RESOURCE R2: Written case studies for discussion

Introduction

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

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

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

How might the written scenarios be used?

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

The case studies contain:

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

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

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

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

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

Potential discussion points concerning the background information:

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

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

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

Potential discussion points:

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

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

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

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

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

Potential discussion points concerning the background information:

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

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

Potential discussion points concerning the unfolding action:

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

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

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

Scenario Three: the relative is the interpreter in exceptional circumstances

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

Potential discussion points concerning the background:

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

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

Potential discussion points from the unfolding action:

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

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

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

Scenario Four: interpreter mediation and nearest relative

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

Potential discussion points from the background:

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

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

Potential discussion points from the unfolding action:

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

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

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

INforMHAA: Interpreter-mediated Mental Health Act Assessments

Best practices for Approved Mental Health Professionals and Interpreters working together

Document Description

This document is an **extracted section** from **INforMHAA Project Guidance & Resources** for use as a handy reference.

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