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NATIONAL COUNCIL ON INTERPRETING IN HEALTH CARE

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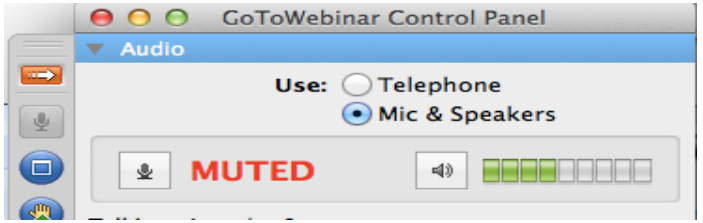
Housekeeping

- This session is being recorded
- Certificate of Attendance
  *must attend full 90 minutes
  *trainerswebinars@ncihc.org
- Audio and technical problems



- Questions to organizers
- Q & A
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Welcome!

Guest Presenter:

Dr. Laura Brookham

- Doctorate in Clinical Psychology – Licensed psychologist in Arizona
- Owner of Red Mountain Psychological Services, LLC (Mesa, AZ)
- Expert witness for
  - Arizona state courts
  - Federal criminal courts
  - Federal immigration courts

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Welcome!

Today's Co-Host:

Jaime Fatás-Cabeza,
MA, USCCI, CHI™

Interpreting for Fragile Patients in Mental Health Encounters

Training Tips for Healthcare Interpreters

Describe your practice, and the type of work you do

Forensic psychology private practice, Red Mountain Psychological Services, LLC

- primary populations: those involved with criminal and immigration courts
- primary settings: jail, detention center, court, private office
- specialty area: forensic clinical and forensic neuropsychological testing and diagnosis
- expert witness: competency opinions, insanity opinions, mitigation evaluations, immigration

Describe kind of patients you see

Special populations (adults only)

- Immigration: migrants, refugees, family members
- Individuals in the LGBTQ community
- Individuals from Native American communities
- Military Veterans
- Individuals with serious mental illness (including trauma and substance abuse)
- Victims of sexual violence and trafficking
- Individuals with neurodevelopmental or neurocognitive disabilities

CENTRAL ARIZONA FLORENCE CORRECTIONAL COMPLEX (ICE) - CORECIVIC

This facility is for adult inmates. Inmates housed here are placed according to their custody level and are incarcerated by a private company contracted by a government agency and are paid a per diem or monthly rate, either for each inmate in the facility or for each bed available. Located at 1155 N Pinal Pkwy in Florence, AZ

Source: https://images.app.goo.gl/ZYcxRYZbNRzjtwam6

FLORENCE DETENTION CENTER

Source: https://images.app.goo.gl/x8q2LUTLWHmLZQeGA

The Eloy Detention Center, a private prison owned by CoreCivic, houses detainees waiting the outcome of their deportation proceedings. Located in Eloy, AZ, USA.

Source: https://images.app.goo.gl/dhgXU9h9coYu3zM2A

ELOY DETENTION CENTER

Source: https://tucson.com/news/state-and-regional/eloy-ends-contract-for-immigrant-detention-center/article_9be29649-3af4-5519-988e-a5621c32fd52.html

For what types of evaluations have you utilized an interpreter?

- Criminal competency - competency to proceed with a criminal trial or to defend oneself
- Immigration competency – competency to represent oneself or to make decisions about a case
- Immigration/ criminal diagnostic – to provide a diagnosis and opine on treatment needs
- Criminal insanity – to determine if a client met the legal definition required to assert an insanity defense
- Basic neuropsychological or cognitive – to get a rough idea of a person's possible cognitive limitations
- Immigration causational – to evaluate the possible cause/consequences of an event leading to an asylum claim
- Courtroom behavior – to evaluate if mental health or cultural or language issues will directly impact one's behavior during court

What languages have your clients spoken?

More than I can possibly remember! It is a common misconception by members of the general public that all migrants are from Spanish-speaking countries, or that all people from Spanish-dominant countries speak Spanish.

- Spanish (Central American, South American, and individuals reared in the United States)
- Guatemalan languages (Mam, other indigenous or regional languages)
- Native American (Navajo, Apache)
- African languages (Arabic, French, other indigenous languages)
- European languages (Spanish, Polish, Russian, etc.)
- Asian languages (Mandarin, Tagalog, and languages from other Asian countries)

What limitations are there when a patient requires the assistance of an interpreter?

Almost all psychological tests developed for use in the U.S. are normed by and for individuals who were born and reared in the U.S., who have English as their first and primary language, and with a racial/ethnic breakdown similar to the most recent U.S. census. Some areas that are difficult or impossible to test when a client has different language and/or cultural heritage are:

- **Tests that rely on language, especially standardized language** (ex: verbal memory, reading, directions)
- **Nonverbal tests that test things that are culturally sensitive** (ex: response speed, chronology, things typically learned during school)
- **Tests that rely on specific cultural experiences** (ex: going to school, reading, use of a pencil, use of a clock, gender-based experiences)
- Nonverbal tests that use **letters and numbers that are not the same in both languages**
- **In some cultures, the concept of testing itself is different** (ex: some cultures intentionally answer a certain percentage of items incorrectly)

ICE detainees are routinely placed in solitary confinement across the country for long stretches of isolation as a means to punish immigrants for minor offenses like consensual kissing or giving haircuts, and frequently placed hunger strikers, LGBTQ people, and disabled people in solitary.
Source: Phoenix New Times
https://www.phoenixnewtimes.com/news/ice-forced-hundreds-of-immigrants-into-solitary-confinement-in-az-11299204

ELOY DETENTION CENTER, COMMON AREA, DAY ROOM

Source:https://images.app.goo.gl/3JH9i51f5krWJSnJ8

ELOY DETENTION CENTER COMMON AREA

Source: https://images.app.goo.gl/Cq3CrnZXirRqgW1r8

Florence Common Area

Source: https://www.dcourier.com/news/2010/mar/26/prison-study-florence-110-year-old-prison-put-tow

When you work with an interpreter, what do you experience when communication is going smoothly?

- When all is going well, it seems like all three of us are on the same page. Nonverbal communication is consistent with the words, and everyone's role seems clear.
- A client/patient tends to make eye contact with the evaluator more than the interpreter (although this is not always due to effective communication and interpretation and can be influenced by culture or mental illness).
- A client/patient does not appear to hesitate much between hearing the question and answering. They feel comfortable and respond quickly.
- A client/patient's responses are consistent.
  - In other words, a person reporting a college education uses expected words and exhibits consistent cognitive functioning. Their responses just seem to make sense.

When you work with an interpreter, what do you experience when communication is *not* going well?

- The client's responses to the questions does not make sense (and not for any cognitive or psychiatric reason).
- I find myself asking far more follow up questions than usual.
- I have trouble establishing concrete or exact answers to my questions, or I receive many conflicting answers at different times in the evaluation.
- I notice that the client/patient is saying much more than the interpreter is saying.
- Nonverbal communication feels strained and the clinical connection takes longer to establish (if it occurs at all).

What do you wish interpreters understood about interpreting in mental health encounters? (1 of 2)

I am assessing for much more than the answers to my questions, including:

- Fine and gross motor skills, scars or facial signs of head injuries or brain trauma, tattoos or cultural signs
- Focus and attention
- Problem solving and ability to tolerate frustration (sometimes I am very direct or rude on purpose)
- Verbal and nonverbal social interaction
- Orientation to person, place, situation, time
- Malingering (intentionally exaggerating or feigning symptoms for potential legal gain)

Language

- I chose my words in English very carefully. Also, some clinical words have different meanings in psychology than in popular culture (in the U.S. and probably other countries as well).
- I often want to see how a client will answer an open-ended or vague question before clarifying. I often ask questions that will almost guarantee a client has to ask a follow-up question.
- I cannot usually tell if a non-English-speaker is using language appropriate to their age and education without assistance from the interpreter.
- I often appear to agree with or restate what a client says, but that does not always mean that I actually agree with what they have said. Partnering with a client/patient is an evaluation technique.

What do you wish interpreters understood about interpreting in mental health encounters? (2 of 2)

There are many common misconceptions about people with mental illness

- Individuals with mental illness are not statistically more dangerous or violent.
- Psychological and cognitive symptoms are not typically overlapped, but I assess for both.

Differences between a treatment provider and evaluator

- An evaluator can testify as an expert witness instead of a fact witness. It is the only role where our clinical opinions are allowed to be given during a legal hearing.
- Every court has a standard for evidence that must be followed. In other words, my clinical opinions all have to be validated by research, and cannot be based only on experience or what I think.
- Psychology is very different than psychiatry, other types of doctors, and other mental health providers (ex: physicians, social workers). For example, I evaluate current symptoms but also rule out all other diagnoses and/or other possible causes for the symptoms (ex: substance intoxication, medical conditions, malingering).
- Psychologists are careful to never wear both hats (treatment and evaluator) with the same client.
- Our “client” is not typically the “patient,” but is instead the person who retained us (often an attorney or a judge).

How might one's mental health be impacted by the situational factors of detainment or their legal case?

The very nature of an individual being involved in a legal matter is stressful. Consider that the client might be experiencing:

- **Symptoms of Adjustment Disorder**, a condition where psychiatric symptoms (depression, anxiety) are caused by a stressful change or situation.
- **Bereavement or loss** – An individual who is detained might be separated from their family, friends, employment, and all aspects of their life over which they previously had control.
- **Isolation** – Despite statements to the contrary, it is extremely common for individuals in detention settings (criminal or immigration) to be in isolation, which can by itself cause mental illness.
- Detention centers have limited medication formularies (medical and psychiatric) so **detainees might not be getting their required medication(s),** or they might be getting different medication(s).
- A client might have escaped a traumatic situation or been **traumatized** during their migration.
- A client might have very **little trust of authority figures** based on real or perceived discrimination (in the U.S. or their country of origin).
- **Situational factors** cause behaviors we might not otherwise see (in both detention officers and detainees).
- People lie, exaggerate, or minimize symptoms because they think it will help their case.

Recommended Resources

Are you aware of any good resources like glossaries and/or organizations that put out patient education materials for mental health?

- National Institute of Mental Health www.nimh.nih.gov
- National Alliance on Mental Illness www.nami.org
- American Psychological Association www.apa.org
- American Counseling Association www.counseling.org

Recommended Glossaries

Glossaries and/or materials for mental health

- National Institute of Mental Health https://www.nimh.nih.gov/health/topics/schizophrenia/raise/glossary.shtml
- Stanford Children's Health Glossary of Child and Adolescent Mental Health https://www.stanfordchildrens.org/en/topic/default?id=glossary---child-and-adolescent-mental-health-90-P02566
- Terms in Psychiatry http://www.priory.com/gloss.htm
- Mental Health Assessment Terminology https://quizlet.com/19478479/mental-health-assessment-terminology-flash-cards
- Routine Psychiatric Assessment, Merck Manual, https://www.merckmanuals.com/professional/psychiatric-disorders/approach-to-the-patient-with-mental-symptoms/routine-psychiatric-assessment
- Lexicon of Psychiatric and Mental Health Terms, World Health Organization, https://apps.who.int/iris/bitstream/handle/10665/39342/924154466X.pdf;jsessionid=A61466BE72FA3521FB2C1420A6E58D1D?sequence=1

What do the *best* interpreters do?

The *best* interpreters introduce themselves to the client and explain their role.

When a client gives an answer that makes sense in their language/culture, but might not in English, the *best* interpreters '*translate'* the literal meaning and *interpret* the language or cultural meaning for the evaluator. For example, "The client said this, but where they are from it might mean this." That way the evaluator can ask clarifying questions if needed (ex: gendered languages, languages that do not have words for some legal terms or mental health symptoms).

The *best* interpreters are not afraid to ask questions. If they need clarification about the meaning of a question, they ask. If a word or term does not exist in the other language, they ask the evaluator for other words or ways to ask the question, they do not use their own.

When a client does not seem to understand the roles of the doctor and interpreter, or when the client is rambling on, the *best* interpreters manage the flow, by interrupting the client politely, and remind them of the roles of the people in the room.

- For example, in the other language, they might say, "I understand what you're saying, but the doctor needs to know everything you are saying so please give me a minute to interpret."

Do you regularly use the pre-session?

Absolutely! Most mental health professionals, however, will have little or no experience or training for working with interpreters.

The American Psychological Association found that of instructors teaching multicultural classes, only 54% provided any training on working with language interpreters, and only 16% provided two or more hours of such training. Many of us were told during our education and/or training that we could not provide any services to anyone outside of the language in which we received our education and training.

My suggestion: If you know you will be working with a mental health professional and have the ability to send them your own pre-session questions or notes, do it. If not and the provider is willing and able to answer a couple of questions immediately before the evaluation starts, tell the client that you are not talking about them, and then take a couple minutes to ask your questions and get on the same page as the provider. Many providers/evaluators will not know what they don't know.

What pre-session topics are important?

How does the evaluator want the interpretation?

- Simultaneous might work in some situations, but it is my strong preference for consecutive.
- Ask the evaluator how they will utilize the interpreter. I have a strong preference for saying one or two sentences and stopping to allow time for interpretation, but many clients do not catch on and need to be interrupted if they begin to ramble or give a very long response.
- Decide how to deal with a client who speaks some of the evaluator's language (and then adjust if things change). There are clinical reasons for redirecting a client back to his/her first or dominant language.

Ensure, when possible, that there are no known cultural factors that will impact the session.

When possible, sit in a location where the evaluator and client can be face-to-face.

What is the evaluator's general purpose? What are they evaluating for? Does the evaluator know of any symptoms that will impact the session (ex: hallucinations, delusions, mania, flashbacks)

Ask what post-session questions the evaluator will, or might, ask?

- Was the client's language appropriate for his/her age, education, reported origin?
- Was the client easy to understand? Did they use the right verb tenses, proper words or slang?

What would you recommend as best practice when partnering with an interpreter for an interpreted mental health encounter?

THINGS THE INTERPRETER SHOULD DO OR NOT DO

- **Ask questions when needed.**
- **Interpret everything**.
  - If a client asks even a basic question (ex: What is the date?) interpret the question. Try to resist the normal urge to answer a simple question, or to explain something to the client.
- After the evaluation, ask the provider about any questions or concerns. If you are worried about the client or their prognosis, debrief with the provider. They might see things very differently than you.
- **Be aware of your own history and triggers**. Do not take a case if it is likely to upset you.
- **Trust your gut.**
  - You are the expert in interpretation no matter how much of an expert the provider is.

THINGS THE PROVIDER SHOULD DO OR NOT DO

- Ask questions and be approachable.
- Be clear about what you need or what you are evaluating for when possible.
- Ensure the interpreter is safe.
- Understand the limitations of working with an interpreter.
- Give clear instructions.
- Be clear about start and end times and stick to them.
- Offer to debrief if needed, especially if the client's story was traumatic or they were psychotic.

Announcements

- Upcoming webinars
- Webinar evaluation form
- Follow up via email:

  TrainersWebinars@ncihc.org
- NCIHC.org/participate

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Home for Trainers Interpreter Trainers Webinars Work Group
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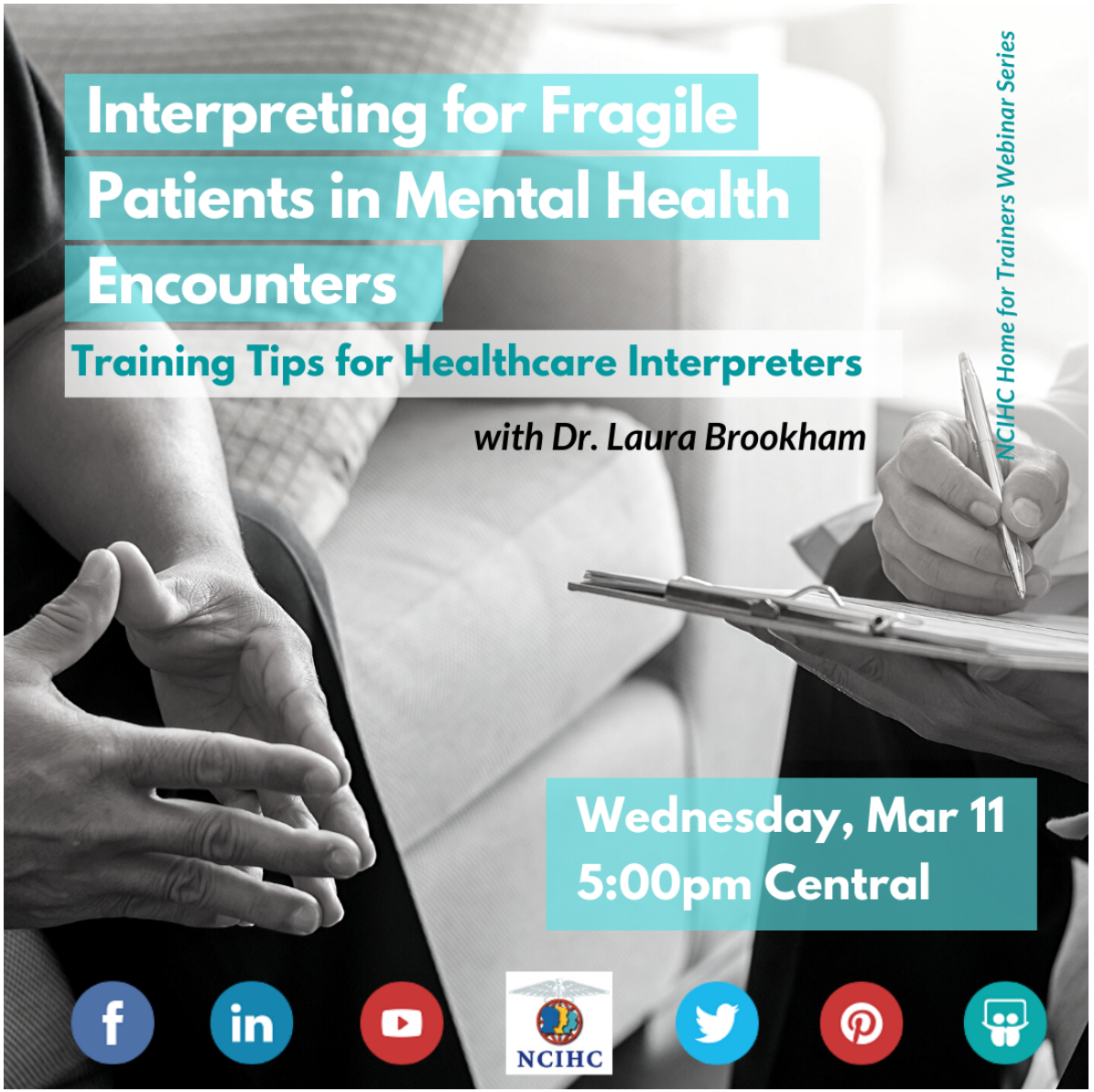

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