

# VTPU

Victorian Transcultural Psychiatry Unit

## IMPROVING THE QUALITY OF MENTAL HEALTH INTERPRETING IN VICTORIA

JULY 2006

Tania Miletic, Harry Minas, Yvonne Stolk, Diane Gabb,  
Steven Klimidis, Marie Piu, Malina Stankovska

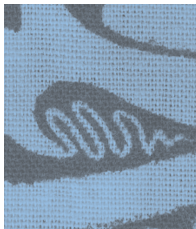
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Victorian Transcultural Psychiatry Unit (VTPU)

Level 2, Bolte Wing, St. Vincent's Hospital,  
Nicholson Street, Fitzroy, Victoria 3065, Australia.  
Tel: +61 3 9288 3300 Fax: +61 3 9288 3370  
Email: [vtpu@svhm.org.au](mailto:vtpu@svhm.org.au) Website: [www.vtpu.org.au](http://www.vtpu.org.au)

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## About this report

*Improving the Quality of Mental Health Interpreting in Victoria* reports the findings of the first component of a two-phase project being undertaken by the Victorian Transcultural Psychiatry Unit (VTPU).

The intent of the first component of the project (Research into training needs in mental health interpreting) investigates the training and professional development activities that are needed to prepare interpreters for work in mental health settings. On the basis of the findings recommendations are made concerning training and professional development programs that would improve the quality of mental health interpreting in Victoria.

The second-phase of the project develops and delivers a brief professional development program for mental health professionals to assist them to work effectively with interpreters. This requires the development of training material and the delivery of training sessions within Area Mental Health Services (AMHS) across the State.

Both phases of the initiative, funded by Victorian Office of Multicultural Affairs (VOMA) and supported by the Mental Health Branch, are aimed at improving the access to, and quality of, mental health interpreting for Victoria's Culturally and Linguistically Diverse (cald) communities.

The objectives of the component of the project reported here are to:


- Assist in the planning and development of curriculum and training materials to prepare interpreters for work in mental health settings.
- Contribute to current work in the area of interpreter training and workforce development.
- Inform future initiatives on the development of mental health interpreting curriculum and the implementation of mental health interpreter training programs to improve the quality of interpreting in mental health services.

The methods employed included:

- Review and documentation of local, Victorian, interstate, national and international information about interpreting practices in mental health, and mental health interpreter training.
- Consultation with key stakeholders to clarify the needs of consumers, mental health services and interpreters regarding interpreting in mental health settings.
- Identification of the specific requirements and considerations of interpreting in mental health settings.
- Development of recommendations regarding the training and support needs of interpreters working in mental health settings, including curriculum development issues.

The body of the project report consists of three sections:

**Part-One: Introduction and Background** considers the importance of interpreting in the provision of mental health services, the available information on issues in interpreting in mental health settings, and information on existing programs and training needs. This section includes: the need for training in mental health interpreting; related mental health



interpreting issues, such as debriefing, the interpreter as cultural consultant and issues surrounding Deaf interpreting in mental health interpreting, and the context of interpreter work and training in Victoria.

**Part-Two: Research Findings from the Mental Health Interpreting Project** reports on the present research findings to provide research information on the training and professional development activities needed to prepare interpreters for work in mental health settings in Victoria. This section includes: Project Methodology, Report on Consultation Process and Research, and the proposed streams for curriculum development and training approaches.

**Part-Three: Conclusions and Recommendations** presents recommendations for the development of curriculum and training for interpreter work in mental health settings in Victoria.

## Executive Summary


Converging (but anecdotal) evidence has indicated that there is a need to better prepare and support interpreters for working in mental health settings, and to ensure that clients and families with low English proficiency receive a high standard of interpreting that facilitates their mental health treatment and care. However, there are limited opportunities for interpreters to access specialist training to prepare for mental health interpreting. The purpose of the current project is to investigate and recommend appropriate training and professional development activities needed to prepare interpreters for work in mental health settings.

A review of existing literature suggests that both interpreters and mental health staff perceive a need for interpreters to receive training to work safely and at a professional standard in mental health settings. A review of local and international mental health interpreting (MHI) curricula and training programs demonstrates that development of a curriculum and training model for Victoria needs to give thoughtful consideration to lessons learned by existing programs. These include the need to develop curriculum and training models that are responsive to the needs of the various levels of professional qualification, training, and experience of interpreters. To meet these professional needs it may be necessary to offer several pathways to MHI training. The need to incorporate issues of interpreter safety and debriefing into curriculum was also apparent, accompanied by development of debriefing protocols and guidelines for mental health staff.

A two-stage project was undertaken, including consultation with key stakeholders and a survey of interpreter practitioners. Key stakeholders were consulted using the Delphi technique, an iterative survey and feedback process designed to achieve consensus. As part of this process two meetings were also held with the 26-member Mental Health Interpreting Reference Group (MHIRG), comprising key stakeholders representing interpreter agencies, Victorian training institutions, interpreter practitioners, and mental health service providers. Individual consultations also were conducted with interstate training providers and a consumer advocate. The consultation findings clarified the specific needs of consumers, mental health staff, training providers and interpreters with regard to interpreting in mental health settings. MHI training was seen as being necessary to improve the quality of mental health interpreting, and interpreter confidence and safety. The most important curriculum topics were considered to be the context of the mental health setting, and technical interpreting issues. The latter topic was particularly recommended by interstate MHI training providers, who cautioned against an undue clinical focus in training.

MHIRG Members expressed commitment to future collaboration in curriculum development. Views were elicited on optimal training program structures, duration, cost, organisational auspice, interpreter incentives, and likely interpreter interest in MHI training, which were incorporated into recommendations below. MHI was viewed as a specialist skill which requires a sound grounding in the interpreting profession. The need for interpreters to receive supervision and/or mentoring was acknowledged, as well as appropriate structures introduced for defusing and debriefing following distressing interpreting encounters.

The Survey of Interpreters' Interest and Need for Training in Mental Health Interpreting was



completed by 64 interpreters, recruited through AUSIT and VicDeaf databases. More than 90% of interpreters expressed interest in receiving mental health interpreting training. Topics preferred by more than 70% of respondents included interpreting in psychotherapy, and in crisis situations, introduction to major mental disorders, and abnormal illness behaviour. The majority acknowledged the need for debriefing opportunities, indicated they had never been offered debriefing, and would prefer to receive it from a mental health clinician. Interpreters indicated the need for mental health services to brief interpreters before interviews and to address interpreter safety issues.

Consumer consultation recommended involvement of consumers in development and delivery of mental health interpreting training to familiarise interpreters with the experience of working with consumers.

The research findings informed the development of a series of recommendations regarding curriculum and training strategies for interpreters working in mental health settings. The recommendations are for four potential pathways to training:

- I. Establish a Mental Health Interpreting Component within an existing course at RMIT University (Melbourne) for interpreters enrolled in NAATI Level 3 training.
- II. Establish a Professional Development Program for experienced NAATI Level 3 interpreters.
- III. Establish an Advanced Course within an Advanced Diploma of Translating & Interpreting, training institution: specialised training for NAATI Level 3 interpreters and above.
- IV. Establish an introductory Mental Health Interpreting component within an existing course at RMIT University (Melbourne) to meet needs of para-professional level interpreters in emerging community languages.

Recommendations are also made regarding curriculum content and development; training administration; funding; rural, regional and systemic issues; an interpreter register; and training of mental health staff. These are all issues that are integral considerations for future initiatives in curriculum and training developments for mental health interpreting in Victoria.

Overall, the project demonstrated that there is renewed recognition that the field of mental health interpreting involves specialist skills, which need to be built on the competencies required for professional interpreting. To enable these specialist skills to be developed all key stakeholders have acknowledged the need to develop relevant curriculum and training programs, and have made clear and feasible recommendations for their development.

The Victorian State Government is committed to improving the current situation of mental health interpreting in Victoria. In order to give substance to this commitment government support is required for development of curriculum and establishment of training programs for interpreters in MHI. In Victoria, with a population characterised by remarkable cultural and linguistic diversity, the provision of high quality interpreting services must be seen as an essential component of the investment in mental health service provision. Such high



quality interpreting services cannot be provided if interpreters do not have the necessary mental health interpreting skills, and if clinicians do not know how to work effectively with interpreters.

## **Recommendations**

### **1. Commitment to Improving the Quality of Mental Health Interpreting**

#### **Recommendation 1.1**

It is recommended that Commonwealth and State Government sources provide funding to higher education and training institutions to establish appropriate mental health interpreting training.

#### **Recommendation 1.2**

It is recommended that the Department of Human Services (DHS) provides funding for the development and delivery of training programs for mental health service providers in working effectively with interpreters and for the development of the necessary print and audio-visual training materials.

#### **Recommendation 1.3**

It is recommended that the DHS provides continuing funding to the Victorian Transcultural Psychiatry Unit to deliver training in working effectively with interpreters to all mental health service providers in the Victorian mental health system.

#### **Recommendation 1.4**

It is recommended that the DHS supports dissemination of guidelines for the provision of briefing and review to interpreters to all mental health clinicians working in the Victorian mental health system.

### **2. Training Programs**

#### **Recommendation 2.1**

It is recommended that DHS integrates into existing DHS language service structures consultation with Mental Health Interpreting Reference Group coordinated by the VTPU.

A number of training pathways will be required to meet the needs of the mental health system and the needs of interpreters.

#### **Recommendation 2.2**

It is recommended that the Victorian State Government supports the establishment a Professional Development Program for existing professional Level 3 interpreters. The development of such a component should begin as soon as is practicable.

#### **Recommendation 2.3**

It is recommended that the Victorian State Government supports the establishment an introductory Mental Health Interpreting component as part of the existing 'Ethics' subject in the Diploma of Translating & Interpreting at RMIT for para-professional level interpreters in emerging community languages. The development of such a course should begin as soon



as practicable.

**Recommendation 2.4**

It is recommended that the Victorian State Government supports the establishment a Mental Health Interpreting component as part of ‘Professional Practice’, a core subject in the Advanced Diploma of Translating & Interpreting at RMIT. The development of such a component should begin as soon as practicable.

**Recommendation 2.5**

It is recommended that the Victorian State Government supports the establishment an Advanced Course in Mental Health Interpreting within the Advanced Diploma of Translating & Interpreting framework. The scoping for the development of such a course should begin as soon as practicable.

### **3. Curriculum Development and Training Program Delivery**

**Recommendation 3.1**

It is recommended that DHS make available financial support for an appropriately qualified full-time Project Officer to coordinate the development of curriculum and training program development and delivery.

### **4. Rural and Regional Issues**

**Recommendation 4.1**

It is recommended that the Victorian State Government makes available to non-metropolitan interpreters the support that will enable them to participate in professional development and ‘award’ training programs in mental health interpreting.

### **5. Incentives to Participate in Further Training**

**Recommendation 5.1**

It is recommended that Victorian Office of Multicultural Affairs (VOMA) makes available a number of full and part scholarships that would encourage appropriately qualified interpreters to undertake training in mental health interpreting.

**Recommendation 5.2**

It is recommended that the Mental Health Branch (DHS) establishes mechanisms that would encourage mental health service agencies to give preference to interpreters who have received training at an acceptable level in mental health interpreting.

# Part One: Introduction and Background

## Introduction

*“Unmet language need is one of the key drivers of social exclusion... and inequity in access to services.”*

(Aspinall, 2005)

Victoria is one of the most culturally and linguistically diverse societies in the world. The Victorian State Government “recognises that the diverse cultural backgrounds, languages and abilities of Victorians provide some of the State’s greatest strengths.” To ensure that all members of the community are treated with fairness and respect, and can participate in the State’s social institutions the Government has enunciated a number of clear principles, including having in place systems and procedures that will enable all Victorians access to Government services and programs free from undue impediment, and ensuring Government strategies and policies are responsive to all Victorians (*Valuing Cultural Diversity*, VOMA, 2002).

Mental health services are among the most complex state services to deliver. The continuing reality of stigma, the pressure of continued increasing demand on area mental health services, and the general social disadvantage and vulnerability of people with mental illness who require these services represent major challenges (Minas et al, 1996; Andary et al, 2003). For people who do not speak fluent English, and who come from a wide variety of cultural backgrounds, seeking and receiving mental health care is frequently a bewildering experience. There is still very little accessible information in languages other than English about mental health and illness, about how to gain access to services when they are needed, and about what to expect of such services.

In the clinical setting the key instrument for assessment and treatment is communication. In the absence of excellent communication between clinician, client and family, high quality clinical work is impossible. Where there are limits in the quality of communication assessment of the nature and severity of the mental health problem, and assessment of risk, will be superficial, frequently incomplete and sometimes dangerously wrong. Where the client has a limited understanding of the explanations given by clinicians and of treatment recommendations, the quality of engagement of the client in the therapeutic process will be constrained. Provision of services that are dependent on excellent communication, such as psychotherapeutic methods, rehabilitation, etc., will be essentially impossible and the therapeutic options are limited to prescription of psychotropic medicines.

For many people requiring the assistance of Victoria’s mental health services communication with clinicians is possible only with the assistance of professional interpreters.

Whilst the Victorian mental health system has taken a leading role in responding to cultural and linguistic diversity in the provision of services, there are continuing difficulties experienced by people from culturally and linguistic diverse backgrounds (CALD) in

accessing appropriate mental health services. Among these difficulties three are particularly relevant here.

1. There is substantial under-utilisation of interpreting services by mental health agencies (Minas, 1991; Minas et al, 1994; Stolk, 1996; Stuart et al, 1996)
2. Interpreters who assist mental health clinicians have not had specific training in the particular skills required for mental health interpreting.
3. Most mental health clinicians have not had any training in how to work effectively with interpreters.

The provision of high quality interpreting services as part of routine mental health practice is both a practical necessity and an ethical responsibility (Minas, 1998).

There is a need to prepare and support interpreters for working in mental health settings, and to ensure that clients and families with low English proficiency receive a high standard of interpreting that facilitates their mental health treatment and care. However, there are limited opportunities for interpreters to access specialist training to prepare them for work in mental health settings. The present research sets out to review the current information available on interpreter training in mental health interpreting, and the training needs and curriculum and program development needs related to establishing such training for interpreters in Victoria.

## Background

*“We strongly believe that no matter what language you speak or whatever your cultural background, you should have the same access to government services as every other Victorian”,*

Minister Pandazopoulos, Minister Assisting the Premier on Multicultural Affairs, 2003.

The VTPU works at the interface of ethnicity, culture and mental health, embodied in education and professional development programs, research and policy development towards improving the quality and accessibility of mental health services to Victoria’s immigrant and refugee communities. In addition to the training of mental health services staff to work effectively with interpreters, the training of interpreters who will find themselves working in mental health settings is of equal importance in improving mental health interpreting within Victoria’s mental health settings.

### **i. Need for Training in Mental Health Interpreting**

The following two sections are largely based on a paper by Yvonne Stolk and Diane Gabb, entitled *Professional Issues in Mental Health Interpreting*, presented in October, 2004, at the Power to the Profession Conference convened by the Australian Institute of Translators and Interpreters (AUSIT).

The need for a specialist training program in mental health interpreting and for a procedure that enables interpreters to receive debriefing when they have interpreted traumatic material

is evident. The nature of interpreting in a mental health setting is considered a highly specialised professional undertaking, presenting “particular interpreting challenges” (The Allen Consulting Group, 2002, p. 12). This is evidenced by the one-time existence of the Mental Health Interpreting Service, and the specialised 6-week training program based at Royal Park Hospital that mental health interpreters were required to undertake. However, in the early 1990’s the Mental Health Interpreting Service and Central Health Interpreter Service (CHIS) training program ceased, as did several specialised services with the assumption that generic skills were sufficient. That this assumption is flawed has been shown by the mental health services’ recent acknowledgment that specialist mental health professions have something to offer beyond what is offered by generic case managers, and by some of the experiences of VTPU staff and Ethnic Mental Health Consultants (EMHCs) with interpreters in mental health settings. At present, only limited formal research has been conducted on these issues.

The demonstration of the need for a specialised mental health interpreting course is provided by a number of sources. In 2000 the Victorian Interpreting & Translating Service (VITS) requested two EMHCs to arrange professional development on mental health interpreting to VITS interpreters by the VTPU. Ultimately this request was not met because of a lack of time to undertake the focused curriculum development that was required. RMIT University has in the past advised that their Advanced Diploma of Interpreting and Translating for Professional Level NAATI accreditation does not include a specific focus on mental health as the course covers approximately 10 domains, of which mental health is only one. According to RMIT University sources, interpreters who have graduated would be expected to obtain specialist training if they want to focus on a specific area such as mental health. In Victoria, such training is not available. There are specialist training courses in other states:

- The NSW Institute of Psychiatry runs a four full-day course over four weeks titled ‘Mental health for health care interpreters, ethnic health workers and bilingual counsellors’ (NSWIOP, Course Handbook, 2005, p.36). The course is long-established and was developed by the NSW Institute of Psychiatry, and continues to be administered and delivered through NSWIOP.
- The Queensland Transcultural Mental Health Centre (QTMHC) has an 8 week (32-hour), Mental Health Interpreting course (QTMHC, Education & Development Handbook, 2002, p. 18). The curriculum was developed by the QTMHC and is mostly delivered by QTMHC staff member/s. The course and curriculum have been recently revised and the course is scheduled to recommence later in 2005.
- The Western Australian Transcultural Mental Health Centre (WATMHC) and TAFE partner run a course in Mental Health Interpreting comprising 3-hour sessions over 10 weeks. The curriculum was developed and is jointly administered by WATMHC and Central TAFE, WA. The curriculum is delivered by mental health clinicians on different mental health area topics, whilst tutors are interpreter practitioners.

There are no such training courses for interpreters on mental health interpreting in Victoria.

Within Victoria, evidence for curriculum development and training needs come from research and anecdotally from mental health staff. What follows should be prefaced with an acknowledgement that many mental health staff lack the competence to work effectively and collaboratively with interpreters, and the VTPU offers training to address this issue as a part of its mandate to mental health clinicians. It is also acknowledged that mental health terminology is very challenging to translate. The interpreter may be used to medical jargon, but mental health jargon may be unfamiliar. Moreover, working in a mental health setting can be disconcerting to the uninitiated. If interpreters have never worked in mental health settings they may be anxious about the people and experiences they may encounter. The stigma towards mental illness that exists in most communities may have influenced interpreter attitudes and expectations, so that interpreters are uncertain about what may transpire during the interview. These views of discomfort in the mental health setting are supported by the recent Survey of Interpreting Practitioners (VITS Language Link, 2004), which found that 11% of the 150 respondents indicated that they preferred not to work in a mental health setting. Some reasons quoted included:

“...while in the waiting room I am alert all the time.”

“Don't like crazy people.”

“...lack of training and familiarisation with the area” (VITS Language Link, 2004, p. 26).

Some interpreters were distressed and stressed by mental health encounters:

“Just too stressful at times! And heart- breaking. At times I would feel very sorry for patients and would think about them for a long time and at times I would feel scared a little” (VITS Language Link, 2004, p. 26).

Others felt that the work was too demanding and insufficiently paid. The issue of remuneration and priority in mental health bookings for those interpreters who had received such training is an important issue for consideration.

Consequently reports from mental health staff of less-than-optimal behaviour by interpreters, need to be understood in the context of a lack of mental health interpreting training and familiarity with the mental health field, together with inadequate support mechanisms.

Anecdotal evidence for the need for training in mental health interpreting comes from the 11 Bilingual Case Managers (BCMs) who are employed in four Western Region mental health services. The role of the BCMs is to increase access and equity in mental health service delivery to ethnic communities. They are expected to have proficiency in their nominated language, and when recruited this is verified through an interview with an interpreter or other BCM. When a BCM jointly interviews a client with a monolingual staff member, an interpreter will be engaged, as the BCM cannot interpret and fulfil her/his clinical role at the same time. It is on these occasions that BCMs have sometimes reported that interpreters have interpreted inaccurately, added or omitted comments, or given the client advice. Only bilingual staff can detect problems in the accuracy of interpreting, as

the quality of the interpreted message cannot be determined by the mental health professional and consumer.

Other issues have also been raised by mental health staff during training in how to work collaboratively and effectively with interpreters. These trainees report that some interpreters show inappropriate behaviour such as over-involvement with the client, or embarrassed laughter at something the client says, or negative attitudes to symptoms the client describes or shows. These attitudes may be due to anxiety and lack of understanding, and insufficient training. Mental health staff also sometimes complain that some interpreters are unable to interpret something 'word for word.' Past training by the VTPU and Ethnic Mental Health Consultants has been designed to educate staff in the notion that other languages are not exact translations of English, and therefore a 'word for word' interpretation is often for linguistic reasons just not possible or appropriate.

Furthermore, there exists a recognition of the need for interpreters and mental health staff to be trained in a way that promotes and clarifies professional roles and team work. Interpreters are often seen by mental health services staff as someone there to be 'used', rather than 'worked with', and often mental health professionals are unclear of the professional role and task of the interpreter. Interpreters can be both disregarded or asked inappropriate requests regarding the client, their illness, culture or communication beyond their professional parameters.

In response to the diverse sources of concern regarding mental health interpreting, the Interpreter Mental Health Training and Debriefing Working Group was set up in 2003 to determine the need for and interest in developing a training program. This Working Group comprised several key stakeholders across interpreter agencies, and mental health service providers<sup>1</sup>. It was clear from preliminary meetings that there was interest in developing training and debriefing strategies. Yet despite this marked interest, the lack of resources and structure to investigate and develop training for interpreters and clinicians in mental health interpreting meant that these efforts were not able to realise proposals at that time.

In spite of the relative paucity of information on mental health interpreting, what does exist reveals clear local and international support for the existence of training for interpreting in mental health settings. There is also a developing body of research and experience that promotes a more inter-professional 'team' model for mental health interpreting training and practice.

Support for the need to develop specialised mental health interpreting training has been reported by a Canadian hospital-based research unit. In their report on the evaluation of the Cultural Consultation Services in mental health in Canada, Kirmayer and colleagues, (2001) identified gaps in the delivery of mental health care to refugee, indigenous and immigrant communities, such as language barriers to access and adequate care. Kirmayer et al. (2001) found that improved quality of care was achieved through specialised teams in transcultural psychiatry, which included interpreters. Amongst the approaches to meet the gaps in equitable mental health care delivery, the 'transcultural teams' used a pragmatic approach to communication barriers that emphasized the use of interpreters and

<sup>1</sup> Past stakeholders involved were the mental health services of North Western Mental Health and the Werribee Mercy Mental Health Program, the Victorian Foundation for Survivors of Torture (VFST), and other contributors and interested parties included the VTPU, AUSit, VITS, NAATI, TIS, the Victorian Deaf Foundation and the now-defunct Central Health Interpreting Service.

cultural brokers. Interpreters were integrated into teams as partners in the assessment and treatment process. To ensure transferability of the model, the research recommended *“the ready availability of a stable pool of professional interpreters, which allows the clinical team to develop a mutual collaboration. Ideally, these interpreters should have specific training in mental health”* (Kirmayer, et al., 2001, p.5).

The research also indicated explicit implications for policy and practice and whilst these were focused on training needs of mental health clinicians, the complexity of the interpreting task in mental health settings was emphasised: *“Interpreting in the context of mental health care is especially demanding because of the technical need to transmit not only the gist of what someone is saying but its precise form and quality (set against a backdrop of cultural norms) in order for the clinician to access the patient’s mental status. Mental health interpreting also involves emotionally intense and challenging situations that may affect all participants. Interpreters need additional training in mental health as well as supervision and support to work with potentially distressing or traumatizing situations”* (Kirmayer, et al., 2001, p.8).

With regards to the role of ‘cultural brokers’ in clinical consultations, Kirmayer and colleagues (2001) recognise the need to *“define and train interpreters... for an extended role as cultural brokers which would require addressing specific ethical issues that challenge the narrow role currently assigned to interpreters”*.

In his paper “Working with an interpreter in psychiatric assessment and treatment”, Westermeyer (1990) emphasises that the interpreter requires specialised knowledge and skills to be able to undertake the task of mental health interpreting, such as understanding denotative versus connotative interpreting for ensuring the message and emotional content are interpreted as well as the need to train from the model of ‘interpreter as colleague’ within a team.

In South Africa, Swartz and colleagues (1998) in their book *Culture and Mental Health* have emphasised the need to develop models of interpreter-clinician roles in mental health settings that encourage more effective team work in mental health settings for clinicians and interpreters. The model they developed views the interpreter within a ‘junior colleague’ model for working with interpreters. This approach addresses the need for training interpreters and clinicians using a more collaborative or ‘collegial’ model<sup>2</sup>.

According to Swartz (1998): *“Viewing the interpreter as a colleague involves recognising the skills the good interpreter brings to the interview and using these skills in a team approach, where the interpreter’s opinion form part of the team judgement about the client. ... The case may be discussed with the interpreter both before and after the interview. At specific points during the interview the clinician and the interpreter may wish to discuss what the patient is saying and how to approach the rest of the interview.”*<sup>3</sup>

Components of the model include: a pre-interview case discussion between the clinician and interpreter; planning the interview process; the clinical interview; post-interview discussion between clinician and interpreter; and debriefing of the interpreter<sup>3</sup>.

<sup>2</sup> Swartz, L. (1998). *Culture and mental health: A southern African view*. Capetown: Oxford University Press.

<sup>3</sup> Cited form: Turner, G. (2003) *Working with Mental Health Interpreters*, *Translinks*, 25, QTCMHC: Brisbane.



Turner (2003) of the QTMHC developed a curriculum which builds from the work of Swartz and others. Turner (2003) in his article, *Working With Mental Health Interpreters*, views the 'interpreter as a colleague' model in the mental health setting as a very appropriate model of interpreting in mental health settings.

Pollard (1998) at the Department of Psychiatry, University of Rochester in the U.S.A. developed a comprehensive curriculum titled *Mental Health Interpreting: A Mentored Curriculum*. The course, comprising curriculum and videotape of interpreting vignettes and facilitated workshops, is aimed at interpreters who occasionally or frequently work in mental health service settings. The model espoused by Pollard (1998) is that of a mentor-trainee model, whereby the mentored-curriculum is designed for use in a learning setting involving an interpreter-trainee and an experienced teacher or mentor setting.


The above-mentioned researchers and training providers offer developments in curriculum and models for training and practice for interpreting in mental health settings. There are other examples of current professional development sessions and workshops, which appear to target more specific interpreter groups and work environments. For example, in the U.S., the Alabama Department of Mental Health and Mental Retardation, offers a one-day training session called "*You Can't Live It- You Can't Live Without It*" *Mental Health Interpreting*<sup>5</sup>, which states that it is designed for interpreters experienced in interpreting in the mental health setting, to introduce mental illness, mental health teams, settings and treatment approaches as well as linguistic and interpreting issues, vicarious trauma, self care and ethical considerations to interpreter trainees.

Also in the US, the University of Minnesota, has developed a Video Cassette Training Program series with a single session focusing on *Interpreting in refugee mental health settings*<sup>6</sup>. The brief (33minute) video provides an overview of the interpreter's role in mental health care, detailing the kinds of skills that interpreters must have. The need for planning language interpretation services is highlighted, with special focus on the risks involved in using untrained interpreters, the complexities of the interpreting process, and the ethical and interpersonal issues involved. The special aspects of interpreting in mental health care settings are highlighted in contrast to interpreting in other settings.

Another targeted training program shows an attempt to meet the unmet demand for interpreters in South East Asian language groups. The Twin Cities Interpreter Project (TCIP), based in Minneapolis and St Paul, USA, presents a model of intensive training over 130 hours which resulted in a new cohort of South East Asian interpreters from varying educational and linguistic starting points. This was achieved with a training team consisting of health care professionals, accredited interpreters, ESL teachers and bilingual tutors. The program aimed at improving speaking skills, explaining cultural differences, general and clinical vocabulary building and providing an opportunity for engaging in the discourse of mental health by actually experiencing mental health settings and getting to know the staff. Standards of professionalism were reported as enhanced by providing a means of self-assessment, together with opportunities to explore the role of interpreter and its ethical implications (Schweda Nicholson, 1994).

<sup>5</sup> Hamerdinger, S. (2005) Director of the Office of Deaf Services, Alabama Dept. of Mental Health and Mental retardation. See: [www.ncpublicschools.org/ec/exceptionality/deaf/interpreters/training](http://www.ncpublicschools.org/ec/exceptionality/deaf/interpreters/training)

<sup>6</sup> Benhamida L, Downing B, Egli B, and Yao Z (1988), Video Cassette Training Program: Interpreting in refugee mental health settings . University of Minnesota, USA.



From the present review, although not exhaustive, it is apparent that curriculum development and training considerations are influenced by the aim of the training program (target group, consumer needs, content scope and professional level), the profession responsible in developing and administering the program (mental health service, interpreter training provider, etc), and the level of curriculum development (resources, understanding of curriculum development issues and requirements, level of input from interested parties, key stakeholders, etc.) and the level of support the program has (financial, institutional, administrative, etc) amongst other considerations.

## **Related mental health interpreting issues**

In reviewing interpreting practices in mental health and information on mental health interpreting, several important related issues need to also be discussed, such as, Debriefing; Interpreter as ‘Cultural Consultant’; and Deaf Issues in Mental Health Interpreting.

### **i. Debriefing**

An issue that is indirectly related to interpreter training for mental health interpreting is that of debriefing. Debriefing can be described as a structured discussion conducted by a trained peer. It provides an opportunity for staff to talk through facts, thoughts, feelings and reactions to a critical incident or distressing experience that occurs during their regular work. An interpreter may need debriefing when they have interpreted in an interview where distressing or traumatic material is discussed, or where there has been violence, self-harm or difficulties in calming someone or a family in crisis. One reason proffered for not wanting to work in a mental health setting mentioned in the VITS Survey was that “No debriefing [was offered] afterwards” (p. 27). A need for debriefing could also be inferred from the comment above that the interpreter “would think about a patient for a long time and feel a little scared”.

The need for debriefing is likely to be high when an interpreter interprets for a refugee or asylum seeker client who recounts the terrible experiences that led to becoming a refugee especially if that interpreter has had very similar experiences. The interpreter may then vividly re-experience similar past events that he or she witnessed or underwent (Lipton et al., 2002). In in-depth interviews with 15 interpreters, Lipton and his colleagues in Western Australia (2002) found that many interpreters reported that they had interpreted in situations which left them feeling quite distressed, and those who themselves came from war-torn countries showed signs of vicarious traumatisation. Through anecdotal experiences with interpreters from refugee backgrounds, the VTPU have found that the majority of interpreters reported that they were usually not briefed before a session to enable them to mentally prepare themselves for unpleasant information that might be discussed during the session.

Unlike mental health professionals, interpreters do not receive training and supervision that provides them with the support needed to process distressing information and, importantly, that enables them to set professional boundaries. Interpreters may be required to repeat

“detailed descriptions of torture and trauma that may necessarily emerge as part of the therapeutic process” (Lipton et al., 2002, p. 3). In this process they must “not only listen empathetically ... but they are also required to repeat it, often finding it necessary to locate language that will appropriately transmit the client’s meaning ... without adequate time for processing the details” (Lipton et al., p. 3-4). This indirect experience of another’s trauma is recognised as potentially being associated with vicarious traumatisation (Lipton et al., 2002). Interpreters may feel overwhelmed by the material they must translate, or fear becoming overwhelmed (p. 3), but at the same time they believe that requirements of confidentiality prohibit them from seeking personal support. They also may feel a sense of powerlessness as they had entered the profession with altruistic aspirations of assisting their compatriots (Lipton et al., 2002). It is pointed out too that interpreters who are traumatised are at both physical and psychological risk, but many of the interpreters surveyed had no understanding of these risks associated with their work. For these reasons Lipton et al. (2002) argue that the mental health system has a duty of care towards the interpreter.

The area of forensic mental health is particularly problematic. It can be very difficult for forensic mental health services to retain interpreters because the nature of the work involves hearing the details of mentally ill forensic patients and their behaviour toward their victims, who are often family members and children or innocent members of the public. This type of clinical investigation inevitably conjures up disturbing images which are very difficult to dissipate from the mind without the provision of professional supervision. The result may be ‘vicarious traumatisation’ where the person is affected by the details and images to the extent that they intrude into thoughts at any time, overtake daily life, affect sleep, create anxiety and fearfulness, and may affect the person’s personal relationships. This may be particularly so in the case of a sexual crime and the accompanying explicit forensic investigation.

There are clear procedures in place in mental health services for mental health professionals to receive debriefing if they have experienced psychological trauma as a result of their work with clients and families (Better Health Channel, 2004; Debriefing Program, not dated). These procedures have been implemented to enable staff to cope with their emotional reactions, which, if not dealt with, may result in quite disabling psychological symptoms. The Ethnic Mental Health Consultant’s enquiries in 2003 suggested that mental health service policy does not extend these procedures to interpreters. This may reflect the relatively invisible status of interpreters in mental health services: whereby the interpreter’s role is seen as merely ‘a conduit’ or ‘a mouthpiece’ between the communicating parties. This can be from both the interpreter’s own perspective and that of the mental health clinician. This position is backed up by a theory of interpreting which “defines the interpreter as a language facilitator between two or more parties who does not otherwise participate in the communication” (De Jongh, 1991). If we subscribe to this idea, we are of course guilty of dehumanising the interpreter whose heart and mind is always present, despite the expectation of professional distance. Interestingly from a legal perspective, all parties present, including the interpreter, are considered to be intricately

involved in the verbal and non-verbal messages transmitted (Eades, 1994). In training mental health staff the VTPU staff emphasise the nature of the professional role interpreters play, while at the same time encouraging them to consider the need for debriefing interpreters to help maintain that professionalism. This has been particularly pertinent for those interpreters who are members of newly arrived communities where there has been no opportunity or time for the lengthy training required for accredited interpreters to emerge, and who have not established external professional supports for maintaining professionalism. Instead, in order to keep functioning in the interpreter role, despite exposure to potentially harming accounts, some individuals may in desperation turn to their families for debriefing and support, which may result in a loss of confidentiality.

The term 'debriefing' requires some clarification, as what constitutes debriefing is often varied and dependent on the context and person using it. A distinction should be made between what might be called review, and the formally-named processes of defusing and debriefing (Better Health Channel, 2004). The clinician should conduct a review with the interpreter following the interview so that they can discuss whether there were any linguistic or other problems in relation to the interpreting task. Unfortunately, because many mental health staff do not know how to work effectively with interpreters, the review interview often does not happen. During the review the clinician should determine whether the interpreter was distressed by anything that occurred in the interview or encounter, and if so, defusing should be offered at that time. Defusing is a kind of emergency intervention that allows the person to talk about their experience with the aim of enabling them to cope with the contents of a difficult interview.

Who might offer that to interpreters remains unclear. Mental health staff are offered defusing and debriefing following traumatic incidents by other specially trained staff (Debriefing Program, not dated). Informal legal advice suggests that mental health services do not have a legal responsibility for debriefing interpreters, but may have a moral responsibility. Moreover Section 22 of the 1985 Occupational Health and Safety Act states that:

Every employer ... shall ensure so far as is practicable that persons ... are not exposed to risk to their health or safety arising from the conduct of the undertaking of the employer ...<sup>7</sup>

The 2003 working group<sup>8</sup> proposed working with mental health services to implement a policy that includes interpreters when defusing and debriefing are offered to clinical staff. If the interpreter is an employee of the service, such as for example they are at some of the major hospitals, then that service has responsibility for debriefing. For contract interpreters, there is an argument that the responsibility for debriefing probably lies with the contractor. However, it is generally accepted in the trauma counselling field that provision of defusing by a person's manager (or someone not of their choosing) can be counter-productive as employees may fear that they will be judged incompetent if they expose their vulnerabilities.

One obstacle to the provision of defusing to interpreters is that they often have another

<sup>7</sup> Section 22 of the Occupational Health and Safety Act, 1985:

*22. Duties of employers and self-employed persons*

Every employer and every self-employed person shall ensure so far as is practicable that persons (other than the employees of the employer or self-employed person) are not exposed to risk to their health or safety arising from the conduct of the undertaking of the employer or self-employed person.

<sup>8</sup> see page 12 above

immediate booking which they may be unwilling to cancel and thus lose income. This raises the question whether a mental health service should also take responsibility for paying the interpreter to stay (or return later) and receive defusing.

Debriefing, as distinct from defusing, raises further issues. Debriefing occurs a few days following defusing, to enable participants in the incident to reconstruct the event, review their experiences in the intervening period and to be offered further support and counselling. Debriefing also may be needed if a person becomes aware that they are traumatised some time after an event. While it may be argued that mental health services should automatically include interpreters in the defusing that is provided to staff, interpreters may be reluctant to contact a mental health service for debriefing if they later realise that an interview or incident is distressing them. It might be argued that the interpreting agency should contract a trauma counselling agency to provide debriefing when needed, on the understanding that no information about who sought debriefing be disclosed to the interpreting agency. This seems an impracticable proposition, as the interpreting agency would need some oversight of the expenditure involved. Another alternative would be that AUSIT funds such a service. However, not all interpreters belong to AUSIT. Anecdotally it has been suggested that the majority of interpreted interviews involve no traumatic material and therefore the need for defusing/debriefing by interpreters is not great. Anecdotally again, it has been suggested that interpreters are not so much traumatised by a single session, but by the accumulation of traumatic material over a period of time that causes what the mental health profession might call 'burn-out'. In fact this may cause interpreters to withdraw from the mental health field altogether. The difficulty is that, while there is much anecdotal evidence, the level of need is not known.

A method of addressing the need for debriefing might be through regular individual or group supervision, such as mental health professionals receive. In mental health services clinicians are provided with supervision to ensure they are practicing competently and professionally, to improve their competence and to provide collegial support. It seems unlikely that interpreters' support needs differ from other professionals given they face the same difficult scenarios. The VITS survey reported some comments consistent with this argument:

“There is a lot of work and no support neither (*sic*) financial or moral or any sort at all” (p. 23)

“Lack of formal peer support structure” (p. 23).

To establish such a process for interpreters needs a collaborative effort, with declarations of commitment from interpreters and their organisations, together with the identification of people who have expertise in debriefing, and experience in mental health interpreting.

Pollard's (1998) mentoring model of interpreter training (described above) provides a model of supervision in the interpreting field. Pollard describes a mentor as a teacher with specific knowledge about mental health interpreting who engages in informal discussions with the learner and who models good mental health interpreting. A mentor may be a

mental health interpreter or a clinician who is bilingual (p. 3). A mentor also could provide a means of quality control, if she or he sometimes accompanies the trainee mental health interpreter on assignments.

An important component of a mental health training curriculum would be to raise interpreters' awareness and understanding of the purpose and need for debriefing. Debriefing is important if for no other reason than that trauma may interfere with optimal role performance. The well-being of the person who is the interpreter is of course the primary concern.

## **ii. The Interpreter as 'Cultural Consultant'**

In mental health settings, interpreters are often used as cultural brokers or cultural consultants. The issue of whether an interpreter should or can provide such service is somewhat contested. On the one hand, the clinician requires a language interpretation of what the client is saying but also needs to understand what the client is saying in the context of the clients' cultural and societal norms. Indeed, an important aspect of training health professionals in knowledge and skills in working sensitively and effectively with people from CALD backgrounds, requires an emphasis on understanding the important cultural components in illness presentation, communication, treatment, etc.

*It is very important for the mental health staff to recognise the different cultural issues associated with mental illnesses in refugees or immigrants to Australia. Therefore communication and briefing of the professional with the interpreter before the interview may help clear some issues and facilitate easier communication.*  
Interpreter practitioner.

Clinicians are also making clinical attributions in regard to the clients' behaviour, body language, clothing and appearance, beliefs, values, lifestyle, etc. Turner (2003) states that in clinical situations it is not possible to be working alongside an interpreter and a cultural broker (where these exist) – in fact the dynamics of having four people interacting is just not possible. Turner notes that interpreters, if appropriate, are often used as cultural brokers. However, there exist differences in debatable issues such as the possibility of any individual being able to act as a broker of a given culture, given there are so many cultural identities such as community ethnic identities, in addition to social identities such as gender, status, economic divisions, rural and urban differences, and so forth. An individual cannot always reflect the cultural meanings of an identity dynamic adequately; indeed the role parameters an interpreter is trained to work within are not clear in relation to the skills and tasks that may belong to a 'cultural broker' role.

If interpreters are to be used as 'cultural consultants', clinicians should make it clear when requesting an interpreter that they wish to utilise that interpreter in the role of cultural broker. This would require not only a skilled use in the language of the client but also an accurate knowledge of the identified culture of the client, as well as the previously mentioned awareness of intra-cultural differences (Turner, 2003).

The issue is important given that despite the uncertainty and appropriateness of the use of interpreters as cultural brokers, interpreters and mental health services staff do report that this practice occurs, and as such requires further consideration.

### **iii. Deaf Issues in Mental Health Interpreting**

Auslan (Australian Sign Language) is the language of choice for many Deaf people (Dawkins, 1991), and is formally recognised in Australian federal policy statements as a “community language other than English”. There have been significant contributions to the area of mental health interpreting from Deaf Interpreting services and training providers. For example, a study was conducted by the Deaf Wellness Center, University of Rochester Medical Center<sup>9</sup>, US that examined the issues relating to interpreter training specifically in relation to interpreting for Deaf clients in the mental health context. The study applied and evaluated an innovative mentored observation-supervision training model for mental health interpreting.

The development of a training program and curriculum should include Auslan interpreters in Victoria and be accessible and appropriate for them. The models of most mental health interpreting programs are not developed for specific language groups, but are instead generic training programs. There are some special issues for interpreting with Deaf people and a curriculum should be developed with the input of appropriate expertise in interpreting with Deaf people in contexts of mental health. This would include aspects of Deaf Culture in addition to ethnic community cultures and other cultural variables like gender, age, social class and so on.

## **Context for Mental Health Interpreting In Victoria**

### **i. Establishing Interpreter Need, Interest and Feasibility**

As noted, evidence exists for the need of specialised mental health interpreting course from a number of sources. A decisive aspect that needs to be addressed regarding the development of specialised mental health interpreting training is that of interpreters’ own perspectives on the need for, and interest in, such training.

No specific survey around issues of mental health interpreting and training for work in mental health settings has been conducted. However, the VITS Survey (2004) revealed an equal distribution of respondents who thought that this kind of specialised training should be delivered by teaching institutions, professional associations, organisations that use interpreters and NAATI.

Part-Two of this report addresses the need for an interpreter’s perspective through a VTPU survey to interpreters in Victoria on mental health interpreting.

*Whatever training can be done would be a big help and the sooner the better.*  
Interpreter practitioner.

<sup>9</sup>Dean, R. K., Pollard, R. Q., English, M. A. (2004). Observation-supervision in mental health interpreter training. In E. M. Maroney (Ed.), CIT: Still shining after 25 years (pp. 55-75) . (Proceedings of the 15th national Convention of the Conference of Interpreter Trainers (CIT).) Monmouth, OR: CIT.

## ii. Current Training & Work Scope

### Accreditation/Recognition

Currently, translators and interpreters can become qualified through completion of an accredited course or accreditation by National Accreditation Authority for Translators and Interpreters, (NAATI) which has certain requirements which must be met by course developers. However, there are differences between States and Territories where courses have been accredited.

### NAATI accreditation

NAATI accreditation is the only qualification officially accepted for the profession of translators and interpreters in Australia. All Victorian Government Translation and Interpreting (T & I) services require translators and interpreters to be NAATI accredited whenever possible<sup>10</sup>.

### i. NAATI Accreditation Levels

NAATI originally established five levels at which interpreters and translators may be accredited, ranging from the low level and incidental use of a language aide (Level 1) to the high level of proficiency which would be required, for instance, at international conferences (Levels 4 and 5). From 1 January 1994 NAATI revised the levels system and nomenclature to include four levels of accreditation, discontinuing the former Level 1 due to the lack of demand by both service providers and candidates.

The four current levels of accreditation are:

Level 2: Paraprofessional Translator, Paraprofessional Interpreter

Level 3: Translator, Interpreter (Professional)

Level 4: Advanced Translator, Conference Interpreter

Level 5: Advanced Translator (Senior), Conference Interpreter (Senior)

NAATI accreditation may be obtained in three ways<sup>11</sup>:

- a) By passing a NAATI test
- b) By completing successfully a course of studies at an Australian tertiary institution approved by NAATI
- c) By providing evidence of specialised qualifications in interpreting/translating obtained from a recognised training institution overseas, or membership of a recognised international professional association, both of which are judged by the Authority to be equivalent to the standards required for accreditation in Australia.

### Victorian training institutions

RMIT University is the only institution in Melbourne offering programs with NAATI accreditation and the only one in Victoria with approval to teach to paraprofessional level (Level 2). RMIT University offers two programs: Diploma of Interpreting (NAATI Paraprofessional, Level 2) and Advanced Diploma of Interpreting and Translating (NAATI

<sup>10</sup> From: "Improving the Use of Translating and Interpreting Services: A Guide to Victorian Government and Policy and Procedures", Victorian Office of Multicultural Affairs, 2003.

<http://www.voma.vic.gov.au/web8/vomasite.nsf/Frameset/VOMA?OpenDocument>

<sup>11</sup> See: <http://www.naati.com.au>



Professional, Level 3). The Diploma of Interpreting trains students in dialogue interpreting to Paraprofessional Level. The following languages were offered in 2004: Amharic, Assyrian, Auslan, Dari, Hakka (Timorese), Japanese, Korean, Mandarin, Oromo, Pushto and Tetum<sup>12</sup>.

The Advanced Diploma of Interpreting and Translating Languages Other Than English (LOTE) trains students in dialogue and consecutive interpreting, translating from English into LOTE and translating from LOTE into English to Professional Level. The following languages were offered in 2004: Arabic, Auslan, Dari, Bosnian, Cantonese, Greek, Japanese, Khmer, Korean, Mandarin, Somali and Vietnamese<sup>13</sup>.

Languages are offered on the basis of student demand and upon advice from the Program Advisory Committee, which represents the industry and monitors its needs. RMIT University recently received funding from VOMA to do training specifically for interpreters from the emerging language groups. Beginning in 2005 RMIT University offered scholarships for students from the Horn of Africa to complete the Paraprofessional Course. Monash University offers a Masters of Japanese Interpreting and Translation; however, the focus is in business-oriented studies and competencies development<sup>14</sup>.

### iii. Languages Spoken in Australia

Within Australia over 200 languages are spoken in the community. The 2001 census indicated 2.8 million people (16% of the population) spoke a language other than English at home, which represents an increase of 213,100 people or 8% since 1996 (ABS, 2005). Almost a quarter of Victoria's population was born overseas, while 43.5% of Victorians were either born overseas or have a parent who was born overseas. Victorians come from 233 countries, speak over 180 languages and dialects and follow 116 religious faiths (VOMA, 2005).

Greek, Arabic and Italian speakers had the largest proportions of Australian-born speakers, reflecting the fact that these languages were mainly brought to Australia 20 or more years ago and have been maintained among their children. Languages spoken by migrants arriving in Australia more recently, such as Mandarin and Tagalog (Filipino), had a smaller proportion of Australian-born speakers. As a result of immigration there are over 100 LOTEs currently spoken in Australia. In all these languages, the services of an interpreter or translator are particularly needed for the ageing sector of the population of more established immigrant communities, particularly when people revert to their mother tongue in older age, and also for the new emerging languages during the initial years of settlement and beyond while migrants / refugees acquire English skills.

VTPU research surveyed mental health services use by Victoria's ethnic communities and revealed a significantly lower rate of mental health service use in Victoria by people born in countries where English was not the first language, and an even lower rate for people who spoke a language other than English at home, when compared with Australian born and English-speaking groups (Klimidis et al., 2000).

<sup>12</sup> See: <http://www.rmit.edu.au/ics>

<sup>13</sup> Ibid

<sup>14</sup> See: [http://www.arts.monash.edu.au/current/coursework/study\\_areas/postgraduate/japanese\\_interpreting\\_translation.html](http://www.arts.monash.edu.au/current/coursework/study_areas/postgraduate/japanese_interpreting_translation.html)

#### **iv. Newly Emerging Languages and Communities**

Recently arrived refugee communities need to access a range of services, including mental health services through interpreters from their own language groups. Emerging languages are not well represented by interpreter agencies or practitioners as many newly arrived immigrants or refugees are not yet established in terms of settlement and employment. The practising interpreters in these emerging or 'unmet demand' languages are mostly non-accredited as there has not been sufficient time or there are not the educational pathways readily available for them to gain accreditation at professional interpreter level.

As mental health interpreting is seen as a specialised area of professional practice, the qualification level of professional level interpreter is considered the required prerequisite. In fact the basic skills and knowledge required for professional interpreting are considered the foundation for the specialised skills and competencies required for interpreting in mental health settings.

There exists the need to meet community needs for emerging language interpreters, as well as meeting training requirements for interpreters in emerging languages. Anecdotal evidence suggests that people who enter the career of translating and interpreting from newly arrived communities, often commence working in the field due to limited availability of qualified interpreters.

It has also been identified that many newly arrived immigrants, particularly from countries with conflict or social injustice, who enter the interpreting profession may come with a community development or 'advocacy' perspective. Anecdotal information informs us that many people see interpreting as a way of 'helping' other recently arrived members of their communities. The issue of approaching the professional role of 'interpreter' from an advocacy perspective can influence the professional role significantly.

#### **v. Rural and Regional Australia**

Interpreter service provision to clients working in rural areas and regional Australia is limited. Many metropolitan-based interpreters are reluctant to accept appointments due to travel costs of fuel and time relative to the appointment fee. Several interpreters expressed their concerns over the higher use of telephone interpreting by rural and regional services. Telephone interpreting is recommended for short, brief conversations such as changing appointment times, or reminding a patient of an appointment. There are substantial difficulties involved when working with interpreters via the telephone in general situations, and specifically in mental health settings.

Furthermore, across many sectors the provision and accessibility to training for rural and regional services staff has been problematic. Interpreters based in rural and regional Victoria are also disadvantaged by training programs mainly being offered in metropolitan Melbourne.

*As now I live far from the metropolitan area I am unable to take part in any such training session. I really needed this 10 – 15 years ago. Now I only take telephone interpreting assignments.* Interpreter practitioner.

## vi. Work Scope and Environments

At present there are no specialist services providers or specialist 'mental health interpreters' in Victoria. The only remnant of the specialised mental health interpreting services can be found within services offered by VITS. Incorporated within VITS LanguageLink are specialist services catering to the Legal, Health, Mental Health, Education and Community fields. When the former specialist services (Mental Health Interpreting Service and Central Health Interpreter Service) ceased operation, many of the interpreters were integrated into VITS. These former 'specialist mental health interpreters' are now considered by VITS as specialist interpreters for bookings in mental health settings<sup>15</sup>. This group is relatively small, and as time passes fewer with this valuable experience are in the interpreting workforce. Without ongoing mental health interpreting training for newcomers, the number of experienced and competent mental health interpreters is decreasing. Consequently many services can rarely access a skilled interpreter in mental health interpreting, and for some language groups they are non-existent.

Experience and expertise as a professional interpreter is considered a minimum requirement for training in mental health interpreting. Yet as there are no training programs or well considered system for recognising trained and experienced interpreters, there are presently no criteria or standards for checking the effectiveness and appropriateness of interpreters working in mental health settings.

Furthermore, because the practice of using interpreters is still largely ad hoc in many settings, frequently little attention is paid to the skills and competency of any given individual called on to interpret, meaning that the different skills and competencies of an L2 and L3 interpreter, for example, are not measured or understood. The accredited 'interpreter' (L3 or 'professional') level should be used for all mental health interpreting situations. However, in some languages (eg, newly emerging demand languages) only 'paraprofessional' interpreter level interpreters may be available.

### **Mental Health Interpreting as a Specialised Training Area**

It has been recommended that mental health interpreting should be seen as a specialised training area, above the general competencies required for professional interpreting. Yet, although Victoria has had 'mental health interpreters' in the past who were given a specialised title reflecting their speciality, current thinking about mental health interpreting as a specialised training area implies that interpreters should be offered the opportunity to gain the appropriate skills to be able to work well in mental health settings, without necessarily becoming part of an exclusively specialist field. In the present situation, there is a need firstly to make training in mental health interpreting available to prepare interpreters to be competent in working effectively in specific mental health settings, or in other settings where mental health issues may be present.

<sup>15</sup> See: <http://www.vits.com.au/services.htm>

.... I feel training is necessary for interpreters who do NOT wish to work in mental health settings. This training is necessary because clients with MH issues attend a variety of appointments- parent/teacher, Centrelink, go to university (Deaf students) etc and the interpreters in these settings need to recognise signs of distress or mental illness (eg altered language) to therefore assist them in everyday interpreting assignments.

Interpreter practitioner.

The next section provides an overview of the key issues and requirements for the development of curriculum and training to prepare interpreters for more effective work in mental health context.

## Curriculum for Mental Health Interpreting

### Curriculum Topics

Drawing on a number of mental health interpreting curricula that have been identified through existing programs, as well as literature and consultations, a list of curriculum topics considered important for training in mental health interpreting was established. The topics cover the three broad areas seen as most important for training interpreters including the knowledge and skills to work more effectively in mental health settings and in mental health teams, and also to understand the professional role expectations that may be required in such work.

Topic areas are broadly comprised of (i) an introduction to mental health settings and clinical professions, with topics including:

1. The interpreter in the psychiatric setting; objectives of mental health interviews;
2. Pathways through the programs of the mental health system; the mental health professions.

(ii) An introduction to mental illnesses and illness behaviour, and treatment issues and approaches:

3. The major mental disorders
4. Abnormal illness behaviour: interpreting challenges
5. The Mental Health Act, involuntary admission and other medico-legal issues
6. Aims of treatment approaches
7. Problems of childhood and adolescence (including child abuse)
8. Family problems
9. Problems of the aged
10. Migration and mental health
11. Survivors of torture and trauma

(iii) Interpreting process and practice issues for mental health interpreting:

12. Professional issues: ethics, confidentiality defusing, debriefing, supervision and peer support

13. Interpreting assessment tests
14. Conveying meaning across cultures: cross-cultural issues in mental health
15. The interpreter as a cultural consultant
16. Mentored experience within the mental health system; exploring the discourse
17. Occupational health and safety issues

The initial review of literature provided the background information for the research conducted for the project. The background review clearly establishes the need for implementing training programs and curriculum to prepare interpreters for work in mental health settings to improve service provision to CALD consumers and families. Beyond this need, there is some complexity in working through some of the issues involved in developing training programs for interpreters in mental health interpreting. These include:

- Thoughtful consideration of what type of model of curriculum development and training is needed for developing appropriate inter-professional practice for interpreters working in mental health settings with mental health clinicians;
- Thoughtful and clear articulation of the aims and objectives of the proposed curriculum and training models to develop feasible curriculum and program streams which meet the needs of the professions and communities. This must take into consideration the languages in demand and those represented by interpreters in Victoria, as well as issues for rural and regional Victoria in both accessibility to training and interpreting service provision;
- Careful selection and development of the topics and learning objectives of the curriculum to ensure that the knowledge and skills developed in training are optimal for the interpreting task within the context of mental health settings;
- Given the nature of mental health interpreting, and working from the experiences of interpreters and service providers in mental health settings, establish training and service responses to issues such as debriefing of interpreters as appropriate. These would need to be implemented (and accessed) by interpreters, interpreter agencies, mental health services staff and mental health service providers as required.
- Thoughtful consideration of the role parameters of interpreters working within mental health settings to establish some protocols or guidelines prescribing some limitations on requests for interpreters to work also as cultural consultants.
- Prepare for and integrate a curriculum that also is responsive to interpreters of Auslan and is conversant with the specific issues for Deaf clients needing interpreters in mental health settings.
- Recommendations for curriculum development and training programs should be relevant and in line with the current training and work scope policies and procedures for training in interpreter practice in Victoria, and in line with national and international trends and developments in this field of training.

*To explore further these issues relating to mental health interpreting and training needs in Victoria, the VTPU developed a project methodology that focused on gaining research information through the use of surveys and consultations with key stakeholders including interpreters, training institutions, interpreter agencies, mental health services staff and consumers<sup>16</sup>. The next section details this research.*

<sup>16</sup> The information derived from the research has been analysed by the VTPU and may not reflect the individual contributions of key stakeholders.

## Part Two: Research Findings from the Mental Health Interpreting Project

Part-Two integrates existing knowledge and research with the current project findings to provide research information on the training and professional development activities needed to prepare interpreters for work in mental health settings in Victoria.

This section aims to provide research information on the training and professional development activities needed to prepare interpreters for optimal work in mental health settings.

### Project Method

The complete project timeline was confined to a three-month period. To maximise the quality of research information in a limited timeframe, the research methodology adopted in the present research draws on two consensus methods of researching and developing expert opinion on the issue of training needs for mental health interpreting, which was facilitated and analysed by the VTPU. Expert opinion was sought from several sources or 'sub-groups' described below.

#### ***Sub-Group 1: Mental Health Interpreting Reference Group***

The main target group were key stakeholders from principal interpreter agencies, key mental health services staff, and key training and education institutions. Representatives from these key stakeholders were invited to participate in the research by becoming members of a Mental Health Interpreting Reference Group (MHIRG). None of the total twenty-six invited Mental Health Interpreting Group (MHIRG) members declined to participate in the research project. The members' details are given in Appendix One.

Members of the MHIRG participated in the following;

- Participation in two surveys on Training Needs in Mental Health Interpreting
- Participation in two meetings of the MHIRG
- Ongoing telephone, email and occasional in-person consultations
- Review and final feedback on recommendations

#### ***Sub-Group 2: Interpreters' Perspective***

A critical target group was composed of Interpreters in Victoria for whom the outcomes of proposed training and curriculum are being designed.

To identify and explore interpreter needs and perspectives on interpreting in mental health and training for mental health interpreting, a survey was developed and administered to interpreters working in Victoria. The Interpreters Survey was developed and administered with the assistance of one of the key professional interpreter organisations, AUSIT. AUSIT, with approval from their Steering Committee, assisted in the dissemination of the Survey to 300 interpreters from their Victorian Interpreter Database and mailed via AUSITs' administration for reasons of database detail confidentiality. VicDeaf also assisted in broadening the Survey target population to include AUSLAN interpreters working in Victoria. VicDeaf used their database of 190 AUSLAN interpreters.

#### ***Sub-Group 3: Training Program Providers in Australia***

Research information was sought from training providers of programs in mental health

interpreting from other states within Australia. Telephone consultations were conducted with the nominated coordinators for each course identified within Australia, namely in Queensland, New South Wales and Western Australia. Further communication was ongoing through email.

#### **Sub-Group 4: Consumers' Perspective**

To gain insight into consumer perspectives on mental health interpreting issues and training needs, a Consumer Advocate was consulted for a consumer perspective. The Consumer Advocate was provided written material for background information on the project as well as key points for consideration, prior to the meeting.

As indicated the research methods varied across sub-groups. Below, are the detailed research methods and findings for each sub-group. Whilst they are reported separately, it becomes evident that the various groups were able to integrate various perspectives through the facilitation of the project worker who arranged information sharing from surveys and consultations, as appropriate.

A summary of the Consultation and Survey Process for the key stakeholders is shown in Figure 1.

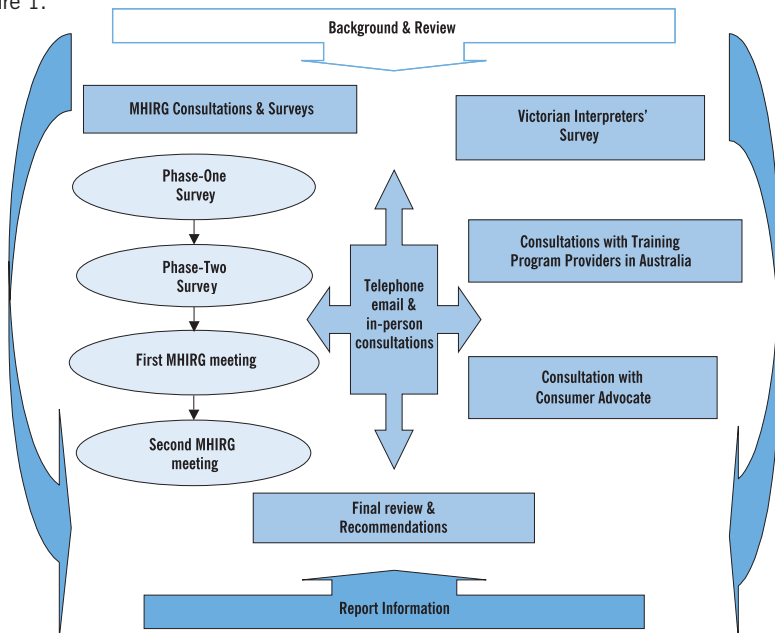


Figure 1. Consultation and survey process for stakeholders involved in the Mental Health Interpreting research project

## Research Findings

The consultation process began by reviewing existing programs in Australia.

### i. Consultations with Training Program Providers in Australia

- Queensland
- New South Wales
- Western Australia

In reviewing established training programs in Australia, three program providers for interpreter training in mental health interpreting were consulted. The programs, curriculum content and training experiences were discussed. There were several similarities with regards to “lessons learned” from programs already running. Through discussions with program coordinators and developers, the following themes emerged that indicate important considerations for the current project:

#### **Clinical content: Curriculum emphasis on practical interpreting not clinical training**

The need to ensure that the curriculum and training aims are directed towards developing and increasing an interpreter’s competence in the task of interpreting rather than focusing on clinical content was seen as a very critical lesson learnt from training programs. All three programs at various stages revised their curriculum and training delivery to reflect this issue. Training providers described the prevalence of interpreters obtaining information on mental illness and treatment towards the development of a professional perspective as ‘para-clinical’. It also reflected who was responsible for curriculum development (e.g., was it developed solely by a mental health professional?), curriculum delivery (e.g. what practical interpreting implications were integrated into the curriculum?), and the need for attention to the type of ‘working models’ the curriculum reflected (ie. inter-professional roles espoused/nature of team work and collaboration).

Programs were revised when the curriculum was considered overly technical in its mental health focus rather than training for practical interpreting in mental health settings. For instance one course provider eliminated a session they offered on ‘Mental Health Terminology’, deciding it was not useful. Rather, the necessary exposure and familiarity of terminology comes more appropriately within the context of learning in other topics and modules, as appropriate.

#### **Integration of debriefing**

With the absence of clear protocols and definition, the experience of other programs has been to integrate debriefing into training through several informal approaches, whilst also recognising the need for the establishment of more formal protocols.

For instance debriefing procedures are seen by some as an aspect of the mandatory training of any training in interpreting, or as part of the process of new interpreter orientation into the profession. Debriefing after a distressing incident when requested or required by an interpreter, is seen as the responsibility of the mental health service. More informal approaches were also reported as being integrated into the training program and



curriculum content such as within modules addressing 'self-care' or actions that the interpreter can take to respond to distressing incidents. One program provider also reported a recent state-funding initiative that has allowed their mental health organisation to work to support a process for a 'supervision program' for interpreters.

All program providers acknowledged the need for more formal protocols to be developed in the long-term.

Valuable information emerged that shaped how issues were presented to Victorian stakeholders as well as 'models' of approaches to issues such as program administration, curriculum development, incentives for interpreters, accreditation issues, cost, and so forth.

## **ii. Mental Health Interpreting Reference Group: Consultations and Survey Findings**

In a review of consensus methods commonly used in medical and health services research, Jones and Hunter (1995) support the distinct contribution of consensus methods as aids to decision making, both in clinical practice and in health service development, namely, the Delphi method and Nominal Group Technique.

The Delphi method and Nominal Group Technique form the basis of the methodology for the present project to research and develop expert opinion from key stakeholders on the issue of training needs for mental health interpreting. Key stakeholders were identified and invited to participate. Only Victorian and directly relevant key stakeholders were invited to participate, forming a Reference Group. The Mental Health Interpreting Reference Group was created which followed on from earlier initiatives to establish an expert group of key stakeholders (Stolk, 2003).

The Delphi method is based on a structured process for collecting and extracting knowledge from a group of experts by means of a series of questionnaires interspersed with controlled opinion feedback (Alder & Ziglio, 1996). The Delphi Method facilitates a communication process which enables the formation of a group judgement that is controlled to reduce the negative social interactive behaviours that may accompany group discussion, and importantly it merges expert opinions into a collaborative model or guidelines of a complex problem (or steers consensus in a particular direction).

Responses obtained from the panel are collated by a central coordinator and fed back to the respondents in a synthesised form. The respondents are then asked for a further response allowing them to revise their initial position if they so wish and to build or deepen through further recommendations and suggestions. The process is then repeated.

The Nominal Group Technique, also known as an Expert Panel, uses a highly structured meeting to gather information from relevant experts about a given issue (for a review of this technique see: Jones & Hunter, 1995). Participants examine, rate and discuss a series of key issues facilitated by an area expert.

Due to project time constraints the ideal Delphi technique, involving several round-by-round survey administrations, was modified to a three-stage process beginning with an electronic

survey (Phase-One, Appendix Two), and an amended second survey (Phase-Two, Appendix Three) which the project worker amended according to areas with established consensus and ongoing issues for discussion.

Following on from these surveys, the information, the established group consensus and development on some issues became the basis for the in-person group meetings Nominal Group Technique or “expert panels” (Phase- Three). The survey findings and issues for discussion that have emerged provided focus for the meetings. Each meeting ran for a minimum of two hours and was facilitated by the project worker and chaired by the VTPU’s Director A/Professor I. Harry Minas.

Telephone, email and occasional in-person meetings between the project worker and MHIRG members was an ongoing feature of the research process that contributed to and clarified information across the phases of the project.

### **iii. Mental Health Interpreting Reference Group Survey Evaluations:**

#### **a. Phase- One Survey Findings**

Of the total twenty-six invited Mental Health Interpreting Group (MHIRG) members, nineteen (non-VTPU staff and not including the MHB/VOMA representative) were asked to complete two surveys and engage in a telephone conversation to gather information on training needs around mental health interpreting.

Fourteen of the nineteen IRG members completed the Phase-One Survey (see Appendix Two), a response rate of 73.7 percent.

#### ***Importance of Training in Metal Health Interpreting:***

All respondents stated that training interpreters for mental health interpreting (MHI) is very important (four on a scale of one to four). Moreover, all respondents answered that MHI training would make a ‘significant difference’ to overall quality of mental health interpreting.

Respondents were asked to rank a series of statements to explain why they think it is or is not important to train interpreters for mental health interpreting on a scale of one ‘most true’ to five ‘least true for me’. The stated reasons that were selected as ‘most true’ for respondents were: that mental health interpreting training is important to ensure accurate interpreting in mental health settings; to improve the safety of interpreters in mental health settings; and to ensure optimal language services to people with a mental illness and their families.

Most respondents (71.4%) rated as ‘true to somewhat true’ the improvement in confidence of interpreters in mental health settings. For approximately seventy percent of respondents, to improve the status of interpreters was ‘somewhat true’ to ‘least true’. The reasons stating that it is ‘not important because professional interpreters can interpret in all settings’ and that it is ‘not necessary because mental health interpreting is only a small portion of

interpreting work' were ranked as 'not very true or least true' for around half of the respondents (42.9 and 50 percent respectively) and not ranked at all for the other 50 percent.

### **Curriculum Topics of Importance**

Of the topics listed (refer to list on pages 28-29 or see Appendix Two) most were considered either quite important or important. Of those considered 'very important', the top five when ranked were:

1. The role of the interpreter in the mental health setting
2. Translation issues in the mental health setting: conveying meaning across cultures
3. Introduction to the major mental disorders
4. Interpreting in crisis situations
5. Issues in interpreting assessment tests

*From a trainers perspective we believe there should be focus on the technical aspects. i.e., an interpreted situation is complex enough to start with: how do all parties work together with the interpreter to maximise a positive outcome for all? MHIRG member.*

### **Program structure**

Most respondents selected either a Professional Development (PD) series of sessions (45.5 %) or a PD course (36.4 %) as the most beneficial structure for a program in mental health interpreting.

It was also commented that it is more appropriate at an Advanced Diploma Level. Although responses varied on estimating duration for the program, one-third of respondents supported a 6 months, one day a week university course, with a low number (15.4 %) preferring 2-3 hours and seven days as possible duration times for the course. Some of the additional comments suggested a PD series may be necessary in the shorter-term and the possibility of a university course may be a longer-term approach.

### **Recognition and Incentives**

Almost half of the respondents located preferential bookings from interpreter agencies as being the most valuable outcome for training participation to interpreters, with preferential bookings from mental health services being preferred as the second most valuable to interpreters. A certificate and NAATI accreditation were also rated as valuable to interpreters.

The cost for mental health interpreting training was considered the responsibility, either partly or fully, of the State Government's Department of Human Services (DHS), followed by a funded training or PD program through the VTU, then by university fee, and lastly with a cost to the interpreter.

If the cost and time of a mental health interpreting training course suited interpreters, half the respondents believed that 'many would attend' (41.7%) but also that it would 'depend

on the incentives' (33.3%). Seventy-five percent of respondents believed that it would be 'likely' to 'very likely' that interpreters would attend such training if the cost was subsidised by DHS, with a reasonable fee to interpreters.

### **Administration and Delivery**

Almost all respondents selected a collaboration of organisations listed as most suitable to deliver MHI training; followed by a preference for the VTU, then CIMH, with a university partner alone or an interpreting agency alone being least preferred.

Almost all respondents supported the position that the training of mental health staff on working with interpreters is 'very important' (91.7%). Some additional comments were recorded on the need to ensure effective interpreting in mental health settings by focusing on training of mental health professionals for effective work with interpreters.

### **Methodology Note:**

#### ***Using the Phase-One information to develop the Phase-Two Survey***

As described earlier, the research methodology applied to the project uses feedback in phases to develop expert opinion on issues. Drawing on feedback relating to both the content of the Phase-One survey as well as the design of the survey the following amendments were made to the Phase-Two survey:

- Questions were removed that had received sufficient response patterns of agreement.
- The questions requiring further information or clarification were restated and amended: for example, Phase-One q.3 on topics suggested for inclusion in mental health interpreter training. As additional topics had been suggested, an amended list was included for ranking and reconsideration in the Phase-Two Survey.
- Using information from several questions on the type or model for a preferential training program in Victoria, the Phase-Two survey presented for consideration three models of training programs within Australia but outside Victoria. A question was included that asked members to consider the type of involvement their organisations may be interested in contributing.
- Given that some additional comments were raised on the need to train mental health professionals on how to ensure effective interpreting in mental health settings, a statement was added in the Phase-Two Survey. The statement fed back the concern and described the second project being conducted by the VTU regarding the training of mental health services staff.

## **b. Phase-Two Survey Findings**

The response rate for the second survey was approximately 58 percent.

### **Additional Topics**

Of the additional topics included these were all ranked as 'quite important'. These were:

- Interpreter Practice/ Process (specific technical issues for interpreters, such as incoherent speech)
- Interpreting in a mental health team/ multiple professions

## ■ Interpreting for the deaf / deaf mental health issues

The issue of 'confidentiality' was suggested as an important topic. However, through discussions it was considered that it would fit within the 'role of the interpreter in mental health settings', and would require a separate topic.

The way that confidentiality is seen as it relates to issues of stigma for people experiencing mental illness and their families was also suggested as a topic.

*Given we are talking about the context of mental illness, issues of social and familial stigma are still uppermost in the minds of those who are the recipients of interpreting services.*  
MHIRG member.

### **Potential Contributions of MHIRG Member Organization**

Representatives were prepared to contribute mostly through curriculum development and delivery, together with promotion and administration. All members expressed continuing commitment to working towards the development of a mental health interpreting curriculum and training program.

## **iv. Findings from Mental Health Interpreting Reference Group (MHIRG) Meetings**

### **a. First Meeting of the MHIRG**

Thirteen members attended the first meeting of the MHIRG. Key issues discussed at the meeting included:

#### ***Debriefing***

Interpreter 'self-care' should be taught within training programs. However there should also be education of mental health services staff to ensure interpreters needs in such situations are not overlooked. Supervision and interpreter peer review groups may be other methods for ensuring the care of interpreters. Another suggestion was made to introduce a mentoring system whereby trained interpreters could provide support and mentoring to less experienced interpreters.

Another important point relates to the need for briefing of interpreters before appointments in mental health settings. However, it is recognised that interpreters may not have time for briefing or debriefing as they may lose income if they did. In this case, the group recognised that there are systemic issues to be addressed for the provision of briefing and debriefing to be integrated into practices within services. Further clarification and protocols need to be established regarding whose responsibility it is for the debriefing of interpreters working in mental health settings.

#### ***Program development logistics***

The optimal length of a program was discussed; for example if a program is too brief it

might attract people with limited interest. Then there are the questions of whether to include emerging language interpreters who have no interpreting experience or whether a program should only admit accredited NAATI level 3 interpreters. Another question is whether there should be a specialised course for emerging languages and whether training for interpreters could be provided for each specific language group. However, it is not envisaged that training for work in a mental health setting would be language-specific.

It was suggested that the MHIRG explore the option of developing a mental health module to be part of an initiative to develop national standards for interpreters and translators, called the Competencies Scoping Project<sup>18</sup> for interpreters and translators. The project attempts to develop national qualification standards to increase consistency and enable training and assessment to integrate with the current training system in Australia, as well as bringing closer the relationship between training and the NAATI framework. The possibility of integrating a mental health module into the interpreter competencies project was suggested for further exploration.

Members were also able to articulate their 'least preferred model' for a mental health interpreting training course. There was agreement that the 'least preferred training model', was a course taught by a single mental health professional who may give too strong a clinical focus, as has been found in other states.

### ***Fees and Incentives***

There are several views on the issue of fees and costs for training development and interpreter participation. Some training providers maintain that a reduced fee for interpreters is an incentive for participation in training, whilst other parties such as interpreter agency representatives maintain that a fee-based course is viewed as more valuable and 'worthwhile' than a non-fee paying training program.

A ***Registry of Interpreters*** to record interpreters' who have completed training in mental health interpreting was considered valuable incentive for interpreters as well as a useful resource for clinicians and interpreter agencies.

A Registry provides the means:

- as an incentive to interpreters who complete specialised training in mental health interpreting
- to increase the possibility of preferential bookings of interpreters who have completed training in mental health interpreting from both interpreter agencies and mental health service providers
- for education providers who can monitor and clarify through the registry, what training and experience the interpreter has (the database will need to clearly state what work environment and competencies the training completed gives the interpreter listed)
- if it was developed as an online database, it could be accessed by interpreter booking agencies and mental health service providers through: the Mental Health Branch website; Interpreter Agencies; VTPU website; or other appropriate sites.

<sup>18</sup> See notice: <http://www.waiti.iinet.net.au/competencies.htm> or the draft document recently released for comment: Service Skills Australia, (May, 2005). Career Paths and Training for Interpreters and Translators: A report on the profile of the industry and the training required for interpreters and translators in Australia- for industry, training providers and agencies. Draft for Comment

### **Recommendations**

There was agreement on the types of training programs needed to meet different target groups of interpreters and desired outcomes. For example, a PD course for experienced interpreters; a TAFE-based course for training interpreters and a PD course for emerging language interpreters.

### **b. Second Meeting of the MHIRG**

Seventeen members attended the second meeting of the MHIRG.

#### **Follow-up from the First meeting of the MHIRG**

##### ***Re: Mental Health Interpreting Competencies as a component of the Competencies Scoping Project towards national qualification standards for interpreters.***

The Competencies Scoping Project proposal is to develop national standards for skills and knowledge needed for competence as an interpreter and translator, and benchmarks for training packages are outlined in a recent draft document (Service Skills Australia, 2005). Competencies, for example at the professional level (L3) include the ability to work across health fields. Mental health, however as a work scope was not specified. The possible development of a mental health component within this process was considered as an inappropriate avenue for the pursuit of mental health interpreting as a training package within this framework.

Expert consultations suggest a limited scope for the approach of the current project due to the more advanced nature of mental health interpreting, which requires good grounding in the interpreting profession. Moreover, expert consultation suggested that Scoping Committee members have considered and already discussed this proposition and did not feel it is appropriate to the current project scope. There is the possibility of continuing discussions around the area of work competencies in mental health settings if this is seen as appropriate. This would be at a later phase of implementation.

#### **Interpreter Survey Feedback**

Feedback from the Interpreter Survey allowed the MHIRG to consider issues from their perspective and to consider how the interpreters responded to certain issues.

#### **Initially Proposed Streams for curriculum development & training approaches**

After presentation of the various pathways, a discussion followed that focussed on what pathways were most important and feasible to pursue. Several suggestions were put forward as possible training pathways.

- Possible Pathways: Proposal to Recommend a Professional Development Program for Emerging Language Interpreters

MHIRG members tended to maintain that the primary training need for emerging language interpreters is in basic principles of working as an interpreter. Mental health interpreting is considered perhaps too specialist for this group.

For many members of newly arrived communities it is hard to distinguish and understand the role of the interpreter. As communities are often very small, issues of trust and

confidentiality can be significant factors affecting interpreting in mental health settings.

Members acknowledged the need for understanding of the mental health setting by emerging language interpreters and that the duration of time required for people to reach interpreter Level 3 is too protracted to meet immediate community needs.

One suggestion was for the possible introduction of a mentoring or other system for supervision, but there are insufficient resources within agencies to implement such a system.

Furthermore, supervisors in the mental health field generally have university training in supervision and management skills, but interpreters do not receive any such training and are not paid in their professional roles for such training or roles.

- Possible Pathways: Proposal to recommend a mental health interpreting component within an already existing subject in the Advanced Diploma of Translating & Interpreting, (eg., 20 hours of Ethics and Professional Practice), targeted at Level 3 training interpreters at RMIT).

This stream was discussed and seen as very feasible given that it targets training interpreters within a course that focuses on the professional role of interpreters. A fully advanced course requires clear aims and content development as well as approval by the training institution. Curriculum development can occur through a collaboration of stakeholders yet program development would require input from the training institution and course provider.

- Possible Pathways: Proposal to recommend a separate specialist Mental Health Interpreting Course to be created as an elective in the Advanced Diploma of Translating & Interpreting, with the target for professional level and experienced interpreters.

The proposed course would be developed for integration into the Advanced Diploma and has positive aspects with regards to more extensive curriculum coverage than with the other proposed training streams. Such a course may develop through the momentum and follow-on from a PD program and course component of an existing course but may not be feasible at present. A new course within an accredited training course would require significant developmental work for its structural implementation into a training institution.

- Possible Pathways: Proposal to recommend a Professional Development program (e.g., workshop through VTPU or RMIT) for professional interpreters with experience.

This stream was seen as a very effective path to pursue given it can be developed and administered through either RMIT or the VTPU (or another organisation) and can feed back into the curriculum development process and future training development process.

In summary, the meeting participants agreed to pursue recommendations for a training stream for (i) a mental health interpreting component within a course subject already running within the Advanced Diploma of Translating & Interpreting, RMIT; and (ii) a Professional Development program or session to be administered by either the VTPU or RMIT.



The training streams proposed here were discussed and refined further through consultations following the meeting. The final summary recommendations are presented in *Part Three: Development of Training Stream Recommendations* of this report.

**Additional Issue:**

**Training of Mental Health Services Staff**

Whilst the current project was not examining the training needs of mental health staff for working with interpreters, several important findings emerged that could directly improve training of mental health services' staff and which in turn would improve the work environment of interpreters in mental health settings. The following points were raised through the project findings and should be integrated into training of mental health services' staff, such as that offered by the VTPU, on working effectively with interpreters. These include:

- Educate mental health clinicians on the nature and complexity of the interpreters' work.
- Clarification of the interpreter's role and the role of the interpreter working within the team.
- Increase clinician understanding of the professional and collegial role of the interpreter in the mental health setting. Terms such as 'using' interpreters is indicative of underlying assumptions about the role of the interpreter and the professional integrity of the interpreter in the setting. As both are professionals, such terminology should not be used.
- Mental health services and clinicians need to increase and support their awareness and ensure provision of, briefing before an appointment with an interpreter, and provision for debriefing after a distressing incident or appointment as appropriate. This issue was discussed by the MHIRG and was further supported by the findings from the Interpreter Survey<sup>19</sup>. Guidelines should be set out by mental health services and communicated to interpreters and interpreter agencies regarding the perspective, of and available provision for, briefing and debriefing of interpreters working in mental health settings.

## v. Interpreter Survey Findings

*Over 80% of interpreters surveyed believed that specialised training in mental health interpreting would make a 'significant difference' towards preparing interpreters for work in mental health settings.*

*Over 90 % expressed interest in receiving such training.*

A Survey of Interpreters' Interest and Need for Training in Mental Health Interpreting (Appendix Four) was developed and administered to interpreters in Victoria through two Interpreter Agency databases:

- the AUSIT Victorian Interpreter Database (which comprises approximately 300 interpreters); from which 40 faxed responses were received, and
- the VicDeaf Database (which comprises approximately 190 Auslan interpreters); of

<sup>19</sup> Specifically, interpreters' expressed a need and desire for debriefing, and especially preference debriefing following a distressing appointment to be initiated by the clinician.

which 24 mailed responses were received.

A total of 64 interpreters responded to the survey. The just over 10% response rate was affected by the short (less than two weeks) response period interpreters had to receive and send back their surveys. Interestingly, it was the interpreters with longer work experience in the field who responded.

### **Work and training experience**

Around 50 % of respondents had worked as interpreters for more than 10 years, with 27 percent of respondents having worked for more than 5 years in the interpreting profession. Eighty-four percent of respondents had done 'a small amount' to 'some' work in the past year with mental health services, whilst less than 10 percent reported 'none'.

A large range of languages were represented by the sample, with 58.1 % reporting L3 and 40.3 % at L2 for their main interpreting languages.

Around 65 % of respondents had had no specialised mental health training; yet 20% of those that had training had between 2 – 8 hours only. The VicDeaf sub-sample made up the larger proportion of interpreters with training of 3-8hrs, and this was attributed by VicDeaf to a past training session that had been run several years ago.

It is important to also note that some interpreters reported using self-learning techniques to prepare for appointments and work in the mental health settings.

*Most of my work is with the Victorian Foundation for Survivors of Torture ...  
I have done a lot of self-learning about mental health and through translating  
information about mental health...*

Interpreter practitioner.

Over 90% of interpreters' surveyed expressed interest in receiving specialist training in mental health interpreting, with 70% also reporting a willingness to pay for such training. The majority of interpreters surveyed (above 80%) believed that specialised training in mental health interpreting would make a 'significant difference' towards preparing interpreters for work in mental health settings.

### **Curriculum**

The topics most preferred by interpreters were:

1. Interpreting and psychotherapy (75%)
2. Interpreting in crisis situations (74.2%)
3. Introduction to the major mental disorders (73%)
4. Abnormal illness behaviour (71.4%)
5. Interpreter Practice/ Process (specific technical issues for interpreters, e.g., interpreting incoherent speech, etc) (66.1%)
6. Safety of the interpreter; briefing and debriefing (64.5%)
7. How to deal with distressing interviews and incidents debriefing issues (64.5%)
8. The family and mental health problems of adolescence (61.3%)

These topics are an important contribution to curriculum development as they reflect both the desire to be familiarised with mental illnesses, illness behaviour and treatment approaches but also the interpreting task in complex situations and in relation to safety and debriefing.

The curriculum that introduces mental illness is seen as important to increase interpreter understanding and competency in working with behavioural and linguistic characteristics of mental illness. Some of the lack of understanding around mental illness and assessment is demonstrated in this statement around the 'reason' for certain questions during a consultation that make the interpreter uncomfortable:

*I would very much like to hear the opinion of a qualified mental health professional on the need/ desirability/ purpose served by the questions invariably asked if people suspected of suffering from mental illness: "Have you had thoughts of committing suicide?" "Have you thought of how you would commit suicide?" or at induction interviews on asylum seeker detention.*

Interpreter practitioner.

This anecdotal statement from one MHIRG member further illustrates the issue:

*"Auslan interpreters say deaf clients can't hear voices (they can) and have difficulties interpreting visual experiences for deaf clients for which there are no words or signs. Training will better prepare interpreters so they'll have less need to ask for clarification from clinicians".*

MHIRG member.

Topics selected by interpreters reflect what was also identified as important for both the area of work and professional interpreting competency. The topics reflect the need to understand some aspects of mental illness, especially illness behaviour as well as the practical issues for interpreting in mental health settings. Training is seen as a way of providing these competencies.

### **Debriefing**

With regards to debriefing, interpreters were asked several questions about their experiences following a distressing appointment, as well as their preferences for forms of debriefing.

Interpreters reported a clear need for debriefing after distressing assignments. One fifth of interpreters reported wanting debriefing most times and 60 % sometimes. Another 17 percent had not yet experienced the need for debriefing but would like the opportunity if required.

Over 50 % reported they had not been previously offered any form of debriefing. Whilst 40% had been offered some form of debriefing, this was only occasional and mostly occurred informally with a clinician, colleague, family or friends.

Debriefing by interpreter agency staff was reported more frequently by Auslan (20%) interpreters than AUSIT (3%) respondents. A key stakeholder has suggested that the comparatively high proportion of Auslan interpreters obtaining agency debriefing may be due to interpreters defusing with booking clerks or managers, who are not trained to debrief.

Significantly, the majority of interpreters (70%) reported that they would prefer debriefing, whether informal or more formal, with a mental health clinician and that this is initiated by the clinician. Other informal debriefing forms were also preferred such as debriefing in a group with other interpreters.

There were also concerns expressed around issues of 'interpreter safety' both whilst waiting for an appointment to commence as well as during appointments within mental health settings:

*... On a couple of occasions I have been attacked by a patient and professionals had not warned me beforehand to expect violent behaviour. As a result, I have become uncomfortable when interpreting in MH environment, as you never know what you are up against.*

Interpreter practitioner.

Similarly, this interpreter draws attention to the procedures currently in place for interpreters within some mental health settings:

*The interpreter shouldn't have any direct contact before the session with the patient. It is very important to consider the safety of the interpreter therefore the interpreter should be granted permission upon arrival to remain in the office and only be in contact with patient with the presence of a professional.*

Interpreter practitioner.

*When I go to a Mental Health Service I'm always asked to wait in the waiting room with other patients. I don't feel very safe because I don't know their conditions. I think we should wait with the staff and not with the patients.*

Interpreter practitioner.

The need to be briefed before appointments was also raised by some interpreters with a focus on the need interpreters have to feel prepared for their appointments with regard to both the nature of the appointment and other possible factors such as those relating to behaviour and speech. The clinician's behaviour and preparedness to 'work with' the interpreter in situations requiring some professional consultation were also considered to be sometimes limited. The clinician's reluctance to allow the interpreter to use simultaneous interpreting when a person won't pause, was one example given.

## vi. Consultation with Consumer Advocate

Consumer Advocate, VTPU<sup>20</sup> and Coordinator of the Spectrum of Cultures Statewide Multicultural Consumer Advocacy Group.

A 'consumer perspective' on issues relating to mental health interpreting was requested from the VTPU's Consumer Advocate. An important issue for consumers relates to communication difficulties and misinterpretation issues when interpreters are used in mental health settings. The Consumer Advocate reported receiving many reports of incidents where medical terminology was misinterpreted, such as the names of illnesses and medications. Often bilingual family members will detect these misinterpretations or consumers themselves will report miscommunications of information.


With regard to the proposed training of interpreters for mental health interpreting, it was recommended that training program structure and delivery should be developed in collaboration with consumers and consumer consultants for training and education. For example, the Consumer Advocate could participate in training role-plays to help build consumers' confidence for training interpreters, and to provide interpreters with the experience of working with consumers, which may lead to more effective interactions between interpreters, clinicians and consumers.

Furthermore, integrating a consumer consultant into the training of interpreters was recommended to help confront some misperceptions about the mentally ill. For the interpreter, working with the mentally ill can be an experience that is often perceived as uncomfortable, confronting and distressing. In line with the needs identified by the MHIRG members, introducing and educating on mental illness and treatment approaches and promoting the 'demystification' of mental illnesses, can be aided by including a Consumer Consultant as part of the training. It can also assist interpreters in changing their perceptions and attitudes towards persons with mental illness. Integral to this, is the experience of engaging with a consumer who is in a well state. This may shift the perception usually gained from only being in contact with the person during illness experiences.

The Consumer Advocate suggested that effective mental health interpreting could be promoted by identifying interpreters who are more experienced in mental health settings, and who are requested by satisfied consumers or service providers. These interpreters can then be used to establish a mentoring system, whereby they can then assist or train other interpreters in better practice in mental health settings. The difference between perceived good and bad interpreters was found in whether or not the 'message' of the communication was effectively communicated. This view supports the focus on "conveying meaning" in the proposed curriculum topics for training interpreters, as this is a specialised skill requiring training and experience.

Some perceptions of less effective interpreters are mostly related to the consumer's feeling that the interpreter is rushing, restricted by time and payment and the need to leave immediately for subsequent appointments. The consumer often feels the interpreter does

<sup>20</sup> The VTPU has part time Consumer and Carer Advocates who are available to provide their perspective on issues confronting consumers and carers from different cultural backgrounds in the mental health sector. They are available to provide advice to government, policy makers and mental health service providers on how the mental health service system can better serve those it was designed to assist. For further information visit: <http://www.vtpu.org.au/programs/consumer/index.php>



not look at the caring nature of interpreting. The consumer may be wanting more involvement from an interpreter who is the consumer's means to communication in order to gain help and support.

This is important to emphasise because it relates directly to the already mentioned issues of training interpreters in 'professionalism'. There seems to be a confounded misunderstanding of the interpreter's role. It has been reported that the clinician 'uses' the interpreter without a clear understanding of the interpreter's role and may also request the interpreter to go outside their role parameters or may not adequately understand the limits and complexity of the interpreting task. The consumer, on the other hand, sees the interpreter as their 'helper' and expects some degree of priority from the interpreter above their work with other parties present. The interpreter themselves can often see their responsibility falling mostly towards the client, in an 'advocacy' type of arrangement. It may be important to train in collaboration with mental health clinicians, interpreter practitioners and consumers to allow perspectives to be shared and roles clarified.

Another important aspect of mental health interpreting is 'family interviews' and other treatment approaches that include the family. In fact, there has been a shift in general mental health service provision towards more family-inclusive approaches. The role of the family is considered to be particularly important in working with clients from immigrant and refugee backgrounds. Consumers feel it is important that training interpreters in mental health would also help in family settings, where the more complex dynamics between the clinician, consumer and family members require high levels of professional competency from the interpreter.

Another issue raised by the Consumer Advocate was that of the interpreter as 'cultural consultant'. Whilst the discussion around this issue is problematic, from a consumer's perspective the interpreter should share any information that can provide or help communicate the meaning of a message more accurately. On the other hand, difficulties can arise when the language of the interpreter and consumer are matched but their cultures are not. This can lead to different meanings of shared words and metaphors of which the clinician should be aware. The potential problems of over-involvement and inappropriate interpretations of meaning and behaviour by the interpreter were also raised.

A recommendation was made to integrate a consumer perspective into any future curriculum and training developments. The recently established Consumer Advocacy Group comprising consumer advocates from various cultural and linguistic backgrounds called the "Spectrum of Cultures Consumer Group" hold bi-monthly meetings facilitated by the Consumer Advocate at VTPU<sup>21</sup>. The group would be one possible avenue for future discussions of curriculum development or training participation.

<sup>21</sup> For contact and program details visit; <http://www.vtpu.org.au/programs/consumer/index.php>

## Part Three: Conclusions and Recommendations

### 1. Commitment to Improving the Quality of Mental Health Interpreting

Effective mental health clinical practice relies on excellent communication between clinician and client. In circumstances where such communication is compromised (e.g. when the client's fluency in English is not sufficient for effective communication) effective clinical practice is impossible. A number of serious difficulties are likely to occur in such circumstances, including failure to establish an effective clinical relationship, failure to engage significant others in the assessment and treatment process, a poor understanding by the clinician of the nature and severity of the client's illness, misdiagnosis, poorly informed care and treatment planning, and non-adherence to treatment recommendations.

High quality interpreting is essential for effective clinical practice in Victorian mental health services. The availability of high quality interpreting where it is required is as basic a requirement for effective clinical practice as the availability of psychotropic medications and other essential elements of public mental health services. Failure to ensure the availability of skilled interpreting when it is required constitutes a failure in duty of care.

The VTPU recognises that strong commitment will be required from all key stakeholders to improve the quality of mental health interpreting in Victoria. The recommendations further reflect the need for a continuing engagement of Commonwealth, State and DHS agencies with mental health services and interpreter agencies to ensure that the following recommendations can be implemented to develop interpreter training programs for more effective mental health interpreting.

#### **Recommendation 1.1**

*It is recommended that Commonwealth and State Government sources provide funding to higher education and training institutions to establish appropriate mental health interpreting training.*

As in other specialised areas of interpreting practice, working effectively in mental health settings presents particular challenges and requires specific skills, in addition to the basic professional skills that interpreters acquire in the generalist training. Interpreters have identified the need for training that would prepare them for work in mental health settings. There is currently no such training program in Victoria.

It is essential that there are a sufficient number of interpreters who are adequately skilled in interpreting in mental health settings to meet the needs of clients and mental health service providers in the public mental health system. The Department of Human Services should designate mental health interpreting as a priority training area and ensure that there is adequate funding for the development and delivery of such training.

The Mental Health Branch (DHS), the Victorian Office of Multicultural Affairs and other

Government Departments can contribute to the training of non-employees through service agreements with interpreting suppliers that specify that interpreters should have training in mental health interpreting. This is particularly important for interpreters working in mental health settings, but also in other departments and services (e.g. the Family Court) where mental health issues are also encountered. This requirement would encourage interpreters to participate in training and establishes the appropriate standard for mental health interpreting.

### **Recommendation 1.2**

*It is recommended that the Department of Human Services provides funding for the development and delivery of training programs for mental health service providers in working effectively with interpreters and for the development of the necessary print and audio-visual training materials.*

Even the most highly skilled interpreters cannot do their work adequately if clinicians do not know how to work effectively with interpreters. Mental health clinicians should be able to make an informed judgement about when the assistance of an interpreter is essential. Clinicians need to appreciate the nature and complexity of the interpreter's work and should understand the interpreter's role in the clinical process. Clinicians should be capable of providing appropriate briefing to the interpreter prior to the clinical interview and, where appropriate, debriefing following the interview.

### **Recommendation 1.3**

*It is recommended that the Department of Human Services provides continuing funding to the Victorian Transcultural Psychiatry Unit to deliver training in working effectively with interpreters to all mental health service providers in the Victorian mental health system.*

The Mental Health Branch's forthcoming Cultural Diversity Strategy should specify that the VTPU's *Working Effectively With Interpreters* program is required training for all mental health service providers.

### **Recommendation 1.4**

*It is recommended that the Department of Human Services supports dissemination of guidelines for the provision of briefing and review to interpreters to all mental health clinicians working in the Victorian mental health system.*

It is necessary that interpreter agencies, interpreters and clinicians are familiar with professional guidelines relating to mental health interpreting to ensure appropriate expectations and practices. The interpreting field does not have any established guidelines



or protocols relating to working in mental health settings.

The issues raised in this report concerning briefing and review should be integrated into DHS program development. Similarly, information in this report and expertise and materials developed in the VTPU training program *Working Effectively With Interpreters* should be promoted to the DHS Diversity Unit for Human Services staff.

Consistency in guidelines should be pursued across both general Human Services staff and Area Mental Health Services staff, where appropriate.

## 2. Training Programs

Training programs are required at a number of levels, ranging from incorporation of relevant mental health issues in the basic training of all interpreters to training that would enable those interpreters who wish to do so to work as specialist mental health interpreters.

The levels of training, in order of complexity and urgency of development, are:

- i. A professional development program in mental health interpreting for existing professional interpreters.

The intent of this is to expose all professional interpreting students to the particular challenges of interpreting in circumstances where mental health issues are important.

- ii. Incorporation of mental health issues in existing formal award professional interpreter training programs.

The intent of this is to expose all professional interpreting students to the particular challenges of interpreting in circumstances where mental health issues are important.

- iii. An advanced course in mental health interpreting for those professional interpreters who wish to specialise in mental health interpreting.

The purpose of such a program is to develop a relatively small group of highly trained specialist mental health interpreters who will play an essential role in advancing the field of mental health interpreting, teaching mental health interpreting in professional and para-professional training programs, and offering skilled supervision for interpreters working in health settings.

The necessary curriculum for these programs should be developed collaboratively by clinicians, educators and interpreting trainers. Programs at different levels can be offered by RMIT University and by the Victorian Transcultural Psychiatry Unit individually and in collaboration. The development of such curriculum and programs should be informed by a Mental Health Interpreting Reference Group consisting of relevant stakeholders.

*Funding support from VOMA, DHS and other government departments is required to develop curriculum and resources for training programs in mental health interpreting.*

The establishment of new training programs through training institutions will require support in curriculum and program development.

VOMA should support the establishment of specialist interpreter training programs, and should support the development and provision of incentives and assistance for people to

undertake such interpreter training and to promote interpreting as a career.

RMIT will enter a partnership with training developers to meet Victorian Qualifications Authority (VQA) criteria for establishing and developing a course through RMIT.

The process for establishing the recommended training according to State level Office of Training and Tertiary Education (OTTE), Department of Education and Training - Victoria requirements and VQA is straightforward. The VTPU recommends the establishment of a new component, within an existing unit in the Advanced Diploma in Interpreting and Translating at RMIT, is the domain of the training institution. According to VQA, the appropriate authority for a new unit recognition is through the establishment by RMIT of a 'Steering Committee' with relevant collaborators (e.g. VTPU) to develop the curriculum and module that is to be offered. This is then recognised through the VQA and is listed on the National Training Information Service.

Once the unit is added to RMIT's Advanced Diploma in Interpreting and Translating, RMIT has the ability to offer any of their units/modules as short courses. The short course option would serve the needs of interpreters who are already trained and who wish to undertake training in mental health interpreting.

Other training options include the pursuit of a NAATI accredited course in Mental Health Interpreting, which would also require financial support for curriculum development and module delivery.

### **Recommendation 2.1**

*It is recommended that DHS integrates into existing DHS language service structures consultation with Mental Health Interpreting Reference Group coordinated by the VTPU.*

DHS existing structures that are able to develop and support work on mental health interpreting - such as the Ministerial Advisory Council on Cultural and Linguistic Diversity (MAC C&LD), language services working group and contributors to the Mental Health Cultural Diversity Strategy - should be encouraged to draw on the established expertise of the Mental Health Interpreting Reference Group through consultations with the VTPU.

State Government should support the establishment of the following training pathways:

### **Recommendation 2.2**

*It is recommended that the State Government supports the establishment a Professional Development Program for existing professional Level 3 interpreters. The development of such a component should begin as soon as practicable.*

### **Recommendation 2.3**

*It is recommended that the State Government supports the establishment of an introductory Mental Health Interpreting component as part of the existing 'Ethics' subject in the Diploma of Translating & Interpreting at RMIT for paraprofessional level interpreters in emerging languages. The development of such a course should begin as soon as practicable.*

### **Recommendation 2.4**

*It is recommended that the State Government supports the establishment of a Mental Health Interpreting component as part of 'Professional Practice', a core subject in the Advanced Diploma of Translating & Interpreting at RMIT. The development of such a component should begin as soon as practicable.*

### **Recommendation 2.5**

*It is recommended that the State Government supports the establishment of an Advanced Course in Mental Health Interpreting within the Advanced Diploma of Translating & Interpreting framework. The scoping for the development of such a course should begin as soon as practicable.*

The establishment of relevant interpreting training programs will require a long-term commitment and resources from DHS and involvement of key stakeholders in the development of an ongoing training contribution to mental health interpreting. The recommended Mental Health Interpreting Reference Group and the Victorian Transcultural Psychiatry Unit will play a vital role in sustaining and coordinating the development of a skilled mental health interpreting workforce in Victoria.

## **3. Curriculum Development and Training Program Delivery**

The development of curriculum for the training of interpreters (professional and para-professional) and the design and management of the necessary training programs is a substantial task. This work requires at least one dedicated project officer and the support of an appropriately constituted reference group. The members of the reference group should include interpreters, interpreting educators, mental health clinicians, consumers and carers. The Project Officer is most appropriately located in the Victorian Transcultural Psychiatry Unit where he/she would receive ongoing support and supervision from VTPU staff. Professional development programs are most appropriately managed by the Victorian Transcultural Psychiatry Unit and courses for formal award are most appropriately managed by RMIT University.

### **Recommendation 3.1**

*It is recommended that DHS makes available financial support for an appropriately qualified full-time Project Officer to coordinate the development of curriculum and training program development and delivery.*

## 4. Rural and Regional Issues

It is important that any programs developed should be available to interpreters who work outside metropolitan settings. This is particularly important in those regional areas of Victoria where refugees are being systematically re-settled.

### **Recommendation 4.1**

*It is recommended that the State Government makes available to non-metropolitan interpreters the support that will enable them to participate in professional development and formal award training programs in Mental Health Interpreting.*

## 5. Incentives to Participate in Further Training

Most interpreters now work in a privatised and fragmented system of interpreting service provision. It is recognised that appropriate incentives may be required to encourage interpreters to participate in further training. There are two broad groups of possible incentives:

1. Financial support for meeting the costs of further training.
2. The institution of processes that will make interpreters who have undertaken further training more competitive in securing work in mental health services.

### **Recommendation 5.1**

*It is recommended that VOMA makes available a number of full and part scholarships that would encourage appropriately qualified interpreters to undertake training in mental health interpreting.*


VOMA should consider this an extension of the current scholarship program for general interpreter training.

### **Recommendation 5.2**

*It is recommended that the Mental Health Branch establishes mechanisms that would encourage mental health service agencies to give preference to interpreters who have received training at an acceptable level in mental health interpreting.*

## Conclusion

This project has demonstrated that there is renewed recognition that the field of mental health interpreting involves specialist skills and that these skills need to be built on the competencies required for professional interpreting. To enable these specialist skills to be developed all key stakeholders have acknowledged the need to develop relevant curriculum and training programs. This is critical, to enable interpreters themselves to work more



effectively in mental health settings, to ensure accurate interpretation in clinical encounters with CALD consumers and families, and also to meet policy makers' requirements for quality language services. As they continue to make policy around improving language access to services, policy makers must also continue to commit to the development and implementation of training programs that best meet the needs and contexts to which they hope to contribute. The present initiative reflects the Victorian Government's commitment and desire to improve the current situation of mental health interpreting in Victoria. The enthusiastic participation of key Victorian stakeholders in the current project has demonstrated that there is a clear commitment to a continuing collaborative effort for establishing curriculum and training programs for mental health interpreting in Victoria.

## Appendix One: Mental Health Interpreting Reference Group List

### Members of the Mental Health Interpreter Reference Group (MHIRG)

Representative	Organisation
Anh Thu Nguyen	SUMMIT, former Bilingual Case Manager
Aroon Naidoo	Cultural Portfolio Holder, Saltwater Clinic, Werribee Mercy MHP
Bella Burns*	RCH-MHS/Travancore
Chris Greatorex	Manager, TIS
Chris Poole	Interpreter practitioner, Chris Poole Interpreting
Coffey, Guy*	Victorian Foundation for Survivors of Torture
Cynthia Toffoli-Zupan	Manager, NAATI
Deirdre Pinto	Mental Health Branch, Victoria
Diane Gabb *	VTPU
Elkins, Veronica*	Aged Psychiatry, Sunshine Hospital
Garlick, Robyn	Aged Psychiatry, NWA Persons, Sunshine Hospital
Harry Gelber	RCH-MHS/ Tranvacore
Harry Minas	Director, VTPU
Khorsheed Khisty	Ethnic MH Consultant, Northern AMHS
Kris Chapman*	Manager Client Services, Vicdeaf, Victorian Deaf Society
Malina Stankovska	VTPU
Margaret Goding	AMHS Area Manager, St Vincent's hospital
Maria Maggio De Leo	President, Australasian Association of Hospital Interpreters and Translators
Marie Piu	VTPU
Mary Vasilakakos	Coordinator, Languages, RMIT
Sandy Leane	Australian Sign Language Interpreting Association (ASLIA)
Sarina Phan *	Branch Chair, AUSIT, Vic/Tas
Senada Softic *	VITS
Silvio Proy *	RCH-MHS
Steven Klimidis *	VTPU
Tania Miletic	Project Worker, VTPU
Tony Blanco *	Clinician, Inner West AMHS
Yvonne Stolk *	VTPU

\* Participants in previous Working Group (2003)

## Appendix Two: Survey One to Members of the Mental Health Interpreting Reference Group

### Victorian Transcultural Psychiatry Unit

#### Research Survey on Training Needs in Mental Health Interpreting (MHI)

#### PHASE ONE: May 5th – May 13th, 2005

The Victorian Transcultural Psychiatry Unit (VTPU) is currently researching the training and professional development activities needed to prepare interpreters for work in mental health settings.

We invite you to complete this survey, which is designed to be a preliminary exploration of the training and professional development needs for interpreting in mental health settings drawing on your professional expertise. Your responses will be completely confidential and collated with other members of the MH Interpreting Reference Group. Please feel free to add any additional comments or concerns. Upon receipt of your completed questionnaire, you will be contacted by telephone to further discuss these issues.

We greatly appreciate your time and commitment to this project.

This research will ultimately inform the planning and development of curriculum/ training materials to prepare interpreters for work in the mental health setting.

Sincerely,

*Tania Miletic*

Project Worker, Mental Health Interpreter Training Project, VTPU.

Please complete and email or fax this questionnaire by May 13th, to:

Tania Miletic

Project Worker, Mental Health Interpreter Training Project, VTPU.

Email: [vtpu@svhm.org.au](mailto:vtpu@svhm.org.au)

Telephone: (+61 3 ) 9411 0321

Fax: (+61 3) 9416 0265

**1. Training interpreters for mental health interpreting is (please circle the number against the relevant answer):**

- Not at all important .....1  
 Somewhat important .....2  
 Quite important .....3  
 Very important .....4

**2. Please think about the reasons for your answer to Question 1. Then rank the following statements from 1 Most true for me to 5 Least true for me to explain why you think it is or isn't important to train interpreters for mental health interpreting. Please add your own reasons if not listed below.**

*Mental health interpreting training is:*

- Important to improve the professional status of interpreters...   
 Important to ensure accurate interpreting in mental health settings.....   
 Important to improve the confidence of interpreters in mental health settings   
 Important to improve the safety of interpreters in mental health settings..   
 Important to ensure optimal language services to people with a mental illness and their families   
 Not important because professional interpreters can interpret in all settings   
 Not necessary because mental health interpreting is only a small proportion of all interpreting work   
 Other (please specify):

*Specific comments:*

**3. a. The following topics have been suggested for inclusion in mental health interpreter training. Please circle on a scale of 1 to 5 how important it is to include each topic:**

**b. Then, please go back and rank from 1 to 5- in the last column which topics are the 5 most important to include**

	Not important	A little important	Quite important	Very important	Not sure	Essential topics
The role of the interpreter in the mental health setting	1	2	3	4	5	<input type="checkbox"/>
The mental health system and the professions	1	2	3	4	5	<input type="checkbox"/>
Introduction to the major mental disorders	1	2	3	4	5	<input type="checkbox"/>
Abnormal illness behaviour	1	2	3	4	5	<input type="checkbox"/>
Translation issues in the mental health setting: conveying meaning across cultures	1	2	3	4	5	<input type="checkbox"/>
The Mental Health Act: involuntary admission and other medico-legal issues	1	2	3	4	5	<input type="checkbox"/>
Migration and mental health	1	2	3	4	5	<input type="checkbox"/>
Interpreting with families	1	2	3	4	5	<input type="checkbox"/>



The family and childhood mental health problems	1	2	3	4	5	<input type="checkbox"/>
The family and mental health problems of adolescence	1	2	3	4	5	<input type="checkbox"/>
Mental health problems of the aged	1	2	3	4	5	<input type="checkbox"/>
Refugees; survivors of torture and trauma	1	2	3	4	5	<input type="checkbox"/>
Issues in interpreting assessment tests	1	2	3	4	5	<input type="checkbox"/>
Safety of the interpreter; briefing and debriefing	1	2	3	4	5	<input type="checkbox"/>
Interpreting in crisis situations	1	2	3	4	5	<input type="checkbox"/>
The interpreter as a cultural consultant	1	2	3	4	5	<input type="checkbox"/>
Interpreting and psychotherapy	1	2	3	4	5	<input type="checkbox"/>
Other topics (please specify)	1	2	3	4	5	<input type="checkbox"/>

*\*Please remember to go back and rank from 1-5- in the last column which topics are the 5 most important to include*

Specific comments:

**4. The most beneficial structure for a mental health interpreting program would be:**

- A course as part of a Diploma in interpreting
- A short Professional Development course
- A Professional Development Series of Sessions
- Other:

Specific comments:

**5. The duration of a mental health interpreter training course should be: (sessions of more than one day would probably be spread over a number of weeks)**

- 2 - 3 hours
- Half a day
- 1 day
- 2 days
- 3 days
- 4 days
- 5 days
- 6 days
- 7 days
- 8 days
- A 6 month 1 day a week university diploma
- Other:

**6. Interpreters would be most likely to attend mental health interpreter training if it was delivered: (please rank from 1 Most likely to 3 Least likely)**

- On week day/s in business hours
- On week day/s in the evening
- On Saturdays

Other arrangements (please specify):

**7. To be of value, interpreters attending mental health interpreter training should receive: (please rank from 1 Most valuable to 5 Least valuable)**

- A certificate
- NAATI accreditation
- Preferential bookings for mental health services from interpreter agencies
- Preferential bookings from mental health services
- A financial loading for mental health bookings
- Other:

*Specific comments:*

**8. The cost for mental interpreter training should be the responsibility of: (please rank from 1 Most appropriate to 4 Least appropriate):**

- Interpreter
- Funded training/ PD Program through VTPU
- University fee
- Partly or fully subsidised by Department of Human Services
- Other:

*Specific comments:*

**9. If mental health interpreting training was offered at a time and cost that suited interpreters, how likely is it that interpreters would attend such training?**

- None would attend
- A few would attend
- Many would attend
- Depends on incentives
- Other:

*Specific comments:*

**10. If half of the cost of mental health interpreting training were subsidised by the Department of Human Services, but a reasonable fee was required from interpreters, how likely is it that interpreters would attend such training?**

- Not likely
- Likely
- Very likely
- Other:

---

**11. The most suitable organisation/s to deliver mental health interpreter training is: (please rank from 1 Most suitable to 5 Least suitable):**

---

- |   |                          |
|---|--------------------------|
| University partner (i.e., RMIT)                                 | <input type="checkbox"/> |
| Victorian Interpreter and Translating Service (VITS)            | <input type="checkbox"/> |
| Centre for International Mental Health, University of Melbourne | <input type="checkbox"/> |
| Victorian Transcultural Psychiatry Unit                         | <input type="checkbox"/> |
| Collaborative between above organisations                       | <input type="checkbox"/> |
| Other organisation (please specify):                            | <input type="checkbox"/> |
- 

*Specific comments:*

---

**12. How much difference would mental health interpreter training make to the overall quality of mental health interpreting?**

---

- |                        |                          |
|------------------------|--------------------------|
| No difference          | <input type="checkbox"/> |
| Some difference        | <input type="checkbox"/> |
| Significant difference | <input type="checkbox"/> |
- 

*Specific comments:*

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**13. How important is the training of mental health staff on working with interpreters? (please circle)**

---

- Not at all important .....1  
Somewhat important .....2  
Quite important .....3  
Very important .....4

Other:

---

*Please consider the above issues and provide any specialised feedback or suggestions:*

---

*Thank you for your time and valuable contribution.*

# Appendix Three: Survey Two to Members of the Mental Health Interpreting Reference Group

## Victorian Transcultural Psychiatry Unit

### Training Needs in Mental Health Interpreting (MHI)

#### PHASE TWO: May 24th – May 27th, 2005

Dear Mental Health Interpreting Reference Group (IRG) members,

Thank you for completing the phase-one survey on the training and professional development activities needed to prepare interpreters for effective work in mental health settings.

Your responses and recommendations have been collated with the responses of other IRG members. From this information we have been able to develop our phase-two survey that will briefly address some additional issues concerning training needs on mental health interpreting. By completing the attached phase-two survey we can move closer to agreement on the key training needs in mental health interpreting, as well as address some additional issues.

We invite you to complete the phase-two survey by May 27th.

Your responses will be confidential and collated with the responses of other members of the MH Interpreting Reference Group. Feedback from both phase-one and two surveys will be provided at the meeting of the Mental Health Interpreting Reference Group on June 1st 2005.

As a reminder, the Mental Health Interpreting Reference Group Meeting will be held on 1st June 2005, 9.30am – 11.30am, at VTPU, Level 2, Bolte Wing, St Vincent's Hospital, 14 Nicholson St, Fitzroy.

This research will inform the planning and development of curriculum and training materials to better prepare interpreters for work in the mental health setting.

We greatly appreciate your time and commitment to this project.

Sincerely,

Tania Miletic

Project Worker, Mental Health Interpreter Training Project, VTPU.

Please complete and email or fax this questionnaire between May 24th - 27th, to:

Tania Miletic

Project Worker, Mental Health Interpreter Training Project, VTPU.

Email: [vtpu@svhm.org.au](mailto:vtpu@svhm.org.au)

Telephone: (+61 3) 9411 0321 Fax: (+61 3) 9416 026

1. The suggested topics from the phase-one survey were considered to be 'quite important' to 'very important' by IRG members. Of those considered 'very important', the top five when ranked were:

6. The role of the interpreter in the mental health setting
7. Translation issues in the mental health setting: conveying meaning across cultures
8. Introduction to the major mental disorders
9. Interpreting in crisis situations
10. Issues in interpreting assessment tests

Some additional topics have been suggested. Please circle on a scale of 1 to 4 how important it is to include each topic:	Not important	A little important	Quite important	Very important
Interpreter Practice/ Process (specific technical issues for interpreters)	1	2	3	4
Interpreting in a mental health team/ multiple professions	1	2	3	4
Interpreting for the deaf / deaf mental health issues	1	2	3	4
Other topic	1	2	3	4

*Specific comments:*

2. a. At present in Australia there are some different training programs available for interpreter training in mental health settings. The courses vary in their structure and focus. Of the three identified programs, all are certificate programs that are best described as Professional Development Series.

**Model A: Queensland**

- Eight sessions by four-hour module/ 32 hours over 8 weeks.
- Curriculum developed by the Qld. Transcultural Mental Health Centre.
- Delivered mostly by QTMHC staff member.
- Subsidised by the QTMHC.

**Model B: Western Australia**

- 10 sessions by three-hours per week over 10 weeks.
- Curriculum developed and administered by WATMHC with a TAFE partner.
- Delivered by mental health clinicians on different mental health area topics/ tutors are interpreter practitioners.

**Model C: New South Wales:**

- Four sessions, full days over four weeks
- Developed by NSW Institute of Psychiatry, and run through NSWIOP
- Delivered by mental health practitioner/s

**These models show various levels of collaboration across organisations.**

- b. Phase-one survey revealed a preference for a collaboration of organisations as being most suitable to deliver MHI training in Victoria.

Please think from your organisation's perspective what area/s you may be most able and willing to contribute towards. Please list which general area you believe your organisation may want to contribute towards:

Development of curriculum/ materials	<input type="checkbox"/>
Delivery of curriculum/ materials/ module/s	<input type="checkbox"/>
Administrative assistance	<input type="checkbox"/>
Promotion of the program	<input type="checkbox"/>
Administration of the program	<input type="checkbox"/>
Other:	<input type="checkbox"/>

*Specific comments:*

*We would be grateful to receive any further comments or suggestions you may have:*

**Note: Interpreter training for mental health professionals**

Most respondents answered that the training of mental health staff on working with interpreters is 'very important' (91.7%).

Some additional comments were raised on the need to ensure effective interpreting in mental health settings by focusing on training of mental health professionals for effective work with interpreters. This issue is also being addressed by the VTPU in a parallel project. The VTPU's work will include the development of training material for mental health professionals working with interpreters and the delivery of training sessions in Area Mental Health services across Victoria. The training will be designed for all mental health professionals in Victoria. This is an initiative of the Victorian Office of Multicultural Affairs and the Mental Health branch of Victoria. The VTPU is happy to provide further information as this project develops.

*Thank you for your time and valuable contribution.*

## Appendix Four: Survey One to Victorian Interpreters

### Victorian Transcultural Psychiatry Unit

#### Survey of Interpreters' Interest in Training in Mental Health Interpreting (MHI)

The Victorian Transcultural Psychiatry Unit (VTPU) is currently researching the training and professional development activities needed to prepare interpreters for effective work in mental health settings. We are interested in exploring whether interpreters would be interested in a training program on interpreting in mental health settings, as well as discovering interpreters' views on the key issues and concerns related to working in mental health settings.

We invite you to complete this survey, which is designed to be a preliminary exploration of your interest in training and professional development needs for interpreting in mental health settings drawing on your professional needs, expertise and practical experience.

Your responses will be completely **confidential** and collated with other interpreters' responses. This research will ultimately inform the planning and development of curriculum/ training materials to prepare interpreters for work in the mental health setting. This project is funded by the Victorian Office of the Multicultural Affairs and supported by the Mental Health Branch.

We greatly appreciate your time and commitment to this project.

Sincerely,

Tania Miletic

Project Worker, Mental Health Interpreter Training Project, VTPU.

Please complete and mail or fax this survey by Friday June 24th, to:

Project Worker, Mental Health Interpreter Training Project, VTPU.

Email: [vtpu@svhm.org.au](mailto:vtpu@svhm.org.au)

Telephone: (+61 3) 9411 0321

Fax: (+61 3) 9416 0265

**A FEW QUESTIONS ABOUT YOU & YOUR WORK**

---

**14. How many years have you worked as an interpreter in Australia?**

- less than 6 months
  - 6 months – 1 year
  - 1 – 2 years
  - 2 – 5 years
  - 5 – 10 years
  - 10 or more years
- 

**15. About how much of your interpreting work in the past year has been with mental health services?**

- none
  - a small amount
  - some
  - most
  - all
- 

**16. Please write the main languages in which you interpret and your level of accreditation in that**

Language ..... Level .....

Language ..... Level .....

Language ..... Level .....

---

**A FEW QUESTIONS ABOUT YOU & YOUR WORK**

---

**17. How much specialised training have you received for interpreting in a mental health setting? (excluding your interpreting diploma course).**

- None
  - less than 3 hours
  - 3 – 8 hours
  - 2 days
  - More than 2 days
- 

**18. Would you be interested in receiving specialist training to enhance your skills for interpreting in a mental health setting?**

- Yes
  - No
- 

**19. If you did receive mental health interpreting training, would you prefer:**

- a single session (2-4 hours)
- a single one-day session
- a series of one-day sessions (e.g., one day over 4-8 weeks)
- a series of 2-4 hour sessions (e.g., over 12 weeks)
- a course as part of an advanced diploma in interpreting
- Other \_\_\_\_\_



**20. When would you be most likely to attend mental health interpreter training if it was delivered:**

- On week day/s in business hours
- On week day/s in the evening
- On Saturdays
- Other (please specify):

**21. Which topics would be of interest to you?**

- The role of the interpreter in the mental health setting
- The mental health system and the professions
- Introduction to the major mental disorders
- Abnormal illness behaviour
- Translation issues in the mental health setting: conveying meaning across cultures
- The Mental Health Act: involuntary admission and other medico-legal issues
- Migration and mental health
- Interpreting with families
- The family and childhood mental health problems
- The family and mental health problems of adolescence
- Mental health problems of the aged
- Refugee issues; survivors of torture and trauma
- Issues in interpreting assessment tests
- Safety of the interpreter; briefing and debriefing
- Interpreting in crisis situations
- The interpreter as a cultural consultant
- Interpreting and psychotherapy
- How to deal with distressing interviews and incidents/ debriefing issues
- Interpreter Practice/ Process (specific technical issues for interpreters, e.g., interpreting incoherent speech, etc)
- Interpreting in a mental health teams with multiple professionals
- Interpreting for the deaf / deaf mental health issues
- Other (please specify)

**22. Would you be willing to pay to attend such training?**

- yes
- no

**23. Which of these outcomes of training are most valuable to you?**

- Priority in bookings with mental health service providers
- Priority in bookings with interpreter agency
- Accreditation certificate
- Certificate of completion
- Other \_\_\_\_\_

## DEBRIEFING

Mental health staff are offered debriefing\*\* if they experience a distressing incident, or are distressed by material they hear from a client. Some interpreters have expressed a need for debriefing after a distressing interpreting assignment.

*\*\*Debriefing can be described as a structured discussion conducted by a trained peer. It provides an opportunity for staff to talk through facts, thoughts, feelings and reactions to a critical incident or distressing experience that occurs during their regular work.*

---

24. Do you ever feel that you would like to have someone to debrief with following a distressing interpreting assignment?

- Yes, most times
- Yes, sometimes
- Not yet, but would like to have the opportunity
- No, never
- 
- Other \_\_\_\_\_

---

25. Have you ever been offered debriefing after such assignments?

- No
- Yes, but only occasionally
- Yes, most times
- Yes, every time
- Other \_\_\_\_\_

---

26. If you have been offered some kind of debriefing before: what type was it?

- Debriefing by MH clinician, initiated by clinician
- Debriefing by MH clinician initiated by interpreter
- Debriefing by Interpreting Agency staff member
- Informal debriefing/ discussion after session with clinician
- Informal debriefing with colleague
- Informal debriefing with friend/ family member colleague
- In a group with other interpreters

---

27. Of these kinds of debriefings which would you prefer:

- Debriefing by MH clinician, initiated by clinician
- Debriefing by MH clinician initiated by interpreter
- Debriefing by Interpreting Agency staff member
- Informal debriefing/ discussion after session with clinician
- Informal debriefing with colleague
- Informal debriefing with friend/ family member colleague
- In a group with other interpreters
- Other \_\_\_\_\_

**28. The most suitable organisation to deliver mental health interpreter training is:**

- |   |                          |
|---|--------------------------|
| University with existing Interpreting course                    | <input type="checkbox"/> |
| Interpreter Agency  | <input type="checkbox"/> |
| Centre for International Mental Health, University of Melbourne | <input type="checkbox"/> |
| Victorian Transcultural Psychiatry Unit                         | <input type="checkbox"/> |
| Collaboration between above organisations                       | <input type="checkbox"/> |
| Other organisation (please specify):                            | <input type="checkbox"/> |

**29. How much difference would specialised mental health training make for preparing interpreters to work in mental health settings?**

- |                        |                          |
|------------------------|--------------------------|
| No difference          | <input type="checkbox"/> |
| Some difference        | <input type="checkbox"/> |
| Significant difference | <input type="checkbox"/> |

**30. Another project the VTPU is conducting involves the training of mental health staff to work effectively with interpreters.**

**How important is the training of mental health staff on working with interpreters? (please circle)**

- |                            |   |
|----------------------------|---|
| Not at all important ..... | 1 |
| Somewhat important .....   | 2 |
| Quite important .....      | 3 |
| Very important .....       | 4 |

*We would be grateful to receive any further comments or suggestions you may have:*

*Thank you for your time and valuable contribution.*

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## Notes







# About the Victorian Transcultural Psychiatry Unit (VTPU)

The mission of the Victorian Transcultural Psychiatry Unit (VTPU) is to strengthen the capacity of Victoria's mental health system to provide effective, equitable and culturally appropriate services to Victoria's culturally and linguistically diverse (CALD) population.

## Authors

Ms Tania Miletic, Project Worker, VTPU  
Associate Professor Harry Minas, Director, VTPU  
Dr. Yvonne Stolk, Research and Education Officer, VTPU  
Ms Diane Gabb, Education and Professional Development Co-ordinator, VTPU  
Associate Professor Steven Klimidis, Research Co-ordinator, VTPU  
Ms Marie Piu, Service and Professional Development, VTPU  
Ms Malina Stankovska, Manager, VTPU

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The information and recommendations presented in this report have been produced by the VTPU and may not necessarily reflect the opinions of each person or organization involved with the Mental Health Interpreting Project.



EMAIL: [vptu@svhm.org.au](mailto:vptu@svhm.org.au)  
WEBSITE: [www.vtpu.org.au](http://www.vtpu.org.au)

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