Mental Health Interpreting Guidelines for Interpreters

Guidelines on definitions, protocols, ethics, practices, self-care and content knowledge for interpreters working in mental health settings

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An interaction between a mental health professional and a person with a mental illness is in many ways different from an interaction between a general healthcare professional and a person with a physical condition. In a mental health interaction, elicitation and demonstration of symptoms, monitored testing, initial diagnosis, therapy, recovery and/or management of symptoms all occur via interactions where the ability to openly communicate, to build rapport and to gain the trust and confidence are critical. Where the mental health professional and the person with a mental illness do not have a common language, the work of the interpreter in building this relationship is critical. The mental health interpreter's renditions therefore play a key role in the work of the mental health professional, as s/he is reliant on these to work effectively with the patient.

There are guidelines that inform mental health professionals on how to work with interpreters, eg. the VTPU's *Guidelines for working effectively with interpreters in mental health settings*. (2006), AUSIT's *Guidelines for Health Professionals Working with Interpreters* (2007) with a 2-page section on mental health and the APS's *Working with Interpreters: A Practice Guide for Psychologists* (2013). From the perspective of the interpreter, guidelines exist for sign language interpreting in ASLIA's *Guidelines for Interpreting in Mental Health Settings* (2011) which describe parameters of interpreting practice with both mental health professionals and patients. The guidelines contained in this document build on ASLIA's (2011) guidelines, and encompass both spoken and sign language interpreters.

The guidelines in this document provide the following: definitions of key terms, protocols, a discussion of ethical considerations, self-care in mental interpreting, content knowledge, and patients' rights and legal terms. Information on medico-legal tribunals and legislation is also provided.These guidelines are intended to assist interpreters so that they can work optimally in mental health interactions with both mental health professional and patient.

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These Guidelines for Mental Health Interpreting are endorsed by AUSIT (Australian Institute of Interpreters and Translators) and ASLIA (Australian Sign Language Interpreters Association).

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I. DEFINITIONS OF KEY TERMS

Mental health

Mental health encompasses a person's psychological, emotional and social well-being. A person's mental health may be discernible through forms of behaviour, physical symptoms or use of language. At the same time, it may not be readily discernible; a realisation or diagnosis of mental health problems may sometimes come about only through an indirect event or through testing and/or systematic observation by another.

A number of factors can contribute to mental health problems. These include: biological features, such as brain chemistry and genes; life experiences such as abuse, violence, torture or other forms of trauma; family history of mental health problems.

Patient

In Australia and in the context of mental health interpreting, the patient[1] who has limited English proficiency (LEP)[2] and/or who is Deaf[3] or hard of hearing[4] is the person requiring the services of an interpreter to communicate with a mental health professional.

Mental health professional

Similar to the patient, the mental health professional requires the services of an interpreter to communicate with an LEP and/or Deaf or hard of hearing patient. The mental health professional may be a psychiatrist, psychologist, counsellor, therapist, mental health nurse,

[1] In these guidelines the term *patient* is used to refer to a consumer of mental health services, i.e. a person with a mental illness who interacts with others in the provision of services. The term *patient* is appropriate for general health or medical contexts. However, within mental health services in Australia, there is a national framework for recovery-oriented mental health services that has begun to advocate the term *consumer of mental health services*. The term *patient* is retained in this document, due to its brevity compared to the term *consumer of mental health settings*.

[2] The term *limited English proficiency* (LEP) is used here as the guiding characteristic of the clients with whom interpreters work. This term is used in preference to the term *language other than English* (LOTE) as it is the proficiency level in English that does not enable functional and reliable communication with an English-speaker. The term LEP also recognises that many clients have some proficiency in English and may often address others in English or code-switch into English. These guidelines address this in section

[3] Many Deaf people who use a sign language such as Auslan *also* have *limited English proficiency* (LEP), i.e. they are both Deaf and LEP. This means that written materials in English are often not appropriate ways to communicate with them, nor are other text-based means of communication such as 'pen and paper'. A Deaf client who requests an Auslan-English interpreter requires such an interpreter to communicate with an English-speaker. An Auslan-English interpreter should be provided to hearing children of Deaf parents where requested as Auslan may be their first language. These Auslan-users may require Auslan receptively but use spoken English for expressive language.

[4] People who self-define as hard of hearing may use Auslan, a spoken language of their culture or both of these. An Auslan-English interpreter should be provided where requested to meet their communication needs as many hard of hearing Auslan-users may use a mix of sign and spoken language.

social worker, general practitioner (GP), support worker, or other healthcare worker who interacts with a patient in a therapeutic, advisory or treatment-based capacity.

Mental health interpreter

A mental health interpreter is an interpreter working in mental health settings. These settings include not only emergency, treatment or rehabilitation settings, but also settings in which the client is identified as a mental health client, e.g. a National Disability Insurance Scheme (NDIS) meeting; a housing and accommodation support meeting with representatives of a relevant support service; a medical setting relating to physical health symptoms that are a consequence of a mental illness or condition.

A mental health interpreter should ideally have training in both general interpreting, and in interpreting in mental health settings. The term 'mental health interpreter' encompasses interpreters for spoken languages other than English and sign language interpreters (Auslan-English interpreters and Deaf interpreters [5]). In Australia, interpreters working in the mental health sector should possess a credential or standard of practice that certifies their level of general interpreting ability, namely **certification** (from 2018 onwards) or **accreditation** (term used from 1977 to 2017). The terms certification and accreditation relate to a system of formal testing of candidates or recognition of existing skill levels so that these represent a certification of an interpreter practitioner granted by the National Accreditation Authority of Translators and Interpreters (NAATI).

Training is a vital and necessary attribute for interpreters to possess in order to work in mental health settings. From 2018 onwards, NAATI will be awarding a higher credential relevant to those wishing to become mental health interpreters or who already work as mental health interpreters, **certified interpreter – specialisation: health interpreting**. This credential will be awarded to interpreters who fulfil both of the following: undertake a course of training in health interpreting that includes a mental health interpreting component; successfully complete a NAATI specialist test in health interpreting that includes a demonstration of skills relevant to mental health interactions. These skills include consecutive interpreting (both dialogue and monologue), simultaneous interpreting (including chuchotage for spoken language interpreting) and sight translation.

Aside from (and beyond) NAATI certification, training through training courses and completion of relevant and appropriate PD courses are key attributes that build and extend the skill-level of a mental health interpreter.

[5] A Deaf interpreter (also known as a Deaf Relay interpreter) is an individual who is usually Deaf, fluent in Auslan, written English and who may have additional proficiency in a foreign sign language or pidgin.

II. PROTOCOLS

There a number of protocols or features that interpreters should attempt to be clear about before the interpreted interaction commences. The following are a list of the chronological stages relevant to the interaction, and the operational and recommended steps to take before, during and after a mental health interaction.

Pre-assignment steps

1. *Pre-interaction information.*

Information about the interpreting assignment that can be gained before the interaction, e.g. address, name of institution, name of clinic or hospital area / ward that give general information about the site / place of the interaction. Where personal information or the identity of the client/s is made available in advance, the interpreter notes whether s/he has worked with a client before and where this is the case, considers whether his/her relationship with the client is still a work-related one, and/or other features that the interpreter may recall about the client's state of health. Where the interpreter believes that s/he can recall information about a client's health, the interpreter should consider carefully how reliable and clear these recollections may be. Interpreters frequently work with many clients and should be mindful of the fact that what they recall from a previous interaction may not always be an accurate reflection of what happened in that past interaction, and that their recollections are subjective.

Pre-interaction steps

2. *Briefing*

In order for interpreters to work effectively with mental health professionals, it is important that they request and have a briefing with the mental health professional for both to work effectively with each other. For the interpreter, this briefing is an opportunity to gain information on the general purpose of the interaction, or what the mental health professional seeks to 'achieve', in a general sense, in the interaction. This information allows the interpreter to be informed of the mental health professional's perspective and intentions towards the interaction. The interpreter is thereupon able to anticipate the way the mental health professional will communicate with the client and the likely type of language to be used.

There are a number of points that can be touched on in the briefing with the mental health professional. Below is a non-exhaustive list from which the interpreter may consider which are relevant to the interaction:

- Previous experience working with interpreters in the simultaneous and/or consecutive mode, and whether spoken or sign language
- Role of interpreter in facilitating communication between speakers/users of different languages
- Ethical code/s by which the interpreter works, including the principle of confidentiality
- General format or purpose of interaction
- Is this the mental health professional's first interaction with the patient

- Any relevant information about the patient's speech/signing, eg. aphasia, stroke-related language problems.
- Safety concerns. If these exist, the possibility of using a code word (eg. "flag") for the interpreter to signal that s/he feels that his/her physical safety is threatened
- If the mental health professional has questions about the language itself of the patient, whether s/he will bring this up in the interaction itself or in a de-briefing after the interaction
- Whether introduction of the interpreter includes (self-)identification of the interpreter with full name, first name or whether the interpreter prefers not to identify him-/herself.
- The issue of the interpreter having had previous contact with the same patient. The interpreter should use professional judgement in carefully considering the following:
    - how accurately the interpreter recalls previous interactions (it is possible that the interpreter may confuse or mix up details of patients' medical histories.)
    - the patients' right to privacy, including the right to choose what information about themselves they wish to divulge
    - if the interpreter believes that s/he should bring up this issue with the mental health professional then the interpreter needs to consider why s/he would do this

The above are only an example of the issues that may be brought up in the briefing. A recommended practice is that at least 15 minutes should be allocated for the briefing and that the briefing time is recognised as working time for the interpreter and is thus remunerated. For family therapy sessions, it is recommended that a longer briefing time be planned.

3. *Outlining of interpreter's role and negotiation of role-relationship*

The briefing serves the purpose of an exchange of information between the interpreter and the mental health professional, so that both are in a position to perform their tasks in the interaction itself and to know how to work together within the interaction. The interpreter should, in the briefing, outline his/her formal role as interpreter for the interaction. The outlining of the interpreter's role is a negotiated practice: the interpreter and mental health professional negotiate and check that they know, in general terms, how the interaction may be structured, if the interpreter would like to introduce him-/herself or allow the mental health professional to introduce him/her and for the interpreter to then outline his/her role to the patient.

Further, the briefing allows both interpreter and mental health professional to touch on issues such features of the patient's speech or signing, the patient's possible use of spoken English or code-switching, how the interpreter will render not only the content of a patient's speech or signing, but also its form, particularly where this may be incoherent, repetitive, highly figurative or metaphoric and so on. This also provides time for the interpreter and the mental health professional to discuss whether the mental health professional will employ diagnostic tools orvisual resources such as use of whiteboards, pictures, therapy cards, games or aural resources such as music, guided meditation/mindfulness recordings and so forth (Anderson, 2012). In addition, the interpreter should enquire whether it is possible or advisable to take notes and/or which mode (consecutive/simultaneous) of interpreting can or should be used. Where the mental health professional seeks guidance on interpreting mode, the interpreter provides information on this.

The interpreted mental health interaction

4. Primary contact with patient

As stated, the interpreter should discuss in the briefing with the mental health professional, issues to do with introduction (of both parties), use of names or forms of address, and explanation of role to the patient. The interpreter should either be introduced, or introduce him-/herself. This does not have to include use of full name or first name if the interpreter does not wish to identify him-/herself. (This should is to be outlined in the briefing.) In the primary contact with the patient at the start of the interaction, the interpreter should consider the following to check with the patient:

- Language for which the assignment is booked, certification/accreditation level of interpreter
- Previous experience communicating via interpreters
- Ethical principles: 'completeness' of interpretations, i.e. the interpreter will interpret all speech/signing from all parties; confidentiality of interaction, i.e. no content or details of the interaction will be passed on to others
- Physical configuration of the interaction
- Use of 1st person "I" in interpretation
- Mode of interpreting (consecutive and/or simultaneous)

In addition to the patient, the interpreter may be working with family members, friends or others associated with the patient. In multi-party group interactions, the interpreter should check the above features with all those with whom s/he will be working. The sign language interpreter may also like to clarify the use of any 'name signs', i.e. names of people who are represented by a specific sign designated for that person. This is particularly pertinent when interpreting signed conversations amongst family members where the mental health professional is 'listening in' to family discussion.

5. Discourse of the mental health interaction

A key aspect of interpreting the speech/signing of others is to focus on the overall meaning of the speaker's output and what is being said/signed. Interpreters align themselves to the *content* of what is said/signed and render this in the other language. However, in mental health interpreting, the *form* of speech or signing is usually important to the mental health professional. Mental health professionals rely not only on the referential content of a patient's utterances, but on the *way* the patient speaks/signs with any of the following also contributing to a diagnosis or to forms of treatment: speed, flow, intonation, cadence, repetition of particular forms, discourse markers (*you know*, *like*), stuttering, disfluencies, incoherent speech and articulation, body language, conspicuous avoidance of forms or constructions (e.g. 1st person singular "I"), conspicuous over-use of constructions (e.g. passive voice) or unusual linguistic practices (e.g. using the 3rd person singular to refer to oneself, alliteration or rhyming sequences) (Boyles & Talbot, 2017).

6. *Patient discourse*

Interpreters need to convey the features of the form of a patient's speech or signing to the mental health professional so that these are apparent to him/her in diagnosing or working with a patient in a therapeutic setting. It is often very difficult to replicate the specific features of the linguistic forms used by a patient *in* the form of the interpretation. Where interpreters are unable to do this, or where the features *cannot* reasonably be replicated in an interpretation (eg. stuttering, alliteration, rhymes), the interpreter should convey to the mental health professional what *form* is being employed by the patient by way of description of this form. When working with a patient, mental health professionals rely on these features of a patient's behaviour, and not only the referential content of their utterance.

Interpreters need to have knowledge of how illness and pain are expressed not only linguistically via terms and statements of well-being, but through other linguistic forms such as euphemism, metaphor, vocalisations, facial expressions or reference to other concepts that index health or well-being. A patient's descriptions of his/her disposition, comfort level and concept of self will reflect his/her personal circumstances and his/her world-view. As a result, for some patients, reference to colours, numbers, places, foods or other symbols (real or metaphoric), or use of analogy or figurative language, may, for example, be the way in which they describe themselves, their symptoms and/or (those in) their environment. A patient may report 'hearing voices' or 'seeing voices'. For spoken language interpreters, this can be a challenge to convey what the patient is saying on behalf of him-/herself, and what s/he is recounting from voices heard. For sign language interpreters, the Deaf patients that they work with may hear voices or may see signed voices. Sign language interpreters need to relay both what is being signed by the patient, and relay what the patient recounts from voices heard or seen. Using their professional judgement, sign language interpreters may need to explain to the mental health professional that Deaf people can both hear as well as see voices.

For sign language users, their language use may be non-standard or idiosyncratic due to their language acquisition history, e.g. that Auslan is not their first language; lack of signing in their upbringing; living remotely and thus having little access to the Deaf community. The interpreter must draw the attention of the mental health professional to the issue of non-standard use of language as it may or may not be relevant to the intervention.

As stated, the *form* of the patient's speech/signing is important to the mental health professional and the interpreter's interpretation of the patient's speech/signing should contain these *forms* (e.g. references to colour, numbers, places and so on.). The interpreter is advised *not* to 'make meaning' out of these forms beyond the referential content that these forms relate to. It is up to the mental health professional to 'make meaning' out of the spoken/signed interpretation, and if he/she has questions about the meaning or other significance of the patient's speech/signing then he/she will ask these questions via the interpreter to the patient. Where the interpreter is not able to readily interpret the patient's speech/signing to reflect these forms, for whatever reason, the interpreter should describe these forms and add that this is his/her [the interpreter's] description, and not what the patient said/signed. It is important in these instances that the interpreter renders the referential content in the way that it is spoken/signed to him/her, but that he/she does not take on the role of 'meaning maker' (Pollard, 1998).

A patient's language may be affected by his/her mental and/or physical condition (e.g. a person living with dementia may have difficulty speaking because of the physical changes that occur

in the brain). A bi- or multilingual patient (of any degree of language mastery) may use one or more languages to express him-/herself, or a mix of languages and/or dialects. The linguistic, prosodic and paralinguistic features of a patient's communicative repertoire may be symptomatically remarkable or not. A trained interpreter is ideally placed to recognise significant variation from what might fall within culturally acceptable linguistic (including prosodic and paralinguistic) parameters.

7. *Mental health professional discourse*

A mental health professional may use different registers in his/her communication with different interlocutors. In general, healthcare staff are trained to use everyday English and avoid technical language when communicating with patients. As part of a multidisciplinary team, however, an interpreter may be exposed to a wide variety of registers, including specialist and technical ones. The same applies to the communicative repertoires of patients, which may show wide variation across register and formality, as well as cohesion and coherence. A mental health professional's language may also be guided by the interpreter's linguistic choices in the rendition, as he/she may reasonably expect this to be a mirror of the LEP and/or Deaf or hard or hearing patient's language.

Interpreters are required to learn the most common terms, such as anxiety, Alzheimer's disease, anorexia, Asperger's syndrome, attention deficit hyperactivity disorder (ADHD), autism, bipolar disorder, bulimia, dementia, depression (including major depression), neurosis, obsessive compulsive disorder (OCD), panic attack, paranoia, phobia (agoraphobia, claustrophobia), post-traumatic stress disorder (PTSD), psychosis, and schizophrenia.

Each term has its definition, symptoms and suggested treatments. Terminology is a part of an interpreter skill repertoire, and interpreters are encouraged not only to know the translation of the various terms, but also learn about the various conditions and the types of medication most commonly used to treat them (Crezee, 2013). Understanding how a condition, disorder or illness presents is important for knowing how an interpreter can recognise signs of potentially dangerous behaviour. This recommendation includes symptoms that are not only mental ones, but physical ones as well.

The physical behaviour of a patient, which includes verbal/signing as well as non-verbal/non-manual behaviour, are very often reflective of the mental health condition that a patient has. It is recommended that interpreters learn about the typical physical symptoms that patients with common mental health conditions often display (Tribe & Raval, 2003). This knowledge serves the purpose of allowing the interpreter to focus more on the verbal/signed behaviour and not to be needlessly distracted by behaviour that may be unusual but nonetheless common amongst patients with particular conditions (Leanza et al., 2014). Nonetheless, the significance of body language and other paralinguistic or prosodic features are as important as words or signs (Anderson, 2012).

<u>Post-interaction</u>

8. *De-briefing*

The de-briefing enables both interpreter and mental health professional to touch base about language, language-transfer or extra-linguistic features that are relevant to the way all parties

communicated with each other. For the mental health professional, this step is important if there are residual questions about the patient's speech/signing or the content or manner in which the interpreter interpreted. For the interpreter, this step allows him/her to relate any features about the patient's or mental health professional's speech/signing that were meaningful to the interaction that may have been only partially or not fully conveyed in the interpreter's interpretations. It can be that the pace, turn-taking habits, speech/signing style of the patient, discourse used by the mental health professional or other linguistic or environmental features may have affected the interpreter's ability to fully interpret everything said/signed during the interaction. Where this occurs, the interpreter should use the de-briefing to inform the mental health professional of what was not fully transferred in his/her interpretations, especially if this relates to features of the patient's speech/signing.

Where distress, confrontation or (potential) aggression occurred in the interaction, the interpreter should consider speaking to the mental health professional about this. The perspective of the mental health professional in regard to a distressing situation can inform and further the interpreter's general understanding of mental health interactions. This, in turn, can be of benefit in preparing for and managing future interactions.

Further to this, recognition and acknowledgement of a distressing situation can be an important first step in managing work-related stress. Acknowledgement of a distressing situation from a mental health professional may also be an important step in seeking services to deal with work-related stress, including that related to secondary traumatic stress (STS), vicarious trauma (VT) and burnout. (See section IV. Self-care in mental health interpreting below).

If the mental health professional questions the interpreter about features of the interaction beyond inter-lingual transfer, the interpreter should reiterate in the de-briefing that s/he conveyed via interpretation all things said/signed by others in the interaction. Where appropriate, the interpreter should also re-explain his/her role to the mental health professional. The AUSIT Guidelines for Health Professionals Working with Interpreters state the following:

> Under the normal circumstances of general health interpreting, you [the mental health professional] should not be asking interpreters to give information about the patient's culture, unless communication has broken down. The importance of culture can be over-emphasised. All patients have different personalities, temperaments and life experience, and may vary considerably in the way they manifest their cultural background. However, professional interpreters know that language expression does not happen in isolation from customs and beliefs, especially in the health area. Interpreters are not producing word-by-word renditions of the patients' messages, but are passing on information across cultures to each party. They provide the **full meaning** of what is said by all parties in the languages spoken and understood by them.
>
> There may be rare occasions when you need to request essential cultural information from the interpreter, or the interpreter may consider that without certain information the message (from either party) may be distorted or there may be a total breakdown in communication. Under these circumstances, the information given by the interpreter should be factual (i.e. verifiable) and generally applicable to the patient's cultural background. Where possible, the patient should be involved in the discussion via the interpreter. Sensitive issues can also be discussed with the appropriate multicultural

> health unit (e.g. Queensland Transcultural Mental Health Centre, Multicultural Access units, Transcultural Psychiatric or mental health units).
>
> (AUSIT – GHPWI, 2007. Original emphasis, square brackets added.)

Interpreters are not mental health but linguistic experts. As the AUSIT GHPWI (2007) source recommends, interpreters should refrain from providing or suggesting an opinion on a client's mental health. The ethical principles of *impartiality*, *clarity of role boundaries*, and *integrity of professional relationships* recommend against a mental health interpreter offering his/her opinion on areas outside those of linguistic mediation.

However, along with their linguistic expertise, interpreters usually possess knowledge of the culture or cultures that may strongly shape clients' lives. In the Deaf community, there can be conventions about accessing or working with other support services that may be not be apparent to those who are not Deaf and that are relevant to the mental health interaction. Similarly, there can be conventions or attitudes shared by other LOTE communities about mental health diagnosis, treatment and health management that are not widely known amongst others outside the LOTE communities. Where an interpreter responds to these questions and provides a response based on his/her knowledge, the interpreter should firstly declare to the mental health professional that s/he is stepping outside his/her role of interpreter, and offering a response that is reflective of his/her personal knowledge only, and not representative of interpreters or the interpreting profession (Tribe & Lane, 2009).

III. ETHICAL CONSIDERATIONS

In an overall sense, spoken language Interpreters are guided by the AUSIT Code of Ethics and Code of Conduct (2012) and sign language interpreters are guided by the ASLIA Code of Ethics and Guidelines for Professional Conduct (2007). Sign language interpreters are also advised to be familiar with the ASLIA (2011) Guidelines for Interpreting in Mental Health Settings. The principles from these codes, especially confidentiality, competence, professional conduct, non-discrimination and professional accountability, are important notions that should be followed in mental health interactions. At the same time, these guidelines recognise also that interpreters may sometimes need to work in ways that differ from the specific intentions of the principles, as there can be features of mental health settings that may make it difficult for interpreters to always follow these principles.

The following are a listing of the principles from the AUSIT Code of Ethics and Code of Conduct, the ASLIA Code of Ethics and Guidelines for Professional Conduct. Excerpts are provided from the ASLIA Guidelines for Interpreting in Mental Health Settings (here abbreviated as 'ASLIA-GIMHS'), in relation to mental health interpreting performed by sign language interpreters and by spoken language interpreters.

1. *Professional Conduct*

Mental health interpreters work with mental health professionals and patients in a respectful and sensitive manner. This includes working towards the general aims of the performance of a mental health interaction and the work of others involved in this. In regard to contact with a patient before an interaction:

> It is *not* recommended that a MH [mental health] interpreter meet with the patient prior to meeting with the MH practitioner. Whilst this is [or may be] generally considered good work practice in other interpreted settings, in a mental health setting, it creates several risks including, but not limited to:
>
> - the possibility of the patient "bonding" with the interpreter rather than the clinician,
> - the patient disclosing information to the interpreter that would be best disclosed to the clinician,
> - the possibility of the interpreter unknowingly undermining work done by the clinician, and
> - the blurring of professional boundaries with a patient who is, by definition of the setting, in a heightened state of vulnerability. (ASLIA-GIMHS, 2011:4)

2. *Confidentiality*

The principle of confidentiality requires that mental health interpreters do not relate information or details from mental health interactions to others outside this interaction. Confidentiality also extends to the protection of information whether an interpreter has worked with a particular patient (client) or mental health professional before. If a patient or mental health professional

asks the mental health interpreter if s/he has worked with the other party before, the mental health interpreter should consider not responding to this question. Further, the mental health interpreter should consider relaying this question to the other party to convey that this question has been asked in the first place, and it is up to them as to how they answer this question, which is then interpreted by the interpreter.

In relation to confidentiality, knowledge of a patient's medical history and privacy, the ASLIA-GIMHS (2011: 3) state the following:

> … sharing of information needs to be counterbalanced with the need to protect the patient's privacy. For example, for whatever reason, a patient may talk about certain events with his or her clinician only when using a specific interpreter. This patient choice – whether it is conscious or unconscious – needs to be respected and managed carefully between the MH interpreters who are sharing the interpreting work with the patient. The guiding principle about the sharing of information needs to be how doing so will enhance the interpreting process and, thus, the patient's care.

At times, mental health interpreters may be privy to background information about the patient. Mental health professionals may ask questions to an interpreter in a briefing or de-briefing about the features that distinguish the patient's cultural-linguistic heritage from other groups. In regard to sign language interpreting, if a mental health professional asks questions about the impact of deafness and how a Deaf person's life experiences may vary from those from the wider community, the sign language interpreter may respond to these questions. Care should be taken to ensure that the clinician's view of the patient is not skewed by knowledge that is too general and which may not be applicable to that particular patient. Similarly, in regard to spoken language interpreting, the interpreter uses his/her professional judgement whether to respond to questions about the patient's cultural-linguistic heritage, and should signal that this information is being given in a general sense, and may not be applicable to the particular patient. (See Section 8. De-briefing above.)

Knowledge of the cultural-linguistic background of a patient is to be distinguished from knowledge about the patient's medical history. Where an interpreter recalls details of a patient's medical history, the interpreter should consider how accurately s/he can remember details, and secondly how relevant these may be to a situation. In most cases, the medical history of a patient is accessible to the mental health professional, and the interpreter is not the only person other than the patient with access to this.

Where the interpreter believes that the withholding of information could have a serious and negative effect on the accuracy of a diagnosis or effectiveness of a treatment, the interpreter should consider whether and how this information can be conveyed to the mental health professional. It should be emphasised that the interpreter should be sure that s/he can recall information about the patient that is relevant to the current interaction and that the withholding of this information could result in serious harm to the patient or others. The interpreter then may outline these concerns after the interaction, in a de-briefing with the mental health professional.

In the de-briefing, the interpreter outlines his/her duty of maintaining confidentiality of information, and the need to respect a patient's right to privacy. The interpreter uses his/her professional judgement in deciding whether these should be overridden by his/her strong belief

that a non-disclosure of this information could result in serious health consequences for the patient or for others. (See Section 8. De-briefing above.)

In situations where the withholding of information (such as allergic reactions, history of self-harm or harm to others) could be life-threatening to the patient or to others, the interpreter is not bound by the principle of confidentiality and must convey this to the most appropriate person, usually the mental health professional. In instances where the information may not have a life-threatening, but serious effect, the interpreter should use his/her professional judgement. Legally, it is not clear whether the defence of acting in the best of interests of the patient (his/her health and/or the health of others) would protect an interpreter from an accusation or charge of breaching the patient's privacy. The ASLIA-GIMHS (2011: 3) state:

> In the case of duty of care in relation to risk of harm to either self or others, it is important for the MH interpreter to know that should they become aware of such risk concerns outside the presence of the MH practitioner, that confidentiality does not bind and the clinician involved needs to be notified of the content expressed by the patient. In part, it is because of this possibility of patient disclosure to a MH interpreter that it is strongly recommended that the MH interpreter does not spend time with the patient outside the presence of the clinician. Interpreters are not trained to manage such scenarios; the clinician is.

It should be re-stated that it is important for the interpreter to consider how clear and accurate his/her recollection of a patient's medical history is. Elsewhere in relation to sign language interpreters working in a team in mental health settings, the ASLIA-GIMHS (2011: 3) recommend the following:

> A cornerstone of interpreting practice is confidentiality. The MH interpreter may find that more than one MH interpreter – each working as a sole practitioner – shares the responsibility for the interpreting work with a particular patient. If this is the case, a handover of information between interpreters is essential to the interpreting process. For example, this could include particular lexical items used in the source language by either a clinician or a patient and the choice of lexical items used by the MH interpreter in the target language as well as information about the type of discourse that may occur and/or the how a patient refers to certain things, particularly if s/he is unwell and disjointed or dysfluent in his or her communication. This information is important to assist the MH interpreter to manage the flow of the discourse between clinician and patient, but is not to be used to produce smooth, flowing target text from source text that was disjointed or dysfluent.

Further information on how the interpreter works in a team with others in rendering patient discourse can be found in Hale (2007: 37-50).

3. *Competence*

This principle requires that an interpreter is competent to carry out an assignment accepted in a mental health setting. This relates to the (varied) contexts of mental health settings, institutional structures, terminology, genres and discourse forms used by those with whom they work. Congruent to the recommendations given in these guidelines about content knowledge and protocols, the ASLIA-GMIHS (2011: 5) recommend that:

> … MH interpreters undertake ongoing reading and/or professional development in order to develop an understanding of psychopathology, the range of therapeutic frameworks utilised in mental health settings as well as the task of language transfer in such settings (e.g. how discourse may vary in mental health settings, the source language terminology that may be used and its possible equivalence in the target language, etc.).

The introduction of an advanced credential, **certified interpreter – specialisation: health interpreting** by NAATI in 2018 is welcomed and this credential should become the aspirational level of skill held by future mental health interpreters.

4. *Impartiality*

Interpreters remain unbiased and impartial throughout the communication exchanged between the participants in any interpreted encounter. However, impartiality does not mean aloofness or a prohibition to show empathy towards a patient. Where this is apparent in the discourse and tone of the mental health professional, this should be rendered by the interpreter. Similarly, the emotional and affective tone of the patient's speech/signing is rendered in the same way to the mental health professional.

In diagnostic testing, it is important that the interpreter renders only what is said/signed or shown by the mental health professional. The interpreter does not aid (or hinder) a patient in giving a response where this is sought by a mental health professional. It is important that the elicited capabilities of a patient are conveyed to the mental health professional without additional assistance from the interpreter (O'Hara & Akinsulure-Smith, 2005).

Interpreters disclose to the mental health professional any relationship that they may have with a patient - family, friendship or other – that could be considered to be a conflict of interest for the interpreter. Where a conflict of interest occurs, the interpreter should disclose this, and consider his/her ability to still interpret impartially, and offer to withdraw from the assignment. Withdrawal from an assignment is usually the optimal outcome when a conflict of interest exists between an interpreter and a patient. The ASLIA-GIMHS (2011: 8) advocate the following:

> The MH interpreter is responsible for maintaining strict professional boundaries with any deaf person met through the context of a mental health setting. Conversely, if a MH interpreter has a personal and/or social relationship with a deaf person, then s/he should not knowingly accept an assignment with that deaf person in a mental health setting. If, upon arrival at an assignment, s/he discovers that the deaf patient is someone within that personal/social circle, the MH interpreter must inform the clinician of this and withdraw from the assignment.
>
> ASLIA acknowledges that this principle may be difficult to adhere to in remote and regional settings, where availability of MH interpreters is limited. However, for the reasons outlined, ASLIA recommends that, whenever possible, this principle is observed and employed by the MH interpreter.

However, the withdrawal from an assignment may not be the optimal outcome if the situation is an urgent one, or if it is not feasible to source another interpreter within a timeframe that is critical to the patient's condition. In such cases, the interpreter discloses the conflict of interest,

declares whether s/he is still able to interpret impartially, and leaves it firstly to the mental health professional to decide whether s/he agrees for the interpreter to interpret, and secondly to the patient that s/he agrees to the interpreter interpreting. If both parties agree, the interpreter should add that either party may withdraw their agreement during the assignment, if either side believes that the conflict of interest that the interpreter is compromising either the content exchanged in the interaction or the overall purpose of the interaction.

5. *Accuracy*

The AUSIT Code of Ethics requires interpreters to be faithful at all times to the meaning of texts and messages, providing optimal and complete interpretations. A faithful interpretation of another's speech or signing includes intonational, prosodic, para-linguistic and other features of the source speech or signing. Interpreters are generally guided by the *meaning* of what is said or signed by others and their interpreters reflect this. However, in mental health interpreting, not only the *meaning*, but also the *form* of a patient's speech or signing is important. Disfluencies, repetitions, use of metaphors or imagery, use of third person about oneself are, for example, features of a patient's speech or signing that can be important in the diagnosis of a mental illness or in the features of talk-therapy treatment employed by a mental health professional. In the same way, the *form* of the mental health professional's speech or signing can be a feature of treatment that should be rendered in the interpreter's interpretations, e.g. unfinished questions, conspicuous use of imperatives, items used in sequences or lists. The *form* of language is focussed on below in sub-sections E, F and G in the section Protocols. The ASLIA-GIMHS (2011: 5) also describe the importance of *form* of language in interpretations:

> In a mental health setting – depending on the working framework and/or the intent of the clinician in that setting – faithfulness of interpretation can mean working as a linguistic informant to the clinician noting when language is disjointed, lacks cohesion and/or is incoherent rather than rendering an interpretation, per se. It is important for the MH interpreter to know that s/he is working faithfully even when what is interpreted does not make sense – it is essential for the MH interpreter to be able to "let go" of making sense. In this way, the MH interpreter provides the clinician with the text s/he needs to work with the deaf patient.
>
> It may be far more useful – depending on the clinician – to make comment about unusual aspects of the patient's language; for example, that a patient who is talking about three family members has placed them all in the same signing space instead of in three separate referential locations rather than simply rendering an interpretation of whatever the Auslan text may be. In part, this is why it is crucial for the MH interpreter to work closely with the clinician to become aware of the clinician's framework and the intent of the assignment.

An effective working rapport between the clinician and the interpreter contributes towards a more faithful interpretation and a more seamless interaction.

6. *Clarity of Role Boundaries / Professional Relationships*

The AUSIT Code of Ethics states that interpreters should not engage in other tasks such as advocacy, guidance or advice. The notion of clarity of role relationships overlaps with the ability of an interpreter to be impartial. In some circumstances, previous contact with a patient (or mental health professional) may present a complication to the mental health interaction. The ASLIA-GIMHS (2011: 7) set out that:

> Other relationships that the deaf patient may have with the MH interpreter – be they personal, social or even at a working level – may be confused within the MH setting by the deaf patient and, indeed, by the MH interpreter. As well, it is possible for the integrity of the interpreting to be compromised by this confusion of relationship and boundaries.
>
> Therefore, it is for this reason that ASLIA strongly recommends that under no circumstances should a MH interpreter engage in personal and/or social interaction with a deaf patient for whom s/he interprets in a MH setting.
>
> Even when only a professional relationship exists, a MH interpreter needs to carefully consider undertaking other interpreting work with a deaf patient outside of the mental health setting. This is recommended for both the patient and the MH interpreter's well being. For the interpreter, it may create a situation that can manifest itself with a blurring of boundaries and/or present challenges in relation to impartiality. For the patient, it may provoke distress or embarrassment to see the MH interpreter in another setting.

The role that the interpreter occupies can be misunderstood due to other reasons, such as those to do with a patient's ability to understand his/her role. For example, where the patient directly addresses the interpreter as the mental health professional, or clearly shows that s/he believes that the interpreter is (also) the mental health professional, the interpreter should re-clarify this to the patient, and interpret this clarification back to the mental health professional (Dabić, 2007). The interpreter should use his/her professional judgement in assessing whether the patient appears to consider the interpreter to be a mental health professional. Some interpreters report using the third person in relaying the mental health professional's speech or signing, as a way to clearly show that the interpreter is repeating another's speech/signing (Bot, 2005). However, this practice should be considered a last resort, and otherwise, interpreters use first person in mental health interpreting interactions, as they do in other interpreted interactions.

7. *Maintaining Professional Relationships*

This principle advocates that interpreters endeavour to secure satisfactory working conditions for the performance of their duties, including physical facilities, appropriate briefing, a clear commission, and clear conduct protocols where needed in specific institutional settings. They ensure that they have allocated adequate time to complete their work; they foster a mutually respectful business relationship with the people with whom they work and encourage them to become familiar with the interpreter role.

The AUSIT CoE (2012: 6) states the following:

> Some settings involve strict protocols where the interpreter or translator is a totally independent party, while others are marked by cooperation and shared responsibilities. Interpreters and translators must be familiar with these contexts, and endeavour to have the people they work with understand their role.

In mental health research, the term 'supervision' is sometimes used to describe how interpreters can work with others. This term is used in two different ways, and both ways differ from its lay meaning that suggests a relationship in which one person occupies a superordinate role and 'supervises' another person who occupies a subordinate role.

In sign language interpreting (Dean, Pollard and English, 2004), the term 'supervision' refers to counselling and therapy that an interpreter has with a person *outside* the mental health interaction, i.e. not with the mental health professional that s/he is working with. The purpose of supervision used in this meaning is to provide protections for the interpreter and his/her own mental health in relation to distressing situations and work-related stress.

In descriptions of spoken language interpreting, the term 'supervision' has been used to refer to something else, namely working with the mental health professional *within* the mental health interaction. A psychotherapist working with multilingual clients (mainly users of spoken LOTEs), Beverley Costa, advocates supervision for "counsellors and interpreters who want to work together collaboratively" (Costa, 2017: 56). Interpreters and counsellors may form a relationship of supervision not only for the sake of the interpreted mental health interaction, but for the well-being of the interpreter in it, and for the interpreter to work effectively with the patient *and* the mental health professional. Costa (2017) advocates that supervision between mental health professional and interpreter should contain three elements: (i) safety, trust and confidence; (ii) triangular dynamics and emotional impact; and (iii) collaborative practice.

This form of supervision that relates to a relationship between the interpreter and the mental health interpreters, is not binding or required of an interpreter. However, where an interpreter works frequently with the same mental health professional, or with professionals at the same mental healthcare facility, an interpreter may consider entering into a relationship of collaborative supervision with others. This relationship may include: formal preparation in regard to the purposes of an interaction, knowledge about the models of therapeutic orientation and therapeutic interventions that will be applied in the interaction, awareness of models of Transactional Analysis in describing human behaviour in therapy interactions (Costa, 2016), or the dynamics that can occur "in the triangular relationship between counsellor, client and interpreter, and… the ways in which power shifts around the triangle, how it is negotiated and to explain the pushes and pulls experienced by all three members involved" (Costa, 2017: 59).

It is again important to note that this embedded notion of supervision is something that interpreters may consider in some mental health interactions where they believe that this can assist them in the performance of their work as a mental health interpreter and address self-care concerns that can arise from mental health interactions. It is important to note that interpreters who engage in this form of embedded supervision still maintain an understanding with others of their role and the boundaries of this role. Collaborative supervision should not

replace professional development; a mental health interpreter is required to develop his/her professional knowledge in a general and a specific sense, drawing on training or self-instruction resources provided from many perspectives.

8. Professional Development

Professional development, additional to training in health and mental health interpreting, is required of interpreters today. The ASLIA-GIMHS recommends that this be a pre-requisite before an interpreter undertakes any mental health interpreting work:

> … no Auslan-English interpreter or DI [Deaf Interpreter] should work in a mental health setting without first undergoing a minimum of 25 hours of professional development that specifically addresses the multi-faceted nature of the mental health context. (2011: 5).

Professional development can take the form of self-directed activities, including acquisition of content knowledge, features of discourse and so on, as recommended by the ASLIA-GIMHS:

> ASLIA recommends that MH interpreters undertake ongoing reading and/or professional development in order to develop an understanding of psychopathology, the range of therapeutic frameworks utilised in mental health settings as well as the task of language transfer in such settings (e.g. how discourse may vary in mental health settings, the source language terminology that may be used and its possible equivalence in the target language, etc. (2011: 5)
>
> In order to move in and out of the many and varied settings that comprise "mental health interpreting", it is necessary to actively engage in the gaining of knowledge about the fields of psychology and psychiatry as these disciplines include many differing theoretical methodologies and approaches. Currency in these is essential to enabling effective interpretation to occur. (2011: 6)

9. Professional Solidarity

This principle refers to the support that mental health interpreters, like all interpreters, extend to each other and to further the interests of the profession. Assistance to others in the area of mental health can be in the form of exchange of content knowledge, descriptions of practices, exchange of information on protocols and a sharing of views on ethical perspectives. Such exchanges do not contain information that could identify people, groups, institutions and the principle of confidentiality is still upheld during such exchanges.

IV. SELF-CARE IN MENTAL HEALTH INTERPRETING

Briefings and de-briefings are necessary for the interpreter to work well in mental health interactions. However, they are not always provided. Briefings and de-briefings should be viewed as part of the interpreted session. De-briefings allow the interpreter to bring up issues that relate to the interpreted interaction. These may include the speech/signing of the patient that the interpreter may have difficulty understanding or rendering into spoken English. These may also include re-visiting difficult situations in which the patient was distressed or appeared to be traumatised. Discussion and reflection on these can assist an interpreter in dealing with and managing an interaction that was upsetting or highly stressful (Diehm & Roland, 2015).

Mental health interpreters, like mental health professionals, are exposed to stressful situations on a regular basis through the nature of their work. The cumulative effect of their work can have a negative effect on their own mental health. Interpreters, like mental health professionals, are exposed to the same risks of developing secondary traumatic stress (STS), vicarious trauma (VT) and burnout. The symptoms of STS are intrusion, avoidance and hyper-arousal. Intrusion is the inability to keep memories of an event from returning. Avoidance is the investment of effort to escape or obviate dealing with a stressor. Hyper-arousal is an elevated level of anxiety, animation or vigilance, whose symptoms include insomnia, irritability, inability to concentrate and jumpiness.

There are 'conventional' ways to deal with work-related stress, such as engaging in activities that are removed from work, and that distract or stimulate a person in other ways, eg. listening to music, physical exercise, meditation. These strategies can often deal with stress encountered and lead to a management of the stress so that the interpreter is still able to work and not suffer an uncomfortably high level of discomfort. However, these conventional ways of 'winding down' from difficult situations at work do not always alleviate, let alone resolve a high level of work-related stress.

A high level of work-related stress, or the cumulative effect of working in distressing and stressful situations, due to the behaviour of others or other factors, is STS, which can lead to burnout. Burnout is associated with emotional exhaustion (e.g. low energy levels, depleted emotional resources), depersonalisation (e.g. detachment in response to some aspects of employment), and reduced personal accomplishment (e.g. negative self-evaluation).

Where mental health interpreters experience STS that may then develop to VT or even burnout, they should consider professional counselling services, for example via the Employee Assistance Program (EAP). The EAP is available in public healthcare facilities across Australia and is available to in-house interpreters working at these. Freelance interpreters who accept contracted assignments have, at present, variable access to EAP, depending on the Language Services Providers with whom they are contracted. Having a self-care pathway identifying the types of assistance available for the different issues that arise is an important feature for interpreter self-care and well-being. The ASLIA-GIMHS guidelines are clear in multiple places about the importance of self-care, reflection on health issues, and:

> … it is strongly recommended that all MH interpreters undergo professional supervision as a minimum standard of practice. It is further recommended that MH interpreters also undergo regular therapeutic work of their own as this will not only enhance an understanding of the clinical setting, it will – more importantly – provide them with a

vehicle for personal reflection to manage the demands of their own inner world and its interaction with the demands of interpreting in mental health settings. (2011: 5)

V. CONTENT KNOWLEDGE

Interpreters need to acquire a knowledge base relevant to mental health interactions. These include: settings, mental health personnel, mental health illnesses, mental health symptoms and services, and treatment of mental health illnesses.

Settings

Mental health interactions can take place in a variety of settings. These include diagnostic testing at a patient's home or in a health care facility, counselling sessions for patients who have experienced trauma, torture, or who have witnessed these and experienced secondary trauma. Other settings include medication-check updates, group therapy, creative therapy (music, art or drama therapy), family conferences, peer-support group sessions, pre-discharge sessions.

The rehabilitation of a patient living a mental illness, such as alcoholism or drug/substance abuse may involve treatment inside and outside healthcare facilities, and on-going monitoring.

Aged-related mental health illnesses such as dementia and Alzheimer's Disease are increasing in frequency due to higher rates of self-reporting or detection and an ageing society. Settings associated with aged-related mental health interpreting include diagnosis, capacity-ascertainment, assessment of lifestyle features, support and management services. In relation to diagnosis, this may determine the content and purpose of a mental health interpreting setting, such as the administration of the mini-mental status examination (MMSE), application of the Rowland Universal Dementia Assessment Scale (RUDAS), Alzheimer's Disease Assessment Scale – Cognitive (ADAS-Cog) or even the administration of neuropsychological tests.

The practice of pharmacotherapy (therapy using pharmaceutical drugs) is common in many mental health settings, and in psychiatry, the use of psychoactive (chemical substance) drugs such as anti-anxiety drugs, anti-depressant drugs, anti-psychotic drugs or mood stabilisers is common. In psychiatric settings, communication between a mental health professional and a patient may be focussed on dosage, desired effect, reactions and side effects of chemical drugs taken by the patient.

Less commonly, the setting may include physical interventions such as electro-convulsive therapy, or instances of psychosurgery (bilaterial cingulotomy or deep brain stimulation).

In some instances, the setting may be focussed on the elicitation of a patient's capacities for the completion of a neuropsychological or psychiatric report. The purpose of this report may be for an application of guardianship for a patient, or it may be instigated by a work place to determine work suitability or capacity. It is important to distinguish the other participants in a setting and the role that they perform. A setting in which neuropsychological testing takes place, administered by a neuropsychologist is a mental health interpreting setting. However, at a tribunal where a tribunal member (presiding officer) requests the submission of a neuropsychological report and interacts with a person with a mental health illness for the purposes of establishing the need for a power of attorney or a guardian, such a setting is *not* primarily a mental health setting, but a court setting.

In other cases, particularly where intervention is requested by others, a mental health interpreter may be working with a Crisis Assessment and Treatment Team (CATT) who assess the likelihood or self-harm, harm to others, and the need for possible involuntary treatment. A decision on involuntary treatment may lead to the need for a patient's circumstances to be decided by a mental health review board or mental health tribunal. The Mental Health Tribunal (formerly Mental Health Review Board) is made up of (in Victoria) a legal member (lawyer), a community member (member of the public) and medical or psychiatrist member (doctor). (The designations and website addresses of the equivalent authorities for each of the states and territories in Australia are given in the Appendix 1.) The medico-legal features of the Mental Health Tribunal distinguish it as a mental health interpreting setting. (Further information on the contents of legislation relevant to mental health patients in all Australian states and territories is contained in Appendix 2.)

In other instances, a legal interaction may be the precursor to what turns out to be a mental health interaction. For instance, a person may appeal against a decision for him/her to not be awarded workers compensation for (physical or mental) injuries suffered at the workplace. Such an appeal may need to go before a Medical Panel (in Victoria) that consists only of doctors. Where an appellant has mental health problems and these are the subject of the appeal, this distinguishes such a setting as a mental health interpreting setting.

Lastly, the setting may be strongly shaped by its urgency, such as working with emergency services: ambulance, police, fire brigade. In emergency situations, triage is the process by which emergency services staff, either remotely (by telephone or video link) or in person determine the priority of a patient's treatment based on the severity of the condition.

Services

Services in mental health care in Australia encompass, in broad terms, the following:

- emergency services (acute mental health initial assessment and screening);
- inpatient and ambulatory services;
- outpatient services;
- clinical health services;
- disability rehabilitation and support services; and
- medico-legal services.

Health professionals attempt to achieve a variety of objectives through the provision of a range of mental health services. These services are usually divided into child & adolescent services, adult services, aged person services, and specialist services. Support and specialist services include disability services, drug and alcohol services, housing and accommodation services, income support services, recreation, and carer programs.

In Australia, there are a number of public organisations or services that provide information to a general, non-specific audience about mental health conditions. These include the following:

- Anxiety conditions: anxiety; generalised anxiety disorder; social anxiety; agoraphobia; obsessive compulsive disorder; post-traumatic stress disorder; panic disorder

(mindhealthconnect - http://www.mindhealthconnect.org.au/) (beyondblue - https://www.beyondblue.org.au/)

- Personality disorders: personality disorder; borderline personality disorder; narcissistic personality disorder (mindhealthconnect - http://www.mindhealthconnect.org.au/)
- Mood disorders: depression; bi-polar (mindhealthconnect - http://www.mindhealthconnect.org.au/)
- Psychotic disorders: schizophrenia; psychosis; paranoia (mindhealthconnect - http://www.mindhealthconnect.org.au/)
- Eating disorders: bulimia; anorexia nervosa; disordered eating (mindhealthconnect - http://www.mindhealthconnect.org.au/)
- Depression; suicide prevention; supporting others; self-harm and self-injury; pregnancy and early parenthood; grief and loss; drugs, alcohol and mental health. (beyondblue - https://www.beyondblue.org.au/)
- Dementia, memory loss and Alzheimer's disease (Alzheimer's Australia - (https://www.fightdementia.org.au/)

In addition, there are other services that are intended for age-specific groups, eg. KidsMatter (http://www.kidsmatter.edu.au/) for children of primary school age, and headspace (https://www.eheadspace.org.au/) for young people aged 12-25 or for their family for them to contact a qualified youth mental health professional.

Terms and definitions used for mental health illnesses (including the terms 'mental conditions' and 'mental disorders')

In hospital and clinical mental health settings in Australia, there are two diagnostic manuals that are currently in use. The first is published by the American Psychiatric Association, the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5). The second is published by the World Health Organization (WHO), the International Classification of Diseases: Classification and Mental and Behavioural Disorders 10th Revision (ICD-10). The following information is taken from the WHO (2010) website on "Mental and Behavioural Disorders". The ICD-10 groups mental and behavioural disorders into ten categories, cited here from WHO (2010):

1. *Organic, including symptomatic, mental disorders*

   Mental disorders grouped together on the basis of their having in common a demonstrable aetiology in cerebral disease, brain injury, or other insult leading to cerebral dysfunction. The dysfunction may be primary, as in diseases or injuries.

   Dementia is a syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgement.

This syndrome occurs in Alzheimer's disease, in cerebrovascular disease, and in other conditions primarily or secondarily affecting the brain.

2. *Mental and behavioural disorders due to psychoactive substance use*

Disorders that differ in severity and clinical form but that are all attributable to the use of one or more psychoactive substances, which may or may not have been medically prescribed.

Identification should be based on as many sources of information as possible. These include self-report data, analysis of blood and other body fluids, characteristic physical and psychological symptoms, clinical signs and behaviour, and other evidence such as drugs being in the patient's possession or reports from informed third parties. Many drug users take more than one type of psychoactive substance.

3. *Schizophrenia, schizotypal and delusional disorders*

This includes schizophrenia, as the most important member of the group, persistent delusional disorders, and a larger group of acute and transient psychotic disorders. Schizoaffective disorders have been retained in spite of their controversial nature.

4. *Mood [affective] disorders*

This block contains disorders in which the fundamental disturbance is a change in affect or mood to depression (with or without associated anxiety) or to elation. Most of these disorders tend to be recurrent and the onset of individual episodes can often be related to stressful events or situations.

5. *Neurotic, stress-related and somatoform disorders*

A group of disorders in which anxiety is evoked only, or predominantly, in certain well-defined situations that are not currently dangerous. The patient's concern may be focused on individual symptoms like palpitations or feeling faint and is often associated with secondary fears of dying, losing control, or going mad. Contemplating entry to the phobic situation usually generates anticipatory anxiety. Phobic anxiety and depression often coexist.

6. *Behavioural syndromes associated with physiological disturbances and physical factors*

The behavioural syndromes and mental disorders included in this classification are associated with physiological dysfunction and hormonal changes in the body. They include eating disorders and non-organic sleep disorders.

7. *Disorders of adult personality and behaviour*

This block includes a variety of conditions and behaviour patterns of clinical significance which tend to be persistent and appear to be the expression of the individual's characteristic lifestyle and mode of relating to himself or herself and others. Specific personality disorders, mixed and other personality disorders, and enduring

personality changes are deeply ingrained and enduring behaviour patterns, manifesting as inflexible responses to a broad range of personal and social situations. They represent extreme or significant deviations from the way in which the average individual in a given culture perceives, thinks, feels and, particularly, relates to others.

8. *Mental retardation*

A condition of arrested or incomplete development of the mind, which is especially characterized by impairment of skills manifested during the developmental period, skills which contribute to the overall level of intelligence, i.e. cognitive, language, motor, and social abilities. Retardation can occur with or without any other mental or physical condition.

9. *Disorders of psychological development*

The disorders included in this block have in common: (a) onset invariably during infancy or childhood; (b) impairment or delay in development of functions that are strongly related to biological maturation of the central nervous system; and (c) a steady course without remissions and relapses. In most cases, the functions affected include language, visual-spatial skills, and motor coordination.

10. *Behavioural and emotional disorders with onset usually occurring in childhood and adolescence*

A group of disorders characterized by an early onset (usually in the first five years of life), lack of persistence in activities that require cognitive involvement, and a tendency to move from one activity to another without completing any one, together with disorganized, ill-regulated, and excessive activity. Hyperkinetic children are often reckless and impulsive, prone to accidents, and find themselves in disciplinary trouble because of unthinking breaches of rules rather than deliberate defiance. Their relationships with adults are often socially disinhibited, with a lack of normal caution and reserve. They are unpopular with other children and may become isolated.

(Source: WHO, 2010)

Treatment of mental illnesses

Section I above identifies and describes mental health professionals (psychologists, mental health nurses, counsellors etc.) performing different roles and working in a variety of settings. Below are scenarios of practices followed by mental health professionals that shape the work that mental health interpreters perform.

When interviewing for specific disorders, e.g. depression or manic behaviour, a mental health professional will ask the patient to describe his/her mood, thoughts about the future, sleeping and eating patterns, thoughts about self-harm or harm to others. When the focus is on substance abuse, for example, the questions will explore the types of substances, exact quantities and situations when the substances are used. Questions focusing on anxieties and phobias will elicit descriptions of physical symptoms, and those relating to psychoses on descriptions of hallucinations and delusions experienced by the patient (Pollard, 1998).

The initial mental health diagnostic interview provides a benchmark against which information obtained in follow-up interviews or reviews during treatment are measured. Reviews focus on the patient's description of changes to the mental health and/or physical symptoms, specifically whether there has been an improvement, a deterioration or no change. The mental health professional may also follow up on general questions regarding the patient's current life situation, to find out if the treatment has had an impact on the patient's everyday life. Therefore, in an interpreted mental health diagnostic interview the mental health professional relies on the interpreter for a complete re-presentation of the patient's language and ideas to make a correct diagnosis and to monitor the effects of the treatment plan.

A mental health treatment plan can include a combination of therapies. These will depend on the diagnosis. As stated above, some mental illnesses require the use of medication (pharmacotherapy). Some commonly used medications include anticonvulsants (mood stabilisers), antidepressants, and antipsychotics. Medication may be prescribed to be taken orally (tablets), as patches, or in the form of injections.

Another type of treatment is talk therapy. There are many types of talk therapy, and they all focus, in different ways, on helping the patient understand how their symptoms are affecting their everyday life and empowering them to make positive changes. Some forms of talk therapy are conducted in one-on-one sessions, while others may be conducted in the form of group therapy.

Some of the more common types of talk therapy are psychodynamic therapy, Cognitive Behavioural Therapy (CBT), Dialectal Behavioural Therapy (DBT), gestalt therapy, relationship counselling, grief counselling, and addiction counselling are described below:

- Psychodynamic therapy (also known as classic psychotherapy) focuses on the patient's past to determine the origin of the mental health problems.

- In CBT the focus is on understanding how thought can influence behaviour, and how changing one's thoughts can change behaviour. CBT is frequently used to treat phobias, anxiety, depression and addictions.

- DBT teaches stress and emotion management and coping mechanisms, and improving relationships. DBT involves skills training, acknowledging thoughts which are usually avoided, as well as cognitive therapy and behaviour changes.

- Gestalt therapy is a humanistic and existential therapy that focuses more so on process (what is happening) over content (what is being talked about). The main goal of gestalt therapy is change through self-awareness, with emphasis on what is current being experienced somatically.

- Relationship counselling is offered for problems involving families, marriages and partnerships. Family therapy (also known as Family and Systemic Psychotherapy) engages the whole family system as a functioning unit. Social context, communication and relationships hare given primary importance in this therapy.

- Grief counselling is indicated following a loss, change or death.

- Addiction counselling addresses various types of addition, e.g. internet addition, gambling, or substance abuse.

VI. PATIENTS' RIGHTS AND LEGAL TERMS

Patients have rights in relation to their power to decide on a form of treatment, information provided to them to make this decision, to access of their medical records as well as other rights. In regard to the rights of patients with mental health conditions, it is recommended that an interpreter working in mental health settings familiarise him-/herself with descriptions of patients' rights in relevant authorative documents such as the Mental Health Act, the Declaration of Human Rights and the Australian Health Care Charter. It is also recommended that an interpreter be familiar with governmental, state or institution policies or guidelines in regard to the provision of language services. Relevant sections of legislation, charters, policy directives or guidelines are provided below together with the implications that these have on the provision of interpreting services and how the interpreter works.

Amongst others, an important right is the right to an interpreter where one is requested or needed. The national *Australian Charter of Healthcare Rights* (2008) states that patients have "a right to be informed about services, treatment, options and costs in a clear and open way", with an even clearer message issued in the 2nd person: "You can use interpreters if English is not your first language. Interpreter services are free and can be provided in person or by phone" (Australian Commission on Safety and Quality in Healthcare, 2015: 2).

Most states and territories also have clear policies about access to an interpreter. For example, the *Australian Charter of Healthcare Rights in Victoria* (Department of Health and Human Services, 2016) is very clear in defining patients' rights: "You have a right to an **accredited interpreter** if you need one when using a **publicly-funded healthcare service**, such as a hospital or community health centre" (2016: 9, original emphasis) and "Interpreters should be provided at important points during your care, such as when discussing medical history, treatments, test results, diagnoses, during admission and assessment and when you are required to give informed consent" (2016: 12).

Mention of the provision of interpreters in mental health laws

Within the area of law and mental health, individual states and territories have legislation that may or may not include mention of the provision of interpreters. In Victoria, the *Mental Health Act 2014* (Part 1, Section 8) requires an interpreter to be provided at the point of admission, and at other points where permission for treatment is requested: "any advice, notice or information given or provided to a patient under this Act [i.e. sanctioned actions undertaken by mental health professionals] must be explained by the person giving the advice, notice or information to the maximum extent possible to the patient in the language, mode of communication and terms which the patient is most likely to understand." The wording of this section relates to the perceptional or cognitive capability of mental health patients. This wording is widely understood and applied to the situation of LEP patients in a way that interpreters are requested for such interactions. The need for interpreters is set out in Part 8, Division 5, Section 185 of the Victorian *Mental Health Act 2014*. Equivalent acts exist in other Australian states and territories, usually with congruent descriptions of the need for interpreting services. In terms of therapeutic treatments provided for a mental health patient, the content of legislation can have consequences on the decisions made in relation to mental health

patients (Kämpf, 2013). This is very often the case in relation to involuntary treatment decisions (Kämpf, 2010).

Legal terms

The Victorian *Mental Health Act 2014* has sections that define key words. These words have specific meanings in the legislation and are used in specific contexts. Interpreters are encouraged to become acquainted with these terms and concepts, their definitions and LOTE equivalents through self-directed study. A selection of key legal terms are presented below (adapted from Victorian Legal Aid, 2016).

protection of rights: for patients, e.g. statement of rights, right to communicate, advance statements, nominated persons.

involuntary / compulsory patients: a person subject to:

a) an assessment order;
b) an court assessment order;
c) a temporary treatment order, treatment order.

involuntary treatment order (community or inpatient):

temporary treatment order (authorised psychiatrist, 28 days max – or potentially 42 if the tribunal extends it in light of exceptional circumstances);
treatment order (Mental Health Tribunal, if <16yo, max 3 months, if 16 and over, duration max 12 months community, 6 months inpatient)

assessment order: 24 hrs or 24 hrs after admission (and possibly up to 96 hours) for inpatients made by doctor or mental health practitioner if person meets assessment order criteria, allows for compulsory examination and detention (if inpatient)
Note: Criteria only requires a person to 'appear to have mental illness'.

treatment criteria: the treatment criteria for a person to be made subject to a temporary treatment order or treatment order are -

a) the person has mental illness; and
b) because the person has mental illness, the person needs immediate treatment to prevent:
    (i) serious deterioration in the person's mental or physical health, or
    (ii) serious harm to the person or to another person; and
c) the immediate treatment will be provided to the person if the person is subject to a temporary treatment order or treatment order; and
d) there is no less restrictive means reasonably available to enable the person to receive the immediate treatment.

advance statement: an advance statement is a document that sets out a person's preferences in relation to treatment in the event that the person becomes a patient.

nominated person: the role of a nominated persion in relation to a patient is to provide the patient with support and to help represent the interests of the patient; and

receive information about the patient (in accordance with this Act); and be one of the persons who must be consulted (in accordance with this Act) about the patient's treatment; and assist the patient to exercise any right that the patient has under this Act.

presumption of capacity: a person is deemed to have capacity to give informed consent if the person understands, is able to remember and use information relevant to the decision and is able to communicate their decision. A person on a treatment order can still be given treatment against his/her wishes, even if s/he has capacity, if certain criteria are met.

informed consent: a person gives this if s/he -

a) has the capacity to give informed consent to the treatment or medical treatment proposed;
b) has been given adequate information to enable the person to make an informed decision;
c) has been given a reasonable opportunity to make the decision;
d) has given consent freely without undue pressure or coercion by any other person; and
e) has not withdrawn consent or indicated any intention to withdraw consent.

restrictive interventions: e.g. notification of use, seclusion, bodily restraint.

complaints (and grievances): e.g. Mental Health Complaints Commissioner, complaints management, conciliation, investigations, compliance notices.

These and other terms are presented in the context of legislation and in greater detail in Appendix 2. Appendix 2 contains 13 tables that set out key words and legal definitions contained in State and Territory legislation in Australia that relate to features of mental illnesses and mental health therapies. Included in Appendix 2 are exclusion criteria from definitions of mental disorders or disturbances and the legal definitions for ‘involuntary treatment orders’ that are administered without the consent of the patient.

APPENDICES

Appendix 1 – List of medico-legal tribunals relevant to mental health

Official judicial bodies powers of each state and territory that conduct mental health inquiries, make and review orders, and hear appeals about the treatment and care of people with a mental illness:

ACT – Australian Capital Territory Civil & Administrative Tribunal – Mental Health

https://www.acat.act.gov.au/application-type/mental_health

NSW – Mental Health Review Tribunal

http://www.mhrt.nsw.gov.au/the-tribunal/

NT - Mental Health Review Tribunal

https://nt.gov.au/law/courts-and-tribunals/mental-health-review-tribunal

QLD - Mental Health Review Tribunal

https://www.mhrt.qld.gov.au/

SA – South Australian Civil and Administrative Tribunal – Mental Health

http://www.sacat.sa.gov.au/types-of-cases/mental-health

TAS – Mental Health Tribunal

http://www.mentalhealthtribunal.tas.gov.au/

VIC – Mental Health Tribunal

http://www.mht.vic.gov.au/

WA – State Administrative Tribunal – Mental Health Appeals

http://www.sat.justice.wa.gov.au/M/mental_health_appeals.aspx

Appendix 2 – Mental health legislation in Australian states and territories

This appendix contains 13 tables.

Table 1 contains key words or definitions (purposes and objectives) found across mental health legislation from all States and Territories. There is some variation in the key words or definitions used from jurisdiction to jurisdiction, and in some States or Territories a more detailed description of the purposes and objectives of mental health legislation is given, while in others this is shorter.

Table 2 contains definitions of what a 'mental illness' in legal terms. These definitions come from legislation from all States and Territories known as the *Mental Health Act*.

Table 3 contains a comprehensive list of diagnostic criteria of mental illness and the representation of these criteria in each State's or Territory's respective legislation.

Table 4 contains regulations from ACT, NSW and NT that are supplementary to the definition of a mental illness. In these supplementary regulations the definitions of a 'mental disorder' (ACT, NSW) and 'mental disturbance' (NT) are described.

Table 5 contains a comprehensive list of exclusion criteria by which a mental illness is *not* diagnosed. Table 4 shows the representation of exclusion criteria in each State's or Territory's respective legislation.

Tables 6-13 contain regulation on medical treatment that can be given to a patient without the patient's consent. This regulation is known as 'treatment order' (ACT) or 'involuntary treatment' (NSW, NT, QLD, SA, TAS, VIC, WA). For each State and Territory information from the regulations is provided in relation to definition of self-harm and of harm to others.

The author would like to acknowledge the contribution of Annegret Kämpf for the collation of mental health legislation from Australian states and rerritories.

Table 1: The Purpose and Objectives of the Mental Health Legislation

legislative terminology	**ACT**	**NSW**	**NT**	**Qld**
main provisions	**5, 6**	**3**	**3**	**3**
additional provisions	**7, 8**	**68**	**9-13**	**5**
provision of care and treatment	5(c)	3(a), 68(b)	3(a)	5(l)
protection of rights	5(d)	3(d)	3(a)	3(2)(a)
rehabilitation/recovery	5(a), 6(j)(v)	3(a), 68(d)		3(2)(c), 5(k)
access to services	5(d), 5(f), 6(e)	3(d)		
information about rights	8(b)	68(i)	3(j), 9(d)	5(d)
respect to will and preferences	6(d), 6(j)(iii)	68(h)		5(b)
informed consent	6(b), 6(g), 6(h), 6(j)(i)	68(h1)	3(d), 7, 9(j)	implied
promotion of capacity	5(b), 6(j)(iv)			
presumption of capacity	6(i), 8(1)(b)			5(b)
decision-making capacity	7, 8	68(h1)		3(1)(a), 14
self-determination/self-reliance	5(b), 6(c)			5(e)
own choices	5(e), 5(f), 5(g), 7(c), 7(d), 6(j)(ii)	68(e)	9(g), 9(m)	5(b)
participation	5(b),5(e), 6(g)	3(e)	9(g)	
support	5(b), 5(c), 5(f), 5(g), 6(g), 6(h), 6(j)(ix), 8(1)(c), 8(1)(d)	68(e), 68(h1)		5(c), 5(d), 5(j)
support to exercise rights	6(j)(viii), 8(b)			5(c), 5(d), 5(j)
voluntary services		3(c)	3(c), 9	

legislative terminology	**ACT**	**NSW**	**NT**	**Qld**
main provisions	**5, 6**	**3**	**3**	**3**
additional provisions	**7, 8**	**68**	**9-13**	**5**
principle of least restriction	5(c)	68(a), 68(f)	8(a)-(c)	3(2)(b), 3(3), 13
human rights	5(d) rights and inherent dignity 6(a) same rights 6(f)(ii) rights, liberty, dignity, autonomy and self-respect	3(d) civil rights	3(a) civil rights 8(b) liberty, rights, dignity, privacy and self-respect 8(c) autonomy	human rights
best interests	8(3)			best interests

Table 1: The Purpose and Objectives of the Mental Health Legislation (continued)

legislative terminology	**SA**	**Tas**	**Vic**	**WA**
main provisions	**6, 7**	**12**	**10**	**10**
additional provisions		**Sched 1**	**11**	**Sched 1**
provision of care and treatment		12(a)	10(b)	10(1)(a)(i)
protection of rights		12(b)	10(c)	Sched 1 A
rehabilitation/recovery	6(a)(i), 7(a)	Sched 1(f)	10(f), 11(1)(b)	
access to services				
information about rights	7(i)		10(g)	Sched 1 P13
respect to will and preferences		Sched 1(m)	11(1)(b)	[8]
informed consent			[68]	[16]
promotion of capacity			[68, 69]	[13]
presumption of capacity			[70]	
decision-making capacity			[68, 69]	
self-determination/self-reliance				Sched 1 P3
own choices		12(e), Sched 1(j)	11(1)(d)	Sched 1 P12
Participation	7(a)		10(d)(i), 11(1)(b)	
Support			[11(1)(k), 11(1)((l)]	Sched 1 P4
support to exercise rights			10(d)(ii)	
voluntary services	7(b)		11(1)(a)	

Table 2: The Definition of Mental Illness

s 10	***Mental Health Act 2015* (ACT)**
	Mental illness means a condition that seriously impairs (either temporarily or permanently) the mental functioning of a person in one or more areas of thought, mood, volition, perception, orientation or memory, and is characterised by – (a) the presence of at least one of the following symptoms: (i) delusions; (ii) hallucinations; (iii) serious disorders of streams of thought; (iv) a severe disturbance of mood; (b) sustained or repeated irrational behaviour taken to indicate the presence of at least 1 of the symptoms mentioned in paragraph (a).
s 4	***Mental Health Act 2007* (NSW)**
	Mental illness means a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms: (a) delusions, (b) hallucinations, (c) serious disorder of thought form, (d) a severe disturbance of mood, (e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)–(d).
s 14	(1) A person is a mentally ill person if the person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary: (a) for the person's own protection from serious harm, or (b) for the protection of others from serious harm. (2) In considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration in the person's condition and the likely effects of any such deterioration, are to be taken into account.

Table 2: The Definition of Mental Illness (continued)

s 6	***Mental Health and Related Services Act 2009* (NT)**
	(1) A mental illness is a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person in one or more of the areas of thought, mood, volition, perception, orientation or memory and is characterised: (a) by the presence of at least one of the following symptoms: (i) delusions; (ii) hallucinations; (iii) serious disorders of the stream of thought; (iv) serious disorders of thought form; (v) serious disturbances of mood; or (b) by sustained or repeated irrational behaviour that may be taken to indicate the presence of at least one of the symptoms referred to in paragraph (a). (2) A determination that a person has a mental illness is only to be made in accordance with internationally accepted clinical standards.
s 10	***Mental Health Act 2016* (Qld)**
	(1) Mental illness is a condition characterised by a clinically significant disturbance of thought, mood, perception or memory. (4) On an assessment, a decision that a person has a mental illness must be made in accordance with internationally accepted medical standards.

Table 2: The Definition of Mental Illness (continued)

s 3	***Mental Health Act 2009* (SA)**
	Mental illness means any illness or disorder of the mind.
s 4	***Mental Health Act 2013* (Tas)**
	(1) For the purposes of this Act – (a) a person is taken to have a mental illness if he or she experiences, temporarily, repeatedly or continually – (i) serious distortion of perception or thought; or (ii) a serious impairment of mood, volition, perception or cognition.
s 4	***Mental Health Act 2014* (Vic)**
	(1) Mental illness is a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory. (3) Subsection (2)(l) does not prevent the serious temporary or permanent physiological, biochemical or psychological effects of using drugs or consuming alcohol from being regarded as an indication that a person has mental illness.
s 6	***Mental Health Act 2014* (WA)**
	(1) A person has a mental illness if the person has a condition that – (a) is characterised by a disturbance of thought, mood, volition, perception, orientation or memory; and (b) significantly impairs (temporarily or permanently) the person's judgment or behaviour. (4) A decision whether or not a person has a mental illness must be made in accordance with internationally accepted standards prescribed by the regulations for this subsection.

Table 3: The Diagnostic Criteria of Mental Illness

	ACT	NSW	NT	Qld
- impairment of				
- thought	serious	serious	serious	significant
- mood	serious	serious	serious	significant
- volition	serious		serious	
- perception	serious		serious	significant
- cognition				
- orientation	serious		serious	
- memory	serious		serious	significant
- characterised by diagnostic criteria (symptoms)				
- delusions	+	+	+	
- hallucinations	+	+	+	
- serious disorder of thought form	+	+	+	
- serious disorder of mood	+	+	+	
- characterised by sustained or repeated irrational behaviour indicating the presence of at least one of the symptoms referred to above	+	+	+	
- impairment of judgment or behaviour				
Mental Health Act, ss	10	4	6	10

Table 3: The Diagnostic Criteria of Mental Illness (continued)

	SA	Tas	Vic	WA
diagnostic criteria (any of these)				
- disturbance of				
- thought		serious	significant	any
- mood		serious	significant	any
- volition		serious		any
- perception		serious	significant	any
- cognition		serious		
- orientation				any
- memory			significant	any
- characterised by diagnostic criteria (symptoms)				
- delusions				
- hallucinations				
- serious disorder of thought form				
- serious disorder of mood				
- characterised by sustained or repeated irrational behaviour indicating the presence of the symptoms referred to above				
- impairment of judgment or behaviour				significant
Mental Health Act, ss	3	4	4	6

Table 4: The Definition of Mental Disorder or Mental Disturbance

ACT	**mental disorder, s 9**
	"Mental disorder" **(a)** means a disturbance or defect, to a substantially disabling degree, of perceptual interpretation, comprehension, reasoning, learning, judgment, memory, motivation or emotion; but **(b)** does not include a condition that is a mental illness.
NSW	**mental disorder, s 15**
	A person (whether or not the person is suffering from mental illness) is a mentally disordered person if the person's behaviour for the time being is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control of the person is necessary: (a) for the person's own protection from serious physical harm, or (b) for the protection of others from serious physical harm.
NT	**mental disturbance, s 15**
	The person's behaviour is, or within the immediately preceding 48 hours has been, so irrational as to lead to the conclusion that: (i) the person is experiencing or exhibiting a severe impairment of or deviation from his or her customary or everyday ability to reason and function in a socially acceptable and culturally appropriate manner; and (ii) the person is behaving in an abnormally aggressive manner or is engaging in seriously irresponsible conduct that justify a determination that the person requires psychiatric assessment, treatment or therapeutic care that is available at an approved treatment facility.

Table 5: The Exclusion Criteria

text of the legislation	ACT	NSW	NT	Qld
exclusion criteria (not *only* because of any of these)				
- political or religious opinion or belief	+	+	+	+
- cultural opinion or belief			+	+
- political or religious activity	+	+	+	
- cultural activity			+	
- philosophy	+	+	+	+
- sexual preference, orientation or promiscuity, sexual activity	+	+	+	+
- immoral or indecent conduct	+	+	+	+
- illegal conduct	+	+	+	+
- alcohol or other drug abuse	+	+	+	+
- intoxication				
- economic or social status		+	+	+
- cultural or racial group		+	+	+
- antisocial behaviour	+	+	+	+
- intellectual/ behavioural nonconformity			+	
- sexual disorder		+	+	
- intellectual disability		+	+	+
- physical disability				
- personality disorder or habit or impulse disorder			+	
- developmental disability of mind				
- family conflict			+	+
- professional conflict			+	
- prior mental illness			+	
- prior involuntary status			+	+
- acquired brain damage			+	
Mental Health Act, ss	11	16	6	10

Table 5: The Exclusion Criteria (continued)

text of the legislation	SA	Tas	Vic	WA
exclusion criteria (not *only* because of any of these)				
- political or religious opinion or belief	+	+	+	+
- cultural opinion or belief				+
- political or religious activity	+	+	+	+
- cultural activity				+
- philosophy	+	+	+	+
- sexual preference, orientation or promiscuity, sexual activity	+	+	+	+
- immoral or indecent conduct	+		+	+
- illegal conduct	+	+	+	+
- alcohol or other drug abuse	+		+	+
- intoxication		+		
- economic or social status	+	+	+	+
- cultural or racial group		+		+
- antisocial behaviour	+	+	+	+
- intellectual/ behavioural nonconformity				
- sexual disorder				
- intellectual disability		+	+	+
- physical disability		+		
- personality disorder or habit or impulse disorder				
- developmental disability of mind	+			
- family conflict			+	
- professional conflict				+
- prior mental illness			+	+
- prior involuntary status				+
- acquired brain damage		+		
Mental Health Act, ss	Sched 1	4	4	6

Table 6: The Requirements for Treatment Order (ACT)

<table>
<tr><th>ACT</th><th colspan="2">self-harm</th><th>harm to others</th><th></th></tr>
<tr><td>s 58(2)(b)</td><td colspan="3">no capacity
The person does not have decision-making capacity to consent to the treatment, care or support and refuses to receive the treatment, care or support.
OR
capacity
The person has decision-making capacity to consent to the treatment, care or support, but refuses to consent.
AND</td><td rowspan="3">if ACAT's belief on reasonable grounds</td></tr>
<tr><td>s 58(2)(c)</td><td>The person is doing, or is likely to do, serious harm to themself;</td><td>OR
The person is suffering, or is likely to suffer, serious mental or physical deterioration</td><td>OR
The person is doing, or is likely to do, serious harm to someone else.</td></tr>
<tr><td>s 58(2)(d)</td><td></td><td>AND if capacity
ACAT must be satisfied that the harm or deterioration, or likely harm or deterioration is of such a serious nature that it outweighs the person's right to refuse to consent).</td><td></td><td>if ACAT is satisfied</td></tr>
<tr><td></td><td colspan="4">- The person has a mental illness.
- The ACT Civil and Administrative Tribunal (ACAT) is satisfied that psychiatric treatment, care or support is likely to
o reduce the harm or deterioration, or the likelihood of harm or deterioration, or
o result in an improvement in the person's psychiatric condition.
- The ACAT is satisfied that the treatment, care or support to be provided under the psychiatric treatment order cannot be adequately provided in another way that would involve less restriction of the freedom of choice and movement of the person.</td></tr>
</table>

Table7: The Requirements for Involuntary Treatment (NSW)

NSW	self-harm	harm to others	
ss 29, 51, 14	A person is a mentally ill person. [A person who is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary:[		if belief on reasonable grounds
	[for the person's own protection from serious harm. In considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration in the person's condition and the likely effects of any such deterioration, are to be taken into account.]	OR [or the protection of others from serious harm.]	
	- With the approval of the Mental Health Tribunal following a mental health inquiry, ss34, 35.		

Table 8: The Requirements for Involuntary Treatment (NT)

<table>
<tr><th>NT</th><th colspan="2">self-harm</th><th>harm to others</th><th></th></tr>
<tr><td rowspan="4">s 14</td><td colspan="3">As a result of mental illness the person requires treatment and without the treatment, the person is likely to cause</td><td rowspan="4">if authorised by psychiatrist and Mental Health Tribunal</td></tr>
<tr><td>serious harm to him- or herself.</td><td>OR
suffer serious mental of physical deterioration.</td><td>OR
serious harm to someone else.</td></tr>
<tr><td></td><td>AND
capacity
The person is not capable of giving informed consent to the treatment or has unreasonably refused to consent to the treatment.</td><td></td></tr>
<tr><td colspan="3">- The person has a mental illness.
- There is no less restrictive means of ensuring that the person receives the treatment.</td></tr>
<tr><td>s 55</td><td colspan="3">- The treatment is authorised by the Mental Health Tribunal.
OR
- The treatment is authorised by a psychiatric practitioner and treatment is necessary:
(a) to prevent the person causing serious harm to himself or herself or to someone else; or
(b) to behaviour of the person likely to cause serious harm to the person or to someone else; or
(c) to prevent further physical or mental deterioration of the person; or
(d) to relieve acute symptomatology.
- Every practicable effort must be made to involve the person in considering the nature and effect of the treatment and any alternatives that are reasonably available.</td><td></td></tr>
<tr><td>s 56</td><td colspan="3">(a) the treatment is in the best interest of the person;
(b) the anticipated benefits of the treatment outweigh any risk of harm or discomfort to the person;
(c) alternative treatments that would be likely to produce equivalent benefits and with less risk of harm are not reasonably available; and
(d) the treatment represents the least restrictive and least intrusive treatment option reasonably available.</td><td></td></tr>
</table>

Table 9: The Requirements for Involuntary Treatment (Qld)

<table>
<tr><th>Qld</th><th>self-harm</th><th>harm to others</th><th></th></tr>
<tr><td rowspan="4">ss 48, 49, 12</td><td colspan="2">capacity
The person does not have capacity to consent to be treated for the illness.

AND
Because of the person's illness, the absence of involuntary treatment, or the absence of continued involuntary treatment, is likely to result in</td><td rowspan="3">if treatment authority is satisfied</td></tr>
<tr><td>imminent serious harm to the person;</td><td rowspan="2">OR
imminent serious harm to others.</td></tr>
<tr><td>OR
the person suffering serious mental or physical deterioration.</td></tr>
<tr><td colspan="3">- The person has a mental illness.
- There is no less restrictive way of ensuring that the person to receive care and treatment for the person's mental illness.</td></tr>
</table>

Table 10: The Requirements for Involuntary Treatment (SA)

<table>
<tr><th>SA</th><th>self-harm</th><th>harm to others</th><th></th></tr>
<tr><td rowspan="3">s 25</td><td colspan="2">Because of a person’s mental illness, the person requires treatment</td><td rowspan="3">if a psychiatrist or authorised medical practitioner is satisfied</td></tr>
<tr><td>for the person’s own protection from harm (incl. harm involved in the continuation or deterioration of the person’s condition).</td><td>OR
for the protection of others from harm.</td></tr>
<tr><td colspan="2">- The person has a mental illness.
- The person requires treatment.
- There is no less restrictive means than detention and treatment order of ensuring appropriate treatment of the person’s illness.
- The option of voluntary treatment or a community treatment order must be considered.</td></tr>
</table>

Table 11: The Requirements for Involuntary Treatment (Tas)

<table>
<tr><th>Tas</th><th>self-harm</th><th>harm to others</th><th></th></tr>
<tr><td rowspan="4">ss 39, 40</td><td colspan="2">capacity
The person does not have decision-making capacity</td><td rowspan="3">if the Mental Health Tribunal is satisfied</td></tr>
<tr><td>Without treatment, the mental illness will, or is likely to, seriously harm</td><td></td></tr>
<tr><td>the person's health or safety.</td><td>OR
the safety of other persons.</td></tr>
<tr><td colspan="3">- The person has a mental illness.
- The treatment will be appropriate and effective in terms of the outcomes referred to in section 6(1).
- The treatment cannot be adequately given except under a treatment order.</td></tr>
</table>

Table 12: The Requirements for Involuntary Treatment (Vic)

<table>
<tr><th>Vic</th><th>self-harm</th><th>harm to others</th><th></th></tr>
<tr><td rowspan="3">ss 5, 55</td><td colspan="2">Because the person has mental illness, the person needs immediate treatment to prevent</td><td rowspan="2">the Mental Health Tribunal is satisfied</td></tr>
<tr><td>serious deterioration in the person's mental or physical health
OR
serious harm to the person</td><td>OR
serious harm to another person.</td></tr>
<tr><td colspan="3">- The person has a mental illness.
- The person will be provided immediate treatment.
- There is no less restrictive means reasonably available to enable the person to receive the immediate treatment.
- The person's capacity to give informed consent must be considered in light of Part 5 Divisions 1-3.</td></tr>
</table>

Table 13: The Requirements for Involuntary Treatment (WA)

<table>
<tr><th>WA</th><th>self-harm</th><th>harm to others</th><th></th></tr>
<tr><td rowspan="4">ss 24, 25</td><td colspan="2">capacity
The person does not demonstrate the capacity to make a treatment decision about the provision of the treatment to himself or herself.</td><td rowspan="3">if a psychiatrist is satisfied</td></tr>
<tr><td colspan="2">Because of the mental illness, there is –</td></tr>
<tr><td>a significant risk to the health or safety of the person;
OR
a significant risk of serious harm to the person.</td><td>OR
a significant risk to the safety of another person;
OR
a significant risk of serious harm to another person.</td></tr>
<tr><td colspan="3">- The person has a mental illness requiring treatment.
- The person cannot be adequately provided with treatment in a way that would involve less restriction on the person’s freedom of choice and movement than making an inpatient treatment order.</td></tr>
</table>

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