981) in which the interpreter usually takes every other turn at talk and also in stable communicative environments. But MHAAs often present a radically different set of communication parameters which require carefully considered practice responses and alterations to typically expected patterns of conversation. Interpreters' ability to contextualise and enact appropriate responses, however, is intimately connected to the capacity of co-present service providers to acknowledge and account for shifts in (usually monolingual) interactional practices occasioned by the presence of an interpreter — which, as our wider study shows (Young et al. 2023), can often be overlooked.

Our focus on interpreting in MHAAs cuts across the fields of both social work and mental health, both of which are under-researched in interpreting studies. The many environmental, inter- and intra-personal demands presented by MHAAs and the statutory requirements that govern the way in which they are carried out make such assessments a particularly complex social practice for interpreters. They are distinct from the more usual forms of structured psychological assessment because they involve a narrative component. After (usually) two doctors have assessed whether an individual has a serious mental disorder, a separate component of the assessment is designed to consider whether compulsory detention under the MHA is required. This entails an interview with an individual by a specially trained and approved non-medical Approved Mental Health Professional (AMHP)[1] who seeks to understand the experience of reality of the person being assessed and to determine whether considering all the circumstances of their case they need to be admitted to hospital for assessment and/or treatment *and* whether they are a danger to themselves or others. This is a socially based, purposeful, face-to-face narrative interaction. Yet, the way in which interpreters, when working with AMHPs, identify, articulate and navigate such complexity has

1. AMHPs are professionals in nursing, occupational therapy, psychology or social work who undertake additional specialist training; most AMHPs (94%) are social work professionals (Department of Health and Social Care 2023).

not been systematically studied either in the United Kingdom or internationally, to which our scoping review (Rodríguez Vicente et al. 2024) attests. Our focus is also timely, given the wider context of Mental Health Act reform in progress in England and Wales at the time of writing (UK Parliament 2024).

Drawing principally on data from interviews that capture accounts of the lived experience of interpreters in MHAAs, with specific reference to their working relationships with AMHPs, this study aimed to shed light on interpreter perceptions of practice with a specific emphasis on interpersonal factors — that is, their perceptions of their relationships with AMHPs and the interprofessional working dynamics in encounters. A particular innovation in this study is the application of Dean and Pollard's (2001, 2013) Demand Control Schema — originally designed to support interpreter decision-making *in situ* — to the analysis of interview data in order to ascertain: the particular demands or stressors that are perceived to have an impact on effective (dyadic and triadic) communication; the scope for meta-communication during assessments and/or in pre-briefing and debriefing processes; and the way interpreter decision-making is managed in practice. A strength of our approach is the inclusion of both signed and spoken-language interpreting in a single study, the analysis of which is enhanced by our ability to leverage the expertise of a multilingual and interdisciplinary research team who have professional experience of and academic expertise in the object of study.

2. Background

MHAAs are carried out under the strict provisions of the law in England and Wales (currently the MHA 1983) and they are underpinned by a set of guiding principles contained in a statutory Code of Practice (the Code) which places the assessed person 'at the centre' through empowerment and involvement (Department of Health 2015, Chapter 1). The Code also highlights the need to ensure that provision is made for groups who may experience difficulty communicating, which includes those with limited proficiency in spoken English (Department of Health 2015, paras 4.4 and 14.42). Equality provisions under the Human Rights Act 1998 and the Equality Act 2010 also apply to the practice of MHAAs.

The law sets out that the team of professionals who conduct MHAAs must include an AMHP whose primary role is to make a decision based on a social perspective separate from the medical or psychiatric perspective in order to ascertain whether compulsory detention is the only option for the individual in the given circumstances. The AMHP's role includes a duty to coordinate the MHAA,

to book interpreters where necessary and to interview in a 'suitable manner' (sec. 13(2), MHA 1983). This statutory specification of 'suitable manner' refers to ensuring that the person being assessed has every opportunity to make themselves understood and that their communication requirements are met. The AMHP's coordination role is underpinned by applying the guiding principles of the MHA, including seeking the least restrictive alternative to compulsory admission (Rooke 2020). AMHPs make the final decision, although MHAAs may also entail having ambulance personnel and the police present.

Although AMHPs discharge specific legal duties and have powers and responsibilities that are set out in the MHA, the Code provides very limited practical information on what interviewing in a suitable manner might look like in practice when an interpreter is involved. This limited information, together with the very limited attention paid to the topic in AMHP education and continuing professional development, explains why possible adjustments to the usual monolingual practice can be and are overlooked, as the findings of a survey of AMHPs ($n = 132$) conducted as part of the INforMHAA study using the Qualtrics platform show (Young et al. 2023). A second survey conducted among interpreters ($n = 39$, including partially completed and completed responses),[2] also through the Qualtrics platform, found that 14 interpreters out of the 18 (78%) who answered the question "How would you assess your own competence in interpreting in MHAAs?" self-reported as having a moderate or high degree of competence even if they had not necessarily undertaken specialist training. This suggests that some interpreters view their generic skills as highly transferable between settings and/or they have a good level of confidence in their ability to negotiate their approach with the relevant professional during assessments. The interpreter's performance in providing accurate communication with the person assessed is crucial, as the deprivation of liberty, which can be one outcome of an MHAA, has significant consequences for a person's civil rights (Department of Health 2015: 22).

2.1 Research gap

A review of the interpreting studies literature in the sub-field of mental health interpreting highlights an emphasis on interpreting in therapeutic and coun-

2. The survey was sent to more than 3,000 interpreters registered on voluntary registers (for which a minimum set of qualifications and experience is required for membership). Although questionnaire fatigue cannot be excluded from a population frequently contacted to participate in academic research, the low response rate points to several issues: few have direct experience of MHAAs as a specialist area of practice; and those who do have experience may not be members of the registers contacted and are therefore more difficult to reach.

selling services (e.g., Tribe & Raval 2003; Bot 2005; Vranjes & Bot 2021) and in psychological assessments (e.g., Burdeus-Domingo et al. 2020) as opposed to interpreting in statutory situations in which a person may be deprived of their liberty for their own and/or others' safety. Much of the literature which focuses on therapeutic encounters is about minoritised language speakers who require emotional and psychological support as a consequence of displacement triggered by situations of violent conflict, natural disasters or persecution, especially as defined under the 1951 United Nations Refugee Convention and its 1967 protocol (e.g., Mirza et al. 2017).

The evidence shows that pre- and post-migration stressors often lead to a greater risk to mental health such as depression and post-traumatic stress disorder (e.g., Ezard 2012; Heeren et al. 2012) and that there is an elevated risk of psychosis among refugee populations compared to indigenous and non-refugee populations (e.g., Dapunt et al. 2017). Furthermore, it is recognised that deaf people who use a signed language can experience societal and structural barriers to mental health support, which can mean that they are more likely to experience severe mental health episodes (Young 2021).

Interpreter mediation in psychiatric services has been the object of research internationally (e.g., Daly et al. 2019; Farroq et al. 1997; Rodríguez Vicente 2021; Tribe & Lane 2009; Wand et al. 2020). However, our scoping review (Rodríguez Vicente et al. 2024) examined the available literature for the enablers of and barriers to good practice and the extent to which interpreter mediation supports or impedes the legal rights and best interests of those being assessed. The review found no pre-existing literature on interpreter mediation in MHAAs or on international statutory equivalents in the empirical literature. This means that the implications of interpreting in statutory circumstances are not being systematically recognised or dealt with; moreover, we found only limited reference to the topic in the grey literature. Related to this, whereas academic research reflects a growing interest in service provision to minority language speakers in general social work practice (e.g., Lucas 2021; Pollock 2023; Tipton 2016; Westlake & Jones 2018), our review finds that (the largely) social worker involvement as AMHPs in interpreted MHAAs specifically has not been made the explicit focus of a research study either in social work or in interpreting studies.

2.2 Interprofessional working

Semantics matter when defining the nature of interprofessional practice involving interpreters. Interprofessional collaboration — understood as the ability of professionals to integrate specific interactional, organisational and socio-political factors when navigating complex systems and a willingness to transcend disciplinary

and/or role boundaries (D'Amour et al. 2008) — would misalign with the scope of the interpreter's role in MHAAs. This would be the case because interpreters are not involved in the organisational, socio-political and legal elements of decision-making *to the extent* primary service providers are. The issue of professional norms, the way they are legitimised and whose take precedence (Inghilleri 2005; Tipton 2012), however, indicate that some boundary work (involving deliberate discussion about roles, duties and responsibilities) is integral to meaningful interpreter-mediated service encounters. Its nature, though, will differ from inter-professional encounters that involve people from the same or allied professions (Napier & Karin 2018). We privilege the term 'interprofessional working' here to emphasise the importance of mutual professional curiosity about roles and responsibilities and the agential potential of the interpreter in ways that avoid misplaced assumptions about an interpreter's contribution to decision-making in MHAAs. The reality is that AMHPs have a statutory responsibility but interpreters do not. Using the term 'interprofessional working' does not obviate the need for collaboration, though, which is essential and integral to all interprofessional working, but we do not understand 'collaboration' in the same way as D'Amour et al. (2008) above.

3. Research design

The interpreter interviews were part of a wider mixed-methods study which included the scoping review mentioned above (Rodríguez Vicente et al. 2024), surveys and interviews with AMHPs ($n=17$) (Vicary et al. 2024; Young et al. 2023), AMHP educators ($n=10$) and service users and carers ($n=4$). Our data were also derived from simulated practice involving the video recordings of four semi-scripted scenarios and the reflections obtained from two online transdisciplinary video observation events.

The interpreter interview data discussed here were derived from ten participants who volunteered to be interviewed through an interpreter survey which was conducted during an earlier phase of the study. All ten interpreters who indicated their willingness to participate were interviewed. Within this group, there was a slight imbalance between signed-language interpreters ($n=6$, including one deaf relay interpreter) and spoken-language interpreters ($n=4$).

Regarding geographical location, the sample included representatives from seven out of the nine regions of England; the South West and North East regions were not represented. Regarding the length of time they had been practising as an interpreter, seven of the interpreters reported having more than 15 years' experience and three between 11 and 15 years. Regarding their experience of MHAAs in

community and/or hospital settings, six interpreters reported having undertaken assignments more than once a month in both settings; three reported a moderate level of experience, defined as approximately one per month in both settings, and one reported having had only very occasional experience in these settings.

The interview protocol (Appendix 1) was developed by the whole research team, drawing on the academic literature and survey responses from both interpreters and AMHPs in accordance with the study's overarching research question: How does interpreter mediation impact on Mental Health Act Assessments and how can interpreter-mediated Mental Health Act Assessments be improved? The protocol was reviewed by the project's Advisory Board and by a Patient and Public Involvement and Engagement (PPIE) group.

The interpreter interviews were conducted online in spoken English or British Sign Language (BSL) by two members of the research team (NRV and JN respectively, who are qualified interpreters and researchers); either the Zoom or the Microsoft Teams platform was used for this purpose. The interviews were scheduled to last up to one hour each: the median was 53 minutes. They were either audio-recorded via the selected online platform or video-recorded where they were conducted in BSL. For the interviews conducted in spoken English an automatic transcript was generated that was checked against the recording for accuracy before being anonymised. Interviews conducted in BSL were translated into written English by an independent translation service and the transcripts were redacted and anonymised for analysis. Ethical approval was granted by the University of Manchester, Research Ethics Committee 5: 2021–12163–20436.

3.1 Initial data analysis and organisation

Three members of the team from interpreting studies (JN, NRV and RT) proceeded to a first round of inductive manual analysis. This was designed to segment the data and explore general patterns across the participant responses to the interview questions. It also enabled the team to get a sense of the relative weight participants placed on the different topics — inspired, among other factors, by the initial phases described in Braun and Clarke's (2022) approach to qualitative thematic analysis. This process involved each member independently reading and annotating a sample of three or four interview transcripts before convening to cross-check for consistency between their approaches. Once all the interviews had been annotated, the three members discussed the outcomes to identify overlaps and consolidate the annotations so as to generate a set of high-level themes that would be applied to the data in the next round of analysis (Appendix 2).

When discussing the themes identified through the initial inductive phase above, we noted that there was a strong alignment with concepts outlined in

the interpreting studies literature, in particular Dean and Pollard's (2001, 2013) Demand Control Schema (DC-S). The Schema was initially developed in the context of sign language interpreter education and was designed to support interpreters' decision-making in situ. Its theoretical underpinnings derive from Karasek's (1979) demand-control theory, which is applied to understand the way workers cope with various stressors in the workplace. In particular, it helps interpreters to identify and articulate the demands that generally fall into one of four categories (Dean & Pollard 2013: 5):

1. *environmental* demands, which relate to the setting, such as specialised terminology or physical surroundings;
2. *interpersonal* demands, which relate to interactions between interpreters and their consumers;
3. *paralinguistic* demands, which are about consumer language, such as idiosyncratic speech and pace; and
4. *intrapersonal* demands, which relate to the interpreter, such as feelings or physiological distractions.

The insight that our inductively generated themes and the four-element structure of the Demand Control Schema were similar resulted in a decision to modify further the set of high-level themes to be applied to the data during the next phase of analysis to reflect this integration. This created a thematic structure that was both inductive and deductive in relation to the DC-S.

The interview data were then imported into the QSR NVIVO 12 environment to permit finer-grained data organisation. The integrated set of high-level themes (referred to as nodes in QSR NVIVO 12) was applied to the transcripts by the same researchers — a process also known as 'coding at nodes' (Richards 1999). The process was iterated so that every interview text was coded by each researcher. At that point in the data-organisation process each node serves as a container for text extracts.[3] From the organisation by high-level node a series of sub-nodes was generated and compared between the researchers. These sub-nodes (see Appendix 3) generally reflected a desire to explore and report both the nuances in interaction and the contextual specifics relating to MHAAs. In addition, the team produced a written reflective account of the extracts under each high-level node; they did so in order to draw together some early reflections on clusters of extracts and the discourse practices of spoken and signed language interpreters, and also to make connections with the main research questions of the study. These notation practices occurred outside the QSR NVIVO 12 environment.

3. A single text extract could be attributed to more than one node.

3.2 Development of a data subset for interpretive analysis

Investigating the complexity of interprofessional working in MHAAs from the interpreter's perspective required a sub-set of research questions that were different from but connected to the overarching research aim of the main study mentioned above. The section of the data analysis reported on here was guided by the following two questions:

- To what extent do interpreter accounts of MHAAs reflect the need for adjustments to practice as a response to features such as atypical communication patterns, and understanding of the statutory nature of the encounter?
- What do the accounts suggest about the nature of gaps in knowledge vis-à-vis each professional's role, duties and responsibilities from the interpreter's perspective, and what are some of the implications for effective interprofessional working?

The questions assume a high probability of adjustment in interpreting practice. In part, this is because of the particular characteristics and the specific context of MHAAs. However, evidence from other parts of the research study (e.g., Young et al. 2023) have clearly indicated that the lack of training and evidence-based research guidelines for this specific context leads both interpreters and AMHPs to develop expertise largely experientially. The potential of experiential learning to shape effective interprofessional working is not discounted, but, given that gaps in knowledge and skills can have serious implications for the outcomes of an MHAA, understanding the way in which the foundations of effective interprofessional working are constructed requires that special attention be placed on the practices and perceptions developed through lived experience.

We evaluated the list of nodes and sub-nodes generated for the whole data set to determine which would be included in a sub-set for interpretive analysis relating to the above questions. Our decisions were guided by our primary interest in reported moments of interpersonal contact in assessments, which led to the exclusion of three of the nodes in Appendix 3: training, interpreters negatively affected by MHAAs, and interpreter need for intra-professional support.

3.3 Approach to the analysis

A reflexive thematic analytical approach (Braun & Clarke 2022) guided the research analysis because of the scope it permits to foreground the reflexivity of those carrying out the analysis. This was essential to account for and employ the experiential worlds the team brought to the data: all were practising interpreters, interpreter trainers and Translation or Interpreting scholars.

The interpretative phase of the analysis involved reviewing the research team's reflective accounts and also undertaking a new round of inductive work on the sub-nodes to identify their keyness in relation to the new research concern. 'Keyness', understood here in the general sense of pertinence to the research questions, does not necessarily equate to prevalence in the data (Braun & Clarke 2006). This process helped us to narrow down the relevance within the sub-nodes, but also to focus more closely on the similarities and differences between the participants. It also ensured that we took stock of the extract in relation to its position in the original interview. This helped us to ensure that contextual cues were not being missed or misconstrued and also to facilitate appropriate scrutiny of interviewer influence on the (re-)construction of the interpreters' lived experiences. For instance, our probing clusters of responses about interpreters' feelings (nervousness and anxiety) showed that they were a motivating factor in seeking pre-assessment knowledge exchange and avoided undue emphasis being placed on the writing-up of interactions about interpreter wellbeing in the post-MHAA phase.

The second major influence on our approach to the analysis was the influence of the DC-S framework, which also influenced the development of the nodes and sub-nodes. We anticipated that demand and control formulation would pose a particular challenge to interpreters working in the context of MHAAs. This would be the case owing to the often complex and sometimes chaotic nature of MHAAs, the involvement of multiple parties and the particular pressure they place on interpersonal interaction and interprofessional working — even for interpreters with considerable professional experience in other service settings. Dean and Pollard (2013) found that many interpreters experience difficulty articulating demands to an extent that effectively supports their hierarchisation and their subsequent identification of appropriate controls. One or more controls may be considered to respond to a demand in ethically valid ways. Here, the schema supports their ranking, taking into account the 'constellation of demands' present in any given situation and their implementation, which occurs along a continuum from 'conservative' to 'liberal'. These were relevant concerns in our approach to the data.

The third major consideration in our approach to the data analysis was to tease out the practice frameworks that the interpreters had drawn on when describing their lived experiences in this type of encounter. This was based on an assumption that a certain cognitive dissonance is generated in MHAAs when a practice challenge or 'demand' does not align with the practice developed in other service settings, the normative participation frameworks (interpreters taking every other turn and clearly delimited turns at talk) and their ability to participate (i.e., the ability of parties to communicate coherently and take questions on board).

However, although such dissonance might reasonably have been assumed, the lack of interpreter training generated discursive constraints that needed to be factored in to the analysis. Such constraints were anticipated in the data in the form of 'silences' — for instance, in relation to knowledge about the statutory nature of MHAAs. In this regard, it is important to note that the original interview protocol did not include questions aimed at eliciting declarative knowledge about the MHA/MHAAs directly. This was designed to allow scope for the interviewees to demonstrate their knowledge on their own terms and also to avoid influencing the language they used to articulate such knowledge.

The form, structure and narrativisation of the interpreters' accounts was the fourth consideration in our approach to the data analysis. Whereas the participants' declarative knowledge about the MHA and MHAAs may have been limited or absent, their accounts nevertheless offer discursive affordances for the analyst in the form of interpreters' intuitive or 'lay' descriptions. It was important for us not to lose sight of the fact that experiences are shaped by the practice of the assessing professionals (AMHPs) regardless of whether these are explicitly verbalised or experiences are internalised and articulated later by interpreters using whatever discourse repertoires and points of reference were available to them. Attending to the slippages and approximations in the interpreters' discourse practices therefore supports a nuanced approach to the way interpreters perceive the process of assessment and the practice of AMHPs.

In this study, the limited access to specific training opportunities necessarily led the interpreters to draw on their wider range of training and practice experiences when making sense of interpreter-mediated MHAAs; in other words, their construal of experiences in MHAAs relies on their existing constructed sense of their (professional) self. This meant that the anecdotes which the interpreters recounted in the interviews unrelated to MHAAs but to illustrate wider points were not curtailed by the interviewers. The researchers conducted additional checks on the extracts assigned to relevant nodes to ensure that the verbatim extracts below pertain to MHAAs directly as opposed to other types of interpreting encounter. However, the discussion does take account of the wider professional experiences of the interpreters in their meaning-making process.

4. Findings

The findings of our interpretive analysis have been grouped into four categories for the purposes of presentation. The categories were developed by attending to keyness, that is, the significance of extracts in the context of the new research questions and in MHAAs, and the extent to which they illustrate the demand

– control relationship. This has meant that some of the findings do not reflect prevalence across the data set. The descriptive approach to labelling reflects the porousness between some of the node boundaries. The first three are reported on in this article and the fourth in a separate publication:

1. interprofessional knowledge exchange;
2. adjustments to practice (modality and gesture);
3. assessed person at the centre; and
4. interpreter meta commentary on interaction/features of talk and signing.

The extracted statements from the participants are clearly labelled to indicate whether they are from a spoken or a signed-language interpreter, using the abbreviations Spk-I and SL-I respectively. DR-I indicates a deaf relay interpreter. Each has been allocated numbers that match the project's coding practices.

4.1 Interprofessional knowledge exchange

The findings relating to this category encompass the topics of briefing, asserting communication preferences and interpreter-initiated comments during MHAAs.

4.1.1 *Briefing*

A pre-encounter briefing is often an optimal space for interprofessional knowledge exchange and our data suggest that interpreters experience a considerable amount of anxiety when they enter an MHAA without knowing some basic information about its purpose or the assessed person's general demeanour. At the same time, they acknowledge that briefings can be unreliable, given the mental state of the person being assessed. The following excerpts illustrate the range of concerns that can arise:

> SL-I 34: *Personally, it is important for me to know whether the person is aggressive. Are they likely to kick off?*
> SL-I 35: *I don't know if the language user is BSL or [do] they [use] international [sign language]? have they had a recent trauma? do they see this professional every week? […] do they have a key phrase that they use a lot?*
> DR-I 30: *[Briefing] is actually ethical because we can provide a better service from that initial conversation.*

However, mixed reactions to interpreter requests for a briefing are reported across the data, including the withholding of information:

> Spk-I 28: *They'll say things like 'when you go into the room, when you meet the patient, you'll find out all about it'.*
> SL-I 32: *[AMHPs] just say 'no, we are just going in. I'm not telling you anything.'*

The signed-language interpreter interviews also emphasised that briefings can possibly offer additional benefits such as enhancing deaf awareness among AMHPs, including awareness of the way a deaf person's upbringing and family background can affect their mental health. SL-I 33 highlighted that if a person has grown up in a deaf family, the interpreter may need take additional steps during the assessment to understand certain signs that are being used. Briefing is also reported as being a space in which certain demands can be raised in advance to prevent unnecessary obstacles arising during an encounter. For instance, before sessions with deaf persons, AMHPs could be encouraged to adjust the discourse practices they may commonly employ when assessing hearing persons. SL-I 32 mentions the phrase "what do we hear? voices?" as an example of AMHP discourse practice that is "not reflective of a deaf person's experiences".

Given that the interpreters interviewed had accumulated considerable experience in interpreting in MHAAs, it is perhaps not surprising that the data do not include any reference to briefing as a space in which to acquire knowledge about the MHA or MHAAs. However, five interpreters (both Spk-Is and SL-Is) described their training as learning-on-the-job, which prompted us to probe the data further for indications of how that learning influenced their understanding of the MHA or the MHAA and consequently their understanding of the MHAA as a statutory undertaking. However, the data patterns observed show only very general or indirect references, which made it difficult for us to gauge fully the level of understanding of the AMHP's role and the legal implications of certain terminology in MHAAs.

SL-I 29, in contrast, shows slightly broader insight into the statutory nature of assessments:

> You are in an assessment to determine whether someone's liberties are being taken away from them so they may be sectioned, as a result from the assessment and so, and I have a responsibility to interpret to the best of my ability.

4.1.2 *Asserting communication preferences*

The communication practices between AMHPs and interpreters are shaped by their respective disciplinary and ethical norms; and the manner in which and the extent to which these preferences are verbalised accordingly carry particular importance in MHAAs. The extracts highlight situations in which asserting a preference can be particularly challenging:

> Spk-I 26: *I think it is very, for me, very important, is to, to make sure that they don't address me, but they address the patient […] I still find 'interpreter, I need the patient to understand that he has to ….' What am I supposed to do with that?*

> Spk-I 28: *Despite the fact I am officially [the assessed person's] interpreter, some of [the family members or friends], some of them really difficult ones will just try and take over that role [...] you have to get in there pretty quickly and say, you know, I'm not happy for this to be happening, I can't do my job. And it's quite surprising, actually, that the health professionals don't always stop that kind of thing happening.*
> SL-I 32: *It doesn't seem to matter how many times I said I can't interpret that until [the deaf assessed person] turn[s] around, [the AMHP] still didn't really seem to understand or take that on board, really, I think it was just so out of their experience.*
> SL-I 33: *I'm quite, I'm quite used to telling people to stop talking at the same time.*

As Dean and Pollard (2013: 27) emphasise, the identification of a demand and its articulation are two separate skills, both of which have implications for effective interprofessional working in MHAAs. The extent to which AMHPs and interpreters overlap in identifying demands and, perhaps more importantly, in their articulation of them can influence the way in which controls are navigated and assigned, as our data show:

> SL-I 29: *There can be an expectation sometimes of 'oh, just interpret', but there are some things that don't translate very well, and so I was explaining any problems with any difficulties with the translation, I will tell you what that problem is, and I might offer you a solution.*

The above extract draws attention to an interpreter's perception of an AMHP's efforts to assert a communicative preference and control ("just interpret"), which the interpreter identifies as a demand. In the same extract we observe the interpreter's preparedness for an AMHP to experience uncertainty in the interpreter-mediated situation and the interpreter's professional expertise in helping to articulate the demand that the AMHP may be experiencing. The mention of "I might offer you a solution" is evidence of an interpreter who has developed a repertoire of control options through professional experience that could be explored during the assessment.

The AMHP's request, as reported by the interpreter in this same extract, is likely to be motivated by reasons that are not immediately available to the interpreter when formulating a control. For instance, it could reflect the AMHP's perception of the best way to fulfil a key communicative goal in an interview, namely, that the legal aspects are fully and correctly conveyed. It could also reflect a particular emotion or tone of the AMHP, that is, it may be a sign of frustration if there is a perception that the interpreter has not been interpreting "directly".[4] The

4. For a discussion of 'direct interpreting' see Hale (2007).

interpreter's observation that "there are some things that don't translate very well" is indicative of their perception that AMHPs can struggle to articulate both the demand and the suggested control — a key point being that the AMHP may not know that they are not aware of this possibility (see Young et al. 2023).

4.1.3 *Interpreter-initiated comments (during MHAAs)*

Interpreter-initiated comments are reported in the data in relation to two categories: interprofessional knowledge exchange and assessed person at the centre (see Section 4.3).

One interpreter reports on an interpersonal demand generated when AMHPs assume that the interpreter possesses a certain level of cultural competence, which prompts a control in the form of an interpreter-initiated comment. An example is recounted of an assessed person not making eye contact and the interpreter in question being asked to give an opinion:

> Spk-I 28: *Of course, I had to say, I can't give you an opinion. I think I said something harmless along the lines of 'yes, I noticed she wasn't looking at any of us, she just kept staring at the floor.'*

The choice of control in this case was further qualified by "I can say things like that, but I can't give an opinion about why she is doing it". The fear of being incorrect and unduly influencing the MHAA shaped the formulation of the control, and the interpreter consequently indicated that they would probably have employed the same control even if the degree of overlap in cultural background had been greater.

In other instances, comments are prompted by matters to do with safety and communication breakdown:

> SL-I 29: *I am not responsible for safety and so, if the person being assessed gets angry, starts lashing, I say I will get up and leave and you are responsible for the safety here, and you are responsible for my safety.*
> […]
> *There are a number of reasons why an assessment might break down. And, especially if a patient is really unwell and, sometimes that is what is meant to happen in an assessment, it completely breaks down […], and you need to be able to have a conversation with the professionals in the room to say this is what's going on.*

4.2 Adjustments to practice (modality and gesture)

Data extracts relating to modality and gesture are not prevalent across the data set. But they are elaborated on here as a theme connected to the adaptations inter-

preters make to their practice in the context of MHAAs because they provide insights into control formulation as it affects the interprofessional working.

For Spk-I 26, adopting simultaneous interpreting as a control was prompted by a demand generated during a pre-encounter brief in which the AMHP was reported as describing the person to be assessed as prone to "talk[ing] without stopping". The control was intended to maximise the information conveyed. However, the interpreter acknowledged that it was not necessarily optimal when taking into account the wider interactional situation in which it might prove disruptive for the assessed person and therefore might require further negotiation with the AMHP.

Another interpreter suggested that the employment of simultaneous interpreting and the physical adjustment it requires of the interpreter's position is not always well understood:

> Spk-I 27: *When I asked for that kind of positioning [to do simultaneous interpreting], they get very confused and, I mean, the other professionals get very confused.*

This same interpreter also described employing whispered simultaneous interpreting (i.e., chuchotage) for the assessed person as a control response to a demand in which several professions involved in the MHAA are in the room talking among themselves. The decision to adopt this mode of interpreting — which involves the interpreter being closely positioned to the assessed person and interpreting (whispering) at the same time as the AMHP is speaking — was based on information received through a briefing about the level of physical danger the assessed person was thought to pose. For this interpreter-interviewee, the control meant that it was agreed that the assessing professionals would speak directly to the assessed person instead of the interpreter, therefore minimising the interpreter's visibility. A key point is that speaking simultaneously could create confusion for the assessed person and lead to a violent outburst. We may infer that the interpreter made this decision to mitigate any potential escalation.

This same interpreter also reported adopting another type of control to encourage direct communication (such as eye contact and the use of the first person) between the AMHP and the assessed person, which involved using the consecutive interpreting mode, that is, waiting for the speaker to finish before interpreting and using a radical physical gesture to forcibly direct the gaze of the co-present others:

> Spk-I 27: *You use your hand to direct and I say kind of like, you know, please look at the doctor, look at the patient, don't look at the interpreter. But I don't say don't look at the interpreter, but I just kind of like put my hand out like that [covers her*

> *face with her hand], flat bomb out and sort of you know, direct the gaze, the eyes of the person, to the person, they should be talking to, not to me, the interpreter.*

The interpreter in question described adopting this practice from other general interpreting practice (in this case, in business settings), which entails making a very radical physical gesture in which the face is hidden to a large extent. This participant did not elaborate further on the perceived impact of the gesture or the simultaneous mode of interpreting.

Similarly, an SL-I reported on changing to consecutive from simultaneous interpreting as a useful control in MHAAs, suggesting that it is a valuable tool but with no further comment as to why:

> SL-I: 29: *I think it also depends on the person being assessed, but I think consecutive interpretation is often a tool that is, that can be valuable.*

In signed language interpreting, simultaneous interpreting is more commonly employed than consecutive as one of the languages is silent, which means that there is no audible overlapping talk, despite it being cognitively more demanding than consecutive interpreting. However, it is increasingly being recognised that consecutive interpreting is beneficial in sensitive settings to capturing content accurately and enhancing the management of turn-taking (see Russell 2005; Russell & Takeda 2015).

4.3 Assessed person at the centre

This category encompasses instances where interpreters describe aspects of their work in ways that indicate how their approach to practice and control formulation takes account of the person being assessed. It is important to stress, however, that person-centredness is reflected in the MHA Code of Practice (through an emphasis on empowerment and involvement); its achievement in interpreter-mediated assessments is therefore a salient feature of interprofessional working.

> SL-I: 29: *Out in the community or around a hearing hospital, it can be more difficult and sometimes there is the perception that you are not part of the team. And [AMHPs] don't want to have a discussion. You are there to just to interpret, but we are not there to just, we don't just interpret in a mental health act assessment, because there's a lot going on.*

One Spk-I interview highlighted a control used by main service providers across settings where interpreter mediation is required, namely, a checking strategy based on the extent to which a service user's response appears to align with the

original question. An incongruent response is regarded as a possible problem with the original interpreted question:

> Spk-I 26: *I have been in situations where I was blamed for not interpreting the question correctly, so you know, 'interpreter you didn't'… 'that's not what I was asking'… 'you have to interpret that question correctly' (…) And all I can say is, but this is the answer I've been given.*

This same interpreter reported that the specific nature of interpreting in MHAAs means that they do not always request a repetition of the question. This is because the need to relay to the assessed person what they as interpreters have said to the AMHP can be considered to confuse and hinder communication rather than support it. The established professional norm of the interpreter having to keep everyone informed of what is being said to ensure inclusivity and help to build trust is therefore called into question in MHAAs:

> Spk-I 26: *If I start intervening asking, you know, can you clarify what you mean by this question? and then telling them the patient, you know, I just had to ask them [the doctor] what they meant, it just confuses everybody, and [assessed persons] are in a state where they don't, they don't really know [what] it is.*

Spk-I 28 reported an example of a situation in which they were denied an opportunity to comment on an assessed person's need for an interpreter. The AMHP had determined that as the person had been in the country for 30–40 years, they had no need of an interpreter, prompting the interpreter to reflect, "how come the mental health professionals are making this decision on behalf of the patient?"

In this case, the interpreter had travelled more than three hours to the MHAA assignment, prompting questions about how the chain of decision-making and interpreter booking is navigated. It also brings into question the reliability of the criteria that individual AMHPs use to assess the language proficiency of the assessed person; and in turn it raises the question of how empowered and involved in decision-making about their own care the person has been.

In another example, SL-I 33 expressed uncertainty about whether to draw the AMHP's attention to an assessed person's eye movement: "And I was a bit nervous to say it. Because I don't like to tread on toes", before going on to recount:

> The vast majority of people wouldn't have picked up on it in a million years, but there was something that was off about the eye movement when [the assessed person was] talking. And you know as an interpreter, you know, part of our job is to do … that so much communication comes from the eyes for the deaf person … [it] was just something about it that didn't sit comfortably with me, and I was right.

This interpreter's reflections were prompted by an observation in which the assessed person was describing an accident and making vague references to a partner. The extract shows how some demands are more difficult to articulate than others. Moreover, it illustrates the way in which demands often arise as a "constellation" in which other demands are present, as Dean and Pollard (2013) observe, requiring the interpreter to navigate attentional resources and control options. The interpreter's choice of control (i.e., to make a comment) was prompted by concern at the individual's safety, which, they later reported, and in their view, turned out to be, well founded.

A similar example concerns reports by Spk-I 31 on interpreter-initiated comments being an appropriate control in situations in which an assessed person appeared to have learning difficulties. In the example recounted by the interpreter, the family members present at the MHAA had not disclosed any information to that effect, whether intentionally or not. The interpreter's choice of control to comment on the possibility of learning difficulties was, according to them, prompted by the demand generated by the assessing psychiatrist's verbalised reflection that the person was only suffering from depression.

5. Discussion

The data analysed in this article reflect the experiences and perspectives of a small sample of signed and spoken language interpreters who have considerable experience (measured in years) of professional activity and a high frequency of MHAA-related assignments. The sample showed a high level of motivation to participate, with several interpreters reporting close family experience of assessments and/or professional training and experience in mental health roles involving psychotherapy, counselling and transcultural mental health advocacy. This undoubtedly enhances the quality of their insights, but it also points to the limitations of their generalisability and raises questions about the way in which less-experienced interpreters approach interprofessional conduct when faced with a similar lack of education and training in MHAAs.

Furthermore, the sensitivities of MHAAs preclude the recording of interactions on ethical grounds, which leads to a focus on retrospective reflection on practice, which can be affected by the vagaries of memory. In this case, the interpreters' meaning-making processes at times entailed offering lengthy anecdotes about practice in other settings which, although they enhanced insights into demand and control formulation to some extent, limited the amount of available data directly relevant to the research questions in this study.

The first research question read: To what extent do interpreter accounts of MHAAs reflect the need for adjustments to be made to practice as a response to features such as atypical communication patterns and understanding of the statutory nature of the encounter? In response to this question, this study has shed some light on the ways in which interpreters adjust their practice in the face of the specific characteristics of MHAAs, including the impact of heightened vigilance about their own and the assessed person's safety on their decision-making. For instance, we observed whispered simultaneous interpreting being employed as a control in situations in which assessed persons were expressing themselves rapidly for long stretches at a time and where the interpreter was confident about the information received regarding the (low) threat an assessed person posed to others. The data suggest that some AMHPs are reported to find recourse to this mode unusual. And although the interpreter in question was conscious of the simultaneous interpreting possibly disrupting the assessed person's communication and needing further negotiation, no instances of such negotiation were expressed, perhaps because the AMHPs (and other assessing professionals present) were not sufficiently confident to suggest an alternative. Overlapping talk could generate a problem if an assessed person were experiencing auditory hallucinations; it could also, more generally, place unnecessary pressure on the attentional resources of both the assessed person and the assessing professionals to block out the source speech and focus on the interpreter. Moreover, this example suggests that a need exists in interpreter training to explain in greater detail the perception of 'disruption' and to support interpreters in their thinking about the diverse demands this choice of control could generate for the assessed person, the AMHP and the other assessing professionals present.

Other adjustments to practice in the form of interpreter-initiated comments were identified through verbalisations about the possible nature of mental illness presented by the assessed person that risked being missed by the AMHP. These interpersonal demands generated ethical tensions, namely, that the outcome of the MHAA could be unsound due to the lack of access to all the relevant information. What is striking about the data here — and is perhaps another reflection of the level of experience across the interpreter interview sample — is that, instead of framing a control in relation to abstract conceptualisations of interpreter neutrality, the interpreters' suspicions of domestic abuse and learning difficulties respectively supported the control formulation grounded in person-centred and safeguarding approaches. This was unexpected to some extent because of the emphasis often placed, anecdotally, by interpreters on neutrality as a driver of control formulation. Such neutrality sometimes results in the complete avoidance of interpreter-initiated comments, as was observed, for instance, among some interpreters who attended joint pilot training events as part of the INforMHAA

study. Much of the uncertainty expressed in interpreter accounts of control formation seems to have stemmed from the extent to which, or even whether, in their training, interpreters are advised about handling aspects of safeguarding and managing risk. This is a point that warrants further investigation.

The second question was: What do the accounts suggest about the nature of gaps in knowledge vis-à-vis each professional's role, duties and responsibilities from the interpreter's perspective, and what are some of the implications for effective interprofessional working? The responses to this question are, first, that interpreters clearly seek greater consistency regarding their role visibility and boundaries in assessments and, second, that they seek to possess the ability to influence effective interpersonal working practices. This is illustrated in the reported lack of opportunities for interpreter introductions or briefings and the rebuttals by some AMHPs when interpreters ask to be given insight into an assessed person's condition before an assessment begins. At times, a strong sense emerges of professionals talking past one another and not to one another productively. Consistent with the findings elsewhere in interpreting studies (Pérez Estevan 2023; Sturman et al. 2018), briefing is viewed as essential support for effective interpreter mediation (e.g., framing questions, handling cultural issues) and, in MHAAs, for interpreter safety and their understanding of the statutory nature of an assessment (Young et al. 2023). Briefing could also serve a possibly educative purpose by enhancing AMHPs' awareness of deaf culture. Furthermore, information provided in a briefing may be unreliable; and although this might be the case in other settings, in the case of MHAAs uncertainties that are able to affect interpersonal dynamics in the room and, therefore, demand identification point to the advanced skills required of interpreters relating to the communicative and participatory abilities of all the parties present. Such interpersonal dynamics could include mood changes or the effects of medication and complex family dynamics (including family language dynamics). Time can be tight (see Vicary et al. 2024), however, and a briefing may not even be viable in emergency situations; but AMHP education, supported by the guidance developed as part of the wider study of which this study forms part, should enable a more targeted approach.

Incongruencies in question-and-answer sequences and the repertoire of checking mechanisms employed by AMHPs are highlighted as affecting interprofessional working practices. Some interpreters view these mechanisms as a demand regarding the potential confusion caused by their attempts to clarify information conveyed by the assessed person. This raises the question of the extent to which such situations are resolved. This finding echoes Westlake and Jones's (2018) study on interpreter-mediated encounters involving families (in general social work) in which they concluded that attempts to clarify possible

misunderstandings were often abandoned, leading to important information being missed.

One notable lacuna in the data is the very limited references to situations in which assessed persons are withdrawn and uncommunicative, which is also a kind of disfluent communication. As observed previously, there is a tendency to emphasise content to the neglect of matters that have to do with the paralinguistic demands of pace, tone and so on: a person can make complete sense in what they convey, but the manner of their expression may betray a deeper-level problem. Taken together with the generally opaque references to the MHA in the data, it is important to stress that such observations do not necessarily equate to limited understanding. Furthermore, while it is not necessary for interpreters to be deeply knowledgeable about the technical aspects of the MHA, we nevertheless argue that a certain vigilance is required on the part of AMHPs when they convey key information about detention, which has particular implications for the assessed persons. For instance, interpreters need to recognise the legal weight of terms such as 'objection' or 'nearest relative' and the need to negotiate their equivalents with AMHPs where necessary.

The key practical recommendations deriving from this analysis include:

- Implement a targeted approach to briefing in which AMHPs and interpreters are open about their level of previous experience in working with interpreters or in MHAAs respectively in order to enable them to develop insights into the assessment and interpreting processes, the statutory frameworks and the interpersonal strategies for handling the complexities common to MHAAs.
- Provide support for educators to enable them to develop sensitivity towards interpreter practice and the ability to deal with the possible impact of mental illness on spoken and sign language use.
- Foster greater contextual awareness of the MHA and the role of the AMHP in encounters during interpreter-mediated MHAAs.
- Devote greater attention to the importance of deaf awareness as part of the initial AMHP education and training.

These recommendations have already served to support joint training initiatives for interpreters and AMHPs and the development of educational resources which are likely to be relevant to adult social care services more generally.[5]

5. See the project website at https://sites.manchester.ac.uk/informhaa/informhaa-resources/.

6. Conclusion

Set against the context of reform of the MHA, this study has sought to contribute to increasing understanding of the complexities of interprofessional working in interpreter-mediated MHAAs with a strong potential to inform the adult social care agenda regarding workforce development, initial AMHP education and improved outcomes for individuals from marginalised groups who are disproportionately detained and who do not speak the majority language (UK Government 2023).

This study has also made several contributions to (signed and spoken-language) interpreting studies and practice. First, it has helped to emphasise the value of including both signed and spoken language interpreting in a single study. The insights from both of these modalities helped to illuminate the broad spectrum of demands facing interpreters in interpreter-mediated MHAAs and shed light on the different approaches to and the availability of interpreter education and support structures in a *single national context*. This conclusion is significant for two main reasons: first, it supports the identification of shared demands in relation to interprofessional working and promotes the cross-fertilisation of best practice between signed and spoken language interpreters; second, it offers a comprehensive and timely set of insights for other key stakeholders to consider.

In addition, it demonstrates the added value of interdisciplinary working in advancing interprofessional working practices and, in so doing, adds to calls for such practices to be employed in other public services, such as healthcare (Hlavac at al. 2022) and police services (Mayfield 2016). The interdisciplinary approach employed in the wider study and the writing of this article supported discussion of both the presences and absences in the interpreter interview data, which have been of consequence in developing guidance and training resources as a wider goal of the study. Interdisciplinary insights, for instance, help to tease out what is salient about the absences in the data; and they do so in ways in which the members of the research team based in interpreting studies tended to overlook in the initial phases of analysis.

Regarding the methodology, Dean and Pollard's Demand Control Schema (DC-S) offers a valuable complementary framework to support the interpretive phase of analysis, given the complexity of the demands arising in MHAAs and the challenges facing interpreters in categorising and articulating them and formulating an appropriate control. Its application helps to illuminate the ways in which previous experience influences the formulation of controls. Furthermore, its application generates insights into the interactional dynamics that unfold in those situations in which certain decisions (including controls suggested by AMHPs to guide the interpreter) have led to AMHP — interpreter interaction and

knowledge exchange and in those situations in which interpreters appear to have navigated entirely on their own. Accordingly, we argue that the emphasis on ethically responsible practice as an interprofessional achievement is underplayed; in addition, we suggest that the DC-S as it is framed currently (i.e., with an emphasis on introspection) could go further towards developing interpreter confidence in the choice of control — something that can be highly consequential in the context of an MHAA.

Future research could usefully build on the findings of this study to explore the wider configuration of interactions in interpreter-mediated MHAAs, for instance, by involving AMHPs and doctors and thereby broadening the scope of interprofessional working practice.

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Appendix 1. Interpreter interview protocol

– To what extent has your initial interpreter training and any subsequent CPD prepared you for interpreting in Mental Health Act Assessments?

- If you have any personal experience (family member/friend) with MHAAs, has this shaped your approach to interpreting at all? How?
- What adjustments, if any, have you made to your interpreting practice based on your experience of MHAAs (in relation to assignments in clinical settings/community settings)?
- During an MHAA would you describe yourself as part of the assessment team in terms of your interpreter role? Are you made to feel part of the team and, if so, does this come with any expectations about your interactions and interventions that you do not commonly encounter in other settings?
- If you have a pre-briefing before an assessment, what sort of discussions typically happen? Is there anything that you look to the main service provider to provide in terms of information and support?
- Are you clear on what strategies will be used (by the main service provider and by you as the interpreter) if the person being assessed is highly distressed, unable to speak clearly or fluently?
- What are some of the main linguistic/cultural/interactional challenges you have faced in assessments?
- Have you been asked to interpret for different professional services in the course of a single interaction with a service user (i.e., in the course of one day)? How have the service transitions been handled? Have you ever been asked to "fill in" for another professional on previous interactions and, if so, how did you respond?
- Have you ever been concerned that one of your interpreting decisions has led to decisions taken by other professionals that you did not anticipate (e.g. an under-/over-estimation of the severity of need/situation)?
- Do you typically have scope for a debrief with AMHPs after an assessment?
- Have you ever been frightened or distressed as a result of interpreting in MHAAs? Were you able to access appropriate support (on the day/later on)? What more do you think could be done to support interpreters for this type of assignment?

Appendix 2. List of themes from initial inductive analysis of whole data set

- Learning on the job
- Frequent absence of prior information or pre-briefing
- Lack of deaf cultural awareness among assessing professionals
- Interpreter concerns over physical safety
- Interpreter concerns about impact of MHAA work on emotional wellbeing
- Inconsistencies in the type and availability of interpreter support
- Impact of medication on assessed person in interpreter-mediated encounters
- MHAA interpreting requiring advanced skills and experience
- Need to translate utterances "as they are"
- Lack of opportunity to explain interpreter role or process
- Interpreter involvement in post-assessment hospital transfer
- Interpreter comments on unusual language use or delivery
- Boundary-crossing due to additional skills or professional experience in counselling work

Appendix 3. List of nodes and sub-nodes

High-level node	Sub-nodes
Training	– Need for specialist training – No mandatory training – Experiential knowledge – What to cover in training
Preparation	– Advance information of help – Desired information in MHAA briefing – Person's condition – List of questions to be asked or forms to be used – Continuity or lack thereof in assessment process – Briefing with no service user present – Person's language level – Full vs standby interpreting – Purpose of session – Legal concepts to be mentioned
Interprofessional working dynamics during assessment	– Need for introduction – Explanation of role – Confidentiality – Impartiality – Process – Positioning – Addressing the assessed person – Management of turn-taking – Clarification requests – Consecutive or simultaneous interpreting – Example of the 'consensus meeting' – Enabling communication – Interpreter playing dumb – Dealing with AMHP ambiguity – Gaze – Pronouns – Dealing with disordered language
Perceptions of the interpreter as part of the team	– Welcome input on linguistic issues not available to the AMHP – Interpreter not part of decision-making – Interpreter awareness of being needed

Appendix 3. *(continued)*

High-level node	Sub-nodes
Interpreters negatively affected by MHAA work	– Personal feelings – Lived experiences – Vicarious trauma – Personal safety – Need for debrief – Awareness of own limitations – No line manager (for freelancers) – Delayed effect – Visualisation (heavy topics)
Interpreter need for intra-professional support	– Talking to interpreter colleagues – Supervision – Mentoring
Environmental demands	– Terminology – People talking over each other – Telephone interpreting
Interpersonal demands	– Interprofessional working – Relationships with AMHPs – Relationship with assessed person – Rapport building
Paralinguistic demands	– Accent or dialect – Interpreting non-sensical utterances
Lack of AMHP familiarity with interpreter mediation	– Different structures of language – Multiculturalism – Interpreting dynamics

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