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Paralinguistic demands in interpreter-mediated Mental Health Act assessments: perspectives from mental health professionals, interpreters and service users

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ABSTRACT

This article explores the perspectives of multiple stakeholders regarding interpreter-mediated Mental Health Act (1983) assessments (MHAAs) in England, elicited as part of the Interpreters for Mental Health Act assessments (INforMHAA) study (2021–2024). Semi-structured interviews with 17 Approved Mental Health Professionals (AMHPs), four spoken and six signed language interpreters and four service users and carers were thematically analysed using the Demand Control Schema theoretical framework. The focus is on the paralinguistic demands faced by interpreters specifically in relation to the disordered communication that can manifest during a MHAA; not what is said but how it is said by the person being assessed, and the strategies (controls) that need to be employed by interpreters in order for AMHPs to get the information they need during the assessment. We suggest that if AMHPs and interpreters work collaboratively as a team, this should mitigate the paralinguistic demands, enhancing assessment effectiveness. The study highlights the need for specialised mental health interpreter training and improved AMHP–interpreter collaboration. This research contributes to the limited literature on interpreter-mediated statutory mental health assessments and points to the advantages of joint training in this specialist field of practice.

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Introduction

This article presents findings on paralinguistic demands in interpreter-mediated Mental Health Act (1983) assessments drawing on data from the INforMHAA project.[1] Specifically, it focusses on the interview component of the assessment that is carried out by

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Approved Mental Health Professionals (AMHPs) in England.[2] Few civil, rather than criminal, laws have the power to deprive individuals of their liberty against their wishes; one is the Mental Health Act 1983 (MHA). For individuals experiencing severe mental illness and who may pose a danger to themselves or others, the MHA authorises a formal assessment potentially leading to their compulsory detention in an appropriate psychiatric facility for the purposes of assessment and/or treatment, protection and care. This is commonly referred to as 'sectioning'. Similar legislations exist in other nations of the UK and internationally (Rodriguez et al., 2024). Mental Health Act assessments (MHAAs) take place in community or hospital settings either as an emergency or planned response to an individual experiencing severe mental health crisis and/or to continue required treatment. The AMHP's role under the MHA is not a clinical one: that is usually the domain of two doctors. Rather, it is to determine whether detention in a secure hospital setting is the only potential alternative given the severity of their mental illness and their risk to themselves or others. Practically this means ascertaining whether the service user[3] is capable of understanding that they require help, whether they are able to consent to voluntary assessment and/or treatment or whether compulsory detention is necessary. As noted elsewhere (Rodriguez et al., 2024; Tipton et al., 2025; Vicary et al., 2024; Young et al., 2023), AMHPs have the responsibility to ensure clear communication and understanding in MHAAs, regardless of what language is being used, and the Code of Practice, written to guide the work of all professions under the MHA, specifically refers to their responsibility to consider whether an interpreter is required (Department of Health, 2015 chapter 4).

Individuals undergoing a MHAA may exhibit unusual ways of using language, i.e. 'disordered communication', and the potential outcomes of a MHAA have serious consequences. Although it is acceptable to change the way you use language without that indicating a pathology (Henner & Robinson, 2023), how individuals change the way they use language has diagnostic import for the doctors assessing them in MHAAs, and can be revealing for AMHPs in reaching a decision about the outcome of that assessment (for example, the extent to which individuals are aware that they are experiencing a mental health crisis and the level of insight they have into their own circumstances at the time). Disordered communication can be as a result of disordered thought, where a person does not have the ability to make sense of what they are thinking or to explain this in a way which makes sense to another person (Elvevåg, 2023). This then results in expression (in spoken or signed language) that is unusual, hard to follow or nonsensical. It can also manifest if the service user is experiencing flight of idea: where they may be having thoughts not necessarily connected with each other or based on ideas that may not be making sense to an observer. The MHAA requires not just a medical/psychiatric assessment but also a narrative component: a legal requirement for an interview 'in a suitable manner' to take place (DoH, 2015 para 14,49; Hall, 2017). This component is important as it determines whether detention is required and is the only option, whether the person would or could agree to voluntary rather than compulsory detention and to help the individual understand their rights. The assessment undertaken during this narrative component is crucial to the final decision that is the responsibility of the AMHP.

In interpreter-mediated MHAAs, the challenge then for AMHPs is to make an assessment of a person's mental state and their ability to engage in discussion about their

circumstances, needs, risks and possible outcomes. When an interpreter is required, this narrative component indirectly creates complexities for the AMHP, who must rely on the interpreter for understanding not just the (linguistic) content of *what* is being conveyed but *how* it is being uttered; in other words, paralinguistic features of communication, as it may be the *how* that gives insight into the mental state. Little is empirically known about the linguistic demands placed on AMHPs and interpreters in this context, and how this could impact on the outcomes of a MHAA and AMHPs' decisions. Even if an interpreter has experience of working in mental health settings, they may not have experience of working in the context of MHAAs and may not realise the significance of doing so.

Foregrounding the study

The presence of an interpreter raises complexities in mental health encounters for all members of the triad, namely the service provider, the interpreter and the service user (Resera et al., 2015). Many challenges have been identified for mental health interpreting (Cornes & Napier, 2005; Doherty et al., 2010; Gallagher et al., 2017; Green et al., 2012) and the importance of cooperation and partnership between therapists and interpreters has been stressed (Bot, 2005; Costa, 2017; Tribe et al., 2026; Vranjes & Bot, 2021; Zimányi, 2013). Until the INforMHAA project, however, the majority of research has focused on interpreting in *non-statutory* mental health contexts that are not specifically governed by legal powers, duties and responsibilities invested in the professionals involved and where outcomes do not include the deprivation of liberty.

In fact, our major international scoping review (Rodriguez et al., 2024) found no literature that has specifically concentrated on interpreting in MHAAs or their international statutory equivalents. Our three main findings were the following. (1) Most research on mental health interpreting focusses on therapy, assessments associated with specific mental disorders/conditions and/or appropriate translation of standardised mental health/psychological assessments in use without any substantiation that studies in general mental health interpreting are sufficiently applicable to the specialised requirements of MHAAs. (2) There is no research that addresses the issue of how interpreter mediation supports or impedes the legal rights and best interests of service users assessed under the MHA or its international equivalents, or any direct evidence from interpreter-mediated MHAA practice. (3) Despite Gentzler's (2003) early call for more interdisciplinary connections in translation studies, there is a somewhat surprising lack of interdisciplinary examinations[4] of mental health interpreting across the fields of interpreting studies and health/social care. One notable exception is the MINDSET project, led by health and social sciences and interpreting studies researchers and makes the case for specialised and interdisciplinary-informed interpreter training within the field of cognitive assessments for dementia (Brijnath et al., 2022, 2024, 2025; Gilbert et al., 2023), while this study extends the question to statutory decision-making where communication may contribute to deprivation-of-liberty decisions.

Therefore, the much-needed body of work generated by the interdisciplinary INforMHAA project has allowed us to examine perceptions of AMHPs, spoken language interpreters (SpIs), signed language interpreters (SLIs) and service users and carers (SUCs) on challenges and best practices for undertaking MHAAs. Our

survey of 24 SpIs and SLIs (Tipton et al., 2025) revealed that information regarding statutory mental health assessments is typically not part of standard interpreter training courses. Only two interpreters surveyed reported familiarity with MHAAs, highlighting a significant gap in training and preparedness for interpreters. At present, interpreting remains an unregulated practice in the UK, with standards upheld only by voluntary registration bodies, meaning that qualifications and standards of interpreting practice can be variable, which adds further complexity to the dynamics of interpreter-mediated MHAAs.

Further compounding the issue, our survey of 132 AMHPs who had direct experience of carrying out interpreter-mediated MHAAs (Young et al., 2023) also revealed concerning trends: merely nine AMHPs could recall any training related to working with interpreters during their qualifying courses; post-approval only 28% had received training on working with interpreters; and nearly 60% of AMHPs expressed that their training did not adequately prepare them to collaborate with interpreters, either in their role as an AMHP or in any other professional setting. Interestingly, despite 92% of AMHPs rating their competence to conduct an MHAA with an interpreter present as moderate or high, 61% indicated that they could not perform MHAAs through an interpreter with the same effectiveness as in monolingual assessments.

Our reflexive thematic analysis (Braun & Clarke, 2022) of 17 semi-structured interviews with AMHPs found that, when conducting MHAAs, AMHPs perceive a time pressure that is exacerbated when they are required to work with an interpreter (Vicary et al., 2024). The AMHPs perceive that delays in conducting MHAAs while waiting for an interpreter, or the extended time it takes to complete an assessment when it is mediated by an interpreter, brings risks and additional pressures to conducting MHAAs. This ultimately impacts on inconsistent practice in how effectively AMHPs work with interpreters.

The assessment requires the AMHP to pay close attention not just to what the individual says, but also *how* they say it, including the degree of insight they may have and whether they are able to comprehend and contribute to a process of arriving at the safest outcome for them and others. This degree of close interaction and engagement is more complex when mediated through an interpreter. Thus, the work of the INforMHAA project has confirmed that achieving consensus between AMHPs and interpreters about how to conduct MHAAs as a co-constructed activity is paramount (Tipton et al., 2025, in preparation).

Theoretical framework: Demand Control Schema

Dean and Pollard (2014) adapted Karasek's (1979) Demand Control Theory to examine the complex occupation of interpreting, particularly in medical and mental health contexts. Demand Control Theory is a vocational analysis method used in studies of occupational stress and reduction of stress-related illness, injury and burnout. Dean and Pollard's Demand Control Schema (DCS) outlines factors or challenges that impact on interpreters, which they classify as *demands*. Demands are not necessarily demanding, just factors that impact on work that require interpreters to enact different controls (or strategies) to mitigate them. There are four categories of demand: environmental, interpersonal, paralinguistic and intrapersonal.[5] DCS has been applied in the analysis

of mental health interpreting with deaf people who use American Sign Language (ASL) (McCay & Miller, 2001), but not specifically in the context of MHAAs until our INforM-HAA project, during which we conducted an analysis of interpersonal demands and the impact on interprofessional working between AMHPs and interpreters (Tipton et al., 2025).

This article focuses on challenges in MHAAs that align with the *paralinguistic demand* category, which Dean and Pollard suggest includes any factors that are specific to ways of speaking or signing that are not related to what is said, but rather *how* it is said, which could impact on the interpreting decisions made. This relates to the potential for the disordered communication from service users that can be witnessed in MHAAs, which can include (Fine, 2008):

- lexical changes (including wrong words/signs, substitutions of words/signs and problems with word/sign finding);
- prosody – unusual ways of talking/signing that are inappropriate to the context (e.g. very slow, very fast, quiet, loud, pausing, etc.);
- incomplete utterances;
- nonsensical speech/signing (different from lexical or grammatical changes and can refer to incoherent speech/signing, speech/signing that lacks cohesion within a turn itself or to what has been previously said by an interlocutor or interpreter);
- content that is influenced by hallucinatory and delusional affects (e.g. the way someone talks is fine and there is no effect on lexicon, grammar, etc. and what they say is intelligible, but its meaning is totally wrong);
- extreme withdrawal including in its most extreme form catatonia; and
- changes in affect that make the actual process of interaction and maintenance of interpersonal communication problematic that then affects language fluency.

Thus, we characterise paralinguistic demands as:

- discordant language use – idiosyncrasies of speaking or signing/clarity of speech or signing/unnecessary repetitive utterances (perseveration); and
- delivery style – volume (loudness/quietness or size of signing space used)/pace/accents /use of gesture/body movement or unusual facial expressions/nature of eye contact.

Crump and Glickman (2011) discuss the paralinguistic challenges of interpreting for deaf people who exhibit disordered communication in a mental health in-patient context. They used DCS to identify demands and pre-assignment controls but did not break down the demands specifically into the four DCS categories, so any discussion of paralinguistic demands is implicit rather than explicit in their discussion. The paralinguistic demands they identified for interpreters included the unusually slow pace of a deaf person's signing, deaf people producing fingerspelled names incorrectly and discordant language use by someone who would normally be considered as a fluent signer. What is interesting is when there is a tension between the paralinguistic demands as outlined in the DCS framework and the changes to language usage associated with serious mental illness

that has clearly characteristic features, which is even more critical to consider in an MHAA.

This article discusses what happens to usual practice when MHAAs are interpreter-mediated, particularly in relation to paralinguistic features of language when disordered communication is present. Applying the use of DCS as a theoretical framework, we present analysis of interviews with AMHPs, spoken and signed language interpreters and SUCs, which overall sought to address this gap in our knowledge, with a focus on the following research questions:

- How does interpreter mediation impact on MHAAs?
- How can interpreter-mediated MHAAs be improved?
- To what extent and how does the involvement of a spoken/signed language interpreter in MHAAs constrain or enable best practices in MHAAs?

And specifically with respect to this paper:

- Do paralinguistic demands create any additional pressures for interpreter-mediated MHAAs?

Methodology

As is increasingly encouraged in interpreting studies (Mellinger, 2020), it is important to acknowledge our positionalities as a research team as these will have influenced the design of the study, participant recruitment, data analysis processes and interpretation of findings. We are an interdisciplinary team comprised of mono/bi/multi-lingual and cross-cultural researchers with diverse backgrounds, including members who are deaf and hearing. Each member contributed expertise spanning the fields of interpreting studies, social work, health studies and deaf studies. Napier, Tipton and Rodriguez are also professional interpreters who practice between English and French, Spanish or British Sign Language (BSL) and International Sign; Young and Vicary are registered social workers who previously worked as Approved Social Workers (AMHP predecessors) and Hulme is a culturally deaf researcher and BSL interpreter user. So, in addition to research expertise, we also brought personal and professional expertise. Our backgrounds enabled us to critically and reflexively evaluate our approach to the research, the findings, the recommendations and outputs.

This article reports findings from semi-structured interviews with 17 AMHPs, five spoken language interpreters, five (deaf and hearing) signed language interpreters and four SUCs (two deaf BSL users, one service user and one carer; and two hearing participants, both carers, one of whom was multilingual and of South Asian heritage). More detailed discussion of the perspectives of these groups separately can be found elsewhere in terms of AMHPs (Tipton et al., in preparation; Vicary et al., 2024; Young et al., 2023), interpreters (Rodriguez et al., 2021; Tipton et al., 2025) and SUCs (Hulme et al., in prep). This paper, however, brings together the multiple perspectives of AMHPs, interpreters and service users simultaneously, which has benefits in comparing and contrasting opinions (Zendedel et al., 2016).

Ethics approval was received from all three universities involved in the study.[6] Given its sensitive nature, particularly close attention was given to approaches for gaining consent and to ensuring that information was accessible in the languages preferred by participants. The majority of participants requested English or BSL. A project advisory board (including a range of professional stakeholder representatives) and a patient and public involvement and engagement (PPIE) group[7] comprised of service users and carers with lived experience relevant to mental health and interpreting contexts contributed to the co-design of participant information materials and interview protocols, advised on accessibility and sensitivity of language and informed recruitment approaches. Their involvement helped ensure that the study design remained attentive to the communicative and ethical complexities associated with interpreter-mediated MHAAs.

Interviews

Interview participants were recruited through convenience and network sampling either because AMHPs and interpreters had responded to our earlier surveys and indicated willingness to be involved in follow-up interviews or were asked directly via the project's PPIE group. We sought wherever possible to include only interviewees that had direct experience of interpreter-mediated MHAAs. One-to-one interviews were conducted online on Zoom or Teams, depending on participant preference/work protocol, and audio- or video-recorded, depending on whether it was conducted in spoken English or BSL. Interviews were conducted by 'matched' identities (i.e. interpreters interviewed SpIs and SLIs, social workers interviewed AMHPs, deaf researcher interviewed SUCs).

All participants were asked questions about their experiences of MHAAs and to share accounts of what they could retrospectively remember. The original interview corpus addressed the broader aims and overarching research questions of the project. For the purposes of this article, we extracted and analysed the subset of responses that were specifically relevant to paralinguistic demands in interpreter-mediated MHAAs. All the questions asked can be seen in the Appendix. Each interviewee was signposted to support after the interview in case their participation led to the manifestation of negative triggers.

Analysis

Automated transcripts of spoken English interviews were downloaded from the interview platform software and checked and corrected for accuracy. BSL interviews were translated by a professional translator into English and checked by the lead author. All transcripts were anonymised for the purposes of analysis and participants were allocated code numbers according to their role (i.e. AMHP, SpI, SLI, SUC), with numbers following the chronological data collection of participants.

We applied Braun and Clarke's (2022) reflexive thematic analysis (RTA) approach as it was imperative to draw on our positionalities and use our personal and professional lenses to interpret the data. This approach also enabled us to develop key themes alongside the reflexive stance of all the participants in how they perceived paralinguistic demands in MHAAs. Analysis was conducted using N-Vivo 12 annotation software,

and responsibility for coding was divided up between different team members. Team members who had conducted the original interviews first independently reviewed a sample of transcripts and created prospective top-level codes. These codes were subsequently compared and discussed to pinpoint areas of agreement, while also recognising subtle differences in perspective, unique codes proposed by individuals that others may have overlooked and broadening or clarifying the scope of what might be included in the top-level code. The three interpreter practitioner team members then reviewed all the codes and re-analysed the data to identify salient themes concerning demands for interpreters.

In relation to the interpreter interviews, it was identified that many of the themes clearly aligned with the DCS categories of environmental, paralinguistic, interpersonal and intrapersonal demands, so the next iterative stage of coding involved the analysis of these four DCS demands as *a priori* codes across all participant interview data. For the AMHP interview transcripts, a separate set of themes were inductively generated relating to AMHP practice (see Vicary et al., 2024). Those themes were then interrogated by the interpreting practitioner authors for the extent to which they were illustrative of DCS. The last stage of analysis involved using a deductive approach, searching the SUC data for examples that elucidated on paralinguistic issues, using search terms that had occurred in quotes from AMHPs and interpreters. This was conducted by Napier (interpreter practitioner) and Hulme (culturally deaf researcher). Across all datasets, analytic attention focused specifically on themes relating to paralinguistic demands, which form the focus of this paper. Analyses relating to interpersonal and intrapersonal demands are reported elsewhere (Rodriguez et al., 2021; Tipton et al., 2025).

Results

The results, drawing on interviews with AMHPs, spoken and signed language interpreters and SUCs, converge on a clear overarching insight: interpreter-mediated MHAAs are shaped as much by *how* language is produced as by *what* is said, and this creates a shared but unevenly understood responsibility across participants. Across AMHPs, there is agreement that paralinguistic features – such as disordered, incoherent, unusually paced or affectively marked communication – are not peripheral but central to clinical judgement. However, the data reveal a persistent gap between this recognition and consistent practice. Interpreters tend to orient toward verbatim rendering of discordant or nonsensical speech as a deliberate strategy to preserve clinically relevant cues, while AMHPs sometimes worry that interpreters may unintentionally 'normalise' or impose coherence on such talk, thereby distorting evidence needed for decision-making.

Another overarching finding is that these challenges are fundamentally *relational and procedural*, rather than purely linguistic. Across interviews, difficulties arise not simply from disordered communication itself but from a lack of shared expectations, limited joint training and time pressures that constrain collaboration. Participants consistently emphasise that effective assessments depend on coordinated teamwork in which interpreters trace the contours of a person's expression, including meta-commentary[8] on delivery style, while AMHPs actively prompt and integrate this information. The data highlights practical conditions that either mitigate or exacerbate these demands, including slower pacing and explicit negotiation of roles. Familiarity between

interpreters, professionals and service users has been emphasised to improve the quality of communication and reduce uncertainty. This has also been found in other healthcare and mental health contexts (e.g. Mapson & Major, 2021; Topçu & Mösko, 2025), but what is novel with respect to MHAAs is that familiarity may affect how communicative behaviour is interpreted in relation to the person's ordinary or out-of-the-ordinary mental state, informing decisions that can lead to compulsory detention and deprivation of liberty. Conversely, lack of preparation, rushed assessments and unfamiliar pairings increase the risk of misunderstanding, mistrust and uneven practice.

Here we present the findings according to the two most salient themes: idiosyncratic language use when a service user is experiencing a severe mental health episode (discordant language use) and how features of the language articulation can impact on the decision-making and outcomes of an MHAA (delivery style).[9]

Discordant language use

The paralinguistic demands identified by interpreters are primarily concerned with the way the service user speaks/signs. Language dysfluency (when the normal flow and smooth delivery of speech are disrupted) is a paralinguistic demand, which then poses a challenge from the interpreting point of view. The interpreters recognised incoherence as potentially having value (i.e. having a better understanding of the condition) and so their control strategy shifts from meaning-based rendering to preserving the disordered speech for AHMPs to work out what that means clinically:

> it was very difficult to interpret for [the service user] because she was talking nonsense basically and you are trying to interpret this nonsense … That happens to some interpreters that in order to be able to interpret they try to normalise the sentence or make it make sense, and you will lose what's going on. So, if [the AMHP] is saying this to the interpreter that we are doing this assessment, the [service user] is not feeling very well and they might say things which might not make sense to you. But we still would like you to interpret in the same way that the [service user] says it so that we could have a better understanding of their condition. That would be a good idea as well. (SpI 031)

One interpreter noted that this goes against the instincts of interpreters or what they have been taught, as interpreters inherently seek meaning in one language, in order to be able to produce 'meaningful equivalents' (Napier, 2002) in the other language. When the interpreter says 'goes against it' they are referring to the fact that failure to accurately reflect the nature of language use (i.e. how they are producing language not just what they are producing) can impact on the ability of the AMHP to determine if an individual can participate in a serious decision concerning required assessment and/or treatment:

> Because it goes against what you are taught, because you're taught you have to understand the message. You are relaying the meaning. If you don't understand you clarify, so that's the general concept. But in mental health that goes against that. You have to relay exactly what the [service user] is saying, even if it doesn't make sense, so you may have to switch to actually translating word-for-word. You know, normally you tell them you don't do that, when you are interpreting or translating you don't do it, but in this situation, you're suddenly saying you have to do word-for-word, because that's how the person is expressing themselves. (SpI 026)

The interview data show generally high levels of confidence and consistency among the interpreters in their handling of discordant language use, with the most frequently cited

control strategy being 'verbatim' (word-for-word) interpreting. The data also highlight a general expectation that the AMHP will follow up on matters arising from unclear discourse:

> Even if you don't understand it, if it doesn't make sense, just relay it word-for-word because that's probably important information for the professional to know that what the person is saying doesn't make sense, and then it's up to the professional to explore that. (SpI 026)

The AMHP interviews, by contrast, include references to fears of interpreters seeking to impose meaning on the service user's discourse, highlighting inconsistencies of practice and pointing to assumptions about how interpreters work and the potential to overlook the need to discuss approaches explicitly prior to an assessment starting:

> One of the most difficult things would be when the interpreter would try to make sense of what the person is saying. They felt it was their role to make sense of what is being said and they did not realise that it was the last thing that they needed to do. It actually distorts really crucial information and affects an important part of an assessment, which is really to understand what is going on in their minds. (AMHP 011)

Even though the AMHPs expect that some service users would produce dysfluent language of various forms and that interpreters would relay that back to them, some of the interpreter interviewees noted that AMHPs do not necessarily trust that they are just conveying what the person has said. That is, that it is the service user who is not making sense rather than the interpreter not being skilled enough:

> I think it is clear, but if I can't understand somebody whether it's the service user or the service provider I say so. But if the service user is using what they call in mental health a "word salad"[10], I have to repeat the word salad and I hope that the [AMHP] doesn't think that *I* am talking word salad. You know, so sometimes if they look at me a bit like "what did you just say?" I just say, "repeating exactly what the [service user] has just said, yes". (SpI 027)

For AMHPs, even in the face of dysfluent language, they are still required to persevere and say very precise things to the service user; they cannot be informal, say it a different way or soften things down too much because of their legal obligation to ensure that the person has been informed (even if that AMHP feels that the individual is unlikely to understand). So, this is partly why AMHPs may ask interpreters to be very literal.

But the lack of clarity about whether it is the interpreter who generates non-sensical language or whether it is an accurate representation of the original utterance can cause friction or uncomfortable dynamics with the AMHP. This is particularly if no ground rules were set at the beginning due to lack of introduction and opportunity for the AMHP to brief the interpreter. This sheds a different light on typical discussions of interpreting accuracy (e.g. Gieshoff & Albl-Mikasa, 2022) and underscores the potential doubts that can arise for AMHPs about the extent to which they feel they can trust interpreters, in the context of the legal importance of their decision-making.

One interpreter also highlighted the importance of conveying to the AMHP other paralinguistic elements of speech that might help in their assessment:

> if somebody is not clear, it doesn't make sense, if they're speaking in a muffled way or even if the language is not one that I was called for I make it known immediately. I will say "Okay, I have heard this, this, this, but did not hear exactly because the speech was unclear for the interpreter". (SpI 027)

It was also observed that it can be an issue if the interpreter does not mediate all the paralinguistic elements or the fact that the language use is not concordant with what would be expected for someone with their linguistic profile. AMHPs need to be mindful of this and not rely solely on the interpretation of *what* is said but ask interpreters to convey *how* something is said (or even not said).

One AMHP suggested that a sign language interpreter may be more adept at picking up discordant communication cues, which spotlights the benefits again of interprofessional working:

> I think the sign language interpreter can pick up on more cues, more subtleties, not just the words if you like? Yeah, just, I suppose, I don't know, impressions, yeah. And also, I think helps with the process. (AMHP 013)

The extent to which information is shared *about* the manner of communicating and not only the content of what is said takes on particular importance in MHAAs. Interpreters recognised the need to make meta-comments on issues perceived as relevant and to which the AMHP does not have access:

> That doesn't mean that we're going to carry out the assessment or we're going to make judgments on somebody's care, but sometimes we're the best placed professional and we need to share some of that information to the other professionals, so that they have a clear idea of what's going on. (SLI 035)

This is a key aspect as it points to the distribution of responsibility around paralinguistic aspects. If the interpreter has direct access to these features of language, and they describe and pass that onto the AMHP, then the AMHP will be able to make more informed decisions about the level of insight the service user has into their own mental state, their level of safety and that of others and whether they have the capacity to agree to receive treatment voluntarily.

With regard to this kind of situation, one service user places strong emphasis on the importance of interpreter familiarity, highlighting how it enables them to maintain focus on progress and avoid repetitive explanations of the past when working with new interpreters. By having the same interpreter, they can avoid revisiting challenging or sensitive topics repeatedly. The interpreter, by being familiar with *how* the service user speaks/signs, becomes more efficient in identifying and conveying these idiosyncrasies of (paralinguistic) talk. This familiarity also plays a crucial role in facilitating effective work and communication, as they become more attuned to each other's dynamics and language use and develop a smooth working relationship:

> You have to see the same interpreter again and again and then it becomes easier in the review meetings. Because you don't feel that you have to retread over difficult ground, but it's a very difficult thing to balance. (SUC 03)

This suggestion was agreed on by an interpreter:

> I think [familiarity] does make a difference because you're going into a known situation, you've got a pretty good idea of how they're going to react, especially to you, as the interpreter, you've got a good idea of the accent … you might, you know, know the trigger points in their histories that upset them. (SpI 028)

It is worth noting that several of the SLIs interviewed worked as in-house interpreters in a specialist deaf mental health facility, meaning they are more likely to build familiarity with service users and AMHPs, thus positively affecting their capacity to read the paralinguistic cues as compared to ad hoc freelance interpreters. AMHPs also noted the benefits of working with interpreters who are familiar with service users:

> I think this is a chap that had already been assessed, and I think he was quite angry about lots of different things, and I think having someone familiar in the room helped to get his points across I think a little bit more. Because a lot of it was about communication and [the interpreter] understood his history, and didn't need to go over any of those questions before. (AMHP 006)

In addition to the various forms of discordant language use we have described above, the delivery style in MHAA interactions is also a paralinguistic demand.

Delivery style

One of the most striking observations from the interviews is in relation to the pace of assessments. Both AMHPs and interpreters noted that the speed needs to be considered carefully, with one AMHP suggesting that speed is a mechanism which is sometimes used to assess the presence of mental illness. Such pressure of speech may be difficult to ascertain where there is a lack of language knowledge for the AMHP:

> [We] are reading other cues aren't we, in the assessment, not just the verbal cues that we don't understand but you can also pick on whether the person is talking quickly, it seems to be that is a little bit faster than what I would expect. You could also check that with the interpreter for example, couldn't you? … I might phrase it to the person, you know, that sounds like you're talking quickly there. But I also may look at the interpreter to help me. (AMHP 013)

Another AMHP gives an example praising interpreters for strategically managing this paralinguistic demand well:

> One of the things is the interpreter to take control of the speed of which people are speaking at. You know how somebody says I'm going to ask a question and then actually are they also ask about four all rolled into one? Interpreters that do it really well will stop you and say, I just need to stop you there because I think that's too much information, so I'm just going to ask the first part and managed the amount of information coming to and from at any given time. That works really well because the [service user], unless they've got pressured speech and you're just not going to be able to slow them down under any circumstance, the [service user] needs to be managed too. They can make sure they're getting their voice across correctly, but the professionals equally need to be managed because we're so task focused on the assessment of this person's mental state. We're not necessarily focusing on how many words we're giving out at any given moment. (AMHP 004)

The above quote illustrates that it is not only the way the service user talks that matters but also the AMHP's delivery of information (particularly in relation to diagnostic labels) that can create a paralinguistic demand. Therefore, the interpreter needs to be aware of this sensitivity to replicate the AMHP's phrasing. Additionally, one interpreter noted that they need to manage the interaction in a way so that it is clear to the SUC that it is the

AMHP that is doing the talking and delivery of information, thus potentially reducing any confusion of the interpreter's role in the interaction:

> I will make it very clear who's conducting the conversation, which would mean interpreting something to the deaf person and then looking back. I need to break the eye contact so that they're absolutely clear they're not having a conversation with me they're having a conversation with them … because I don't want there to be any confusion about who is conducting the assessment. (SLI 032)

If the pace is too fast, then this can also prompt the service user to address the interpreter directly to enquire what is going on:

> From my experience, [the service user] starts a side conversation with me to clarify what is going on, so I have to kind of update them throughout the process. Or maybe the interaction is going too fast, for example, when two hearing people speak to each other it can be hard to keep up so I will relay that information to them. (SLI 030)

These are important examples from a paralinguistic point of view. However, a tension is created between the AMHP's and the interpreter's competing goals. If there is a time pressure to conduct the assessment (e.g. because of the time limit on when the assessment needs to be completed, they have already been waiting for the interpreter for some time or the interpreter is only available for a limited time), AMHPs may feel the pressure to speed up the assessment (Vicary et al., 2024). But there are clearly tangible benefits both to AMHPs and interpreters to slow down to ensure effective communication.

Linking back to the earlier point about familiarity, one AMHP felt that when they (and not just the service user) had worked with an interpreter before, this also benefited the assessment as the interpreter could better read the AMHP's delivery style:

> Sometimes I usually get [interpreters] I know a lot of the time, and that's helpful because they know what my style is … when I'm doing assessments. So, that helps as well, but that's not always a possibility. (AMHP 002)

This can be particularly useful when the AMHP has no direct understanding of the language being used to determine if the delivery style of the service user is manifesting mental illness in some way:

> If you are an AMHP that does not understand the spoken language, you can't monitor or judge the adjustments the interpreter has made, for example, making the language softer or emphasising the legal power of language. (AMHP 011)

As has been found for healthcare more generally (e.g. Zhang et al., 2021), the need for collaborative interprofessional working in MHAAs in order to develop trust and strategic decision-making for both the AMHP and the interpreter is reinforced (Tipton et al., 2025), whilst recognising that it is the AMHP's responsibility to make the ultimate decision about whether someone is 'sectioned'.

Discussion

Analysis of the interview data has shed light on the complexities and challenges faced by multiple participants during MHAAs, particularly focusing on paralinguistic demands. Taken together, the gist of the dataset is that interpreter-mediated MHAAs operate as a *co-constructed communicative task under high stakes*, where paralinguistic meaning is

critical but fragile. The findings consistently point to the need for more explicit, shared frameworks of practice – particularly joint training and clearer role alignment – to ensure that subtle features of communication are accurately conveyed and appropriately interpreted in decisions that may ultimately restrict an individual's liberty. Two salient themes emerged from the data concerning discordant language use and delivery style, providing insights into how AMHPs, interpreters and service users navigate these paralinguistic challenges.

Interpreters highlighted significant challenges in interpreting when service users, especially those experiencing psychosis, use discordant communication that disrupts the natural flow of speech, making it difficult for interpreters to accurately convey what is being said. Interpreters noted a conflict with their training, as they are typically taught to seek meaning in one language to provide 'meaningful equivalents' in another. However, in MHAAs, they emphasised the need to relay non-sensical utterances exactly as spoken/signed.

It is noteworthy that the examples on giving meta-comments about service users' utterances came from the signed language interpreter interviewees only. This may be reflective of variability in the use of signs by individuals which interpreters regularly have to navigate across service contexts, i.e. such meta-comments may be more a part of the sign language interpreter's repertoire and practice routine. This does not mean that spoken language interpreters never employ meta-comments as a control in MHAAs, but their accounts of strategies used to handle disordered/dysfluent communication in our data tended to privilege general points about method (e.g. verbatim translation and simultaneous interpreting), to the exclusion of comments on specific oddities of language use they have handled in the past. We know of no available training for spoken language interpreters in the UK that includes a focus on expressions of disordered thinking or unusual uses of language (i.e. incorporating insights from clinical forensic linguistics). So practitioners inevitably currently have an impoverished range of reference points when articulating how they deal with this.

Service users and carers suggested that familiarity with interpreters can be beneficial, as interpreters are more likely to accurately understand their language output and any elements that may be discordant forms of communication. AMHPs and interpreters both also noted the benefits of familiarity.

AMHPs are reminded that there could be discordant communication that only interpreters can recognise. Although the importance of this was recognised by some of the AMHPs interviewed, interpreters seemed to suggest this is not always the case, which points to the need for interprofessional working and also for training for AMHPs and interpreters on best practices for working together. The lack of clarity about whether non-sensical language is generated by the interpreter or the service user can lead to uncomfortable dynamics during assessments. Nevertheless, it can be seen that some of the AMHP participants recognised the efforts made by interpreters to mitigate for paralinguistic demands.

The use of sensitive language was emphasised by AMHPs, for example in how they deliver information that may be confronting, distressing or could trigger an emotional response. They stressed the importance of interpreters matching the sensitive language used by AMHPs during assessments. Interpreters reiterated that it is critical to convey

information about the way someone talks, not just what they say, as these can indicate critical factors, such as an escalation of agitation.

All participants highlighted the need to slow down the pace of conversation during assessments. When the conversation pace is too fast, service users may get confused and start talking directly to interpreters, creating additional demands for interpreters to update the AMHP. Furthermore, AMHPs noted the importance of monitoring speed of speech to assess the presence of mental illness.

Distorted communication of any kind can negatively impact on the quality of (mental) healthcare (Lesch & Saulse, 2013), so effective collaboration between service users, interpreters and AMHPs is crucial for accurate assessments, otherwise there is a risk of language and cultural discordance (as noted by Schouten et al., 2022 in generic mental health care consultations).

Our findings reveal that AMHPs need to be aware of the impact that communicating via an interpreter can have on their evaluation of paralinguistic features of a person's language use. But critically, interpreters also need to be aware of the complexity of interactions possible between varied impacts of mental state and paralinguistic features that extend beyond an acknowledgement of nonsensical or dysfluent speech/communication into more subtle markers of positive and negative symptoms of psychosis.

There is a shared responsibility for both AMHPs and interpreters to ensure that all relevant linguistic information is conveyed during assessments, and that any language discordance or challenges with delivery style should be identified. By working together and joining forces, combining their expertise, identifying paralinguistic elements is a result of teamwork and smooth working dynamics. These findings extend beyond the immediate context of MHAAs by highlighting how responsibility for meaning is distributed in interpreter-mediated institutional encounters where relevant meaning is not confined to the purely linguistic or propositional content of what is said or signed, but also includes how communication is produced, including discordance, dysfluency, pace, volume, affect, gesture, signing space and other features of delivery. Access to this layer of meaning depends on coordinated interprofessional work, as interpreters may be best placed to identify paralinguistic features that are not directly accessible to AMHPs, while AMHPs are responsible for recognising the potential relevance of such information for their decision. Yet, there is also a challenge for interpreters in knowing *when* best to report observations or for AMHPs to prompt the interpreter by seeking to elicit information. Much of the time this might operate at quite an intuitive level; however, the variability in interpreter training/experience in these types of encounters means that AMHPs may need to prompt more than they think. This highlights the importance of having clear guidelines for AMHPs and interpreters in working together.

Limitations of the study

We recognise that the relatively small samples of interviews with multiple stakeholders means that the findings may not be broadly generalisable to all practising AMHPs or interpreters, or to SUC experiences. Furthermore, we recognise that participants engaged with interviewers in a controlled situation far removed from the actual setting of potentially high-risk mental health assessments, and this should be taken into

account in the interpretation of findings. Nevertheless, this study illuminates the intricate challenges of paralinguistic demands during MHAAs from multiple perspectives.

Conclusion

Our study confirms that paralinguistic demands are present in MHAAs as well as other mental health contexts (Crump & Glickman, 2011; McCay & Miller, 2001), and it is evident that interprofessional working – AMHPs and interpreters working as a team in collaboration – is as important in MHAAs (Tipton et al., 2025) as it is in therapy (Costa, 2017), healthcare (Hlavac & Harrison, 2021), generic mental health consultations (De Cotret & Leanza, 2023; Schouten et al., 2022) or in social care (Berthold & Fischman, 2014) to achieve necessary outcomes. It is the ultimate responsibility of AMHPs to make decisions, so an important aspect of AMHPs and interpreters working collaboratively means that paralinguistic demands are more likely to be noticed, shared and taken into account in MHAA assessments.

Drawing on multiple perspectives from AMHPs, spoken and signed language interpreters and service users and carers can inform joint training models for AMHPs and interpreters, and the insights from SUCs is an important component in suggesting enhancements to interprofessional practice. Additionally, drawing on interdisciplinary expertise brought a richness to research design, data analysis and writing that may not have been as evident if approaching this topic within each of our separate disciplines.

Implications of the study

The findings emphasise the need for ongoing (ideally joint) training and awareness among AMHPs and interpreters in the UK on collaborative and interprofessional working to identify and reflect the paralinguistic elements of talk and legal terminology that is particular to MHAAs, especially in diverse linguistic and cultural contexts. They also highlight the need for guidance for AMHPs and interpreters working together, in addition to guidelines for psychologists working with interpreters (BPS, 2026; Tribe, 2009; Tribe & Thompson, 2011).

Hlavac's (2017) Australian guidelines acknowledge that

> a Crisis Assessment and Treatment Team (CATT) assess the likelihood of 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.

However, the guidelines do not go into any further detail about the *process* of the assessments or acknowledge the role of paralinguistic issues in informing the detention decision. Furthermore, Tribe's (2026) guidance acknowledges the effect of mental illness on interpreting, for example recognising how psychotic symptomatology can affect all languages, but it does not go in depth into how to respond to this from the interpreting perspective.

As such, the INforMHAA project has produced a detailed, open access guidance document and training/learning resources for AMHPs and interpreters drawing on evidence

from our study,[11] which are complemented by video scenarios. These can be used for self-led learning for professional development purposes, but as per Hanft-Robert et al.'s (2023) recommendation, we suggest that use of the videos and resources would be more effective as part of training programmes. It is encouraged that these resources are embedded in AMHP and interpreter education and so can contribute directly to improved AMHP–interpreter interprofessional working in MHAAs in the UK. The resources will also be useful to equivalent professionals and interpreters in other countries in gaining insight into recommendations for interprofessional working in statutory mental health assessments.

Notes

1. INforMHAA project – Interpreter-Mediated Mental Health Act assessments – https://sites.manchester.ac.uk/informhaa/
2. 95% of AMHPs are social workers. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/843539/AMHP_Workforce_Plan_Oct19__3_.pdf
3. Someone being assessed in an MHAA may not necessarily previously be a service user, but for the purposes of this article, for brevity, we use the term service user to mean anyone being assessed in a MHAA. Service user is the standard term in the UK, rather than 'patient', as service users are not necessarily patients if they are being assessed for the first time.
4. Interdisciplinarity is defined as 'the integration of the contributions of several disciplines to a problem or issue by bringing interdependent parts of knowledge into harmonious relationships through strategies such as relating part and whole or the particular and the general. Therefore, interdisciplinary approaches address the holistic complex of interrelationships […] with the aim to encourage combined thinking and sharing of methods towards solutions that cross traditional boundaries between them' (Manolakelli, 2022).
5. Environmental demands: specialised terminology or physical surroundings; interpersonal demands: interactions between interpreters and their service providers and service users; paralinguistic demands: how language is presented; intrapersonal demands: interpreter's own feelings or physiological distractions.
6. University of Manchester (approval no: 2021-12163-19345), Heriot-Watt University (approval no: HREC/4100/XXXXX) and Open University (approval no: 2021-1431-4565).
7. The establishment of patient and public involvement and engagement (PPIE) groups to advise health and social care researchers is a standard procedure in the UK, and a requirement of the National Health Service and funders such as the National Institute for Health and Care Research – P172, including the School for Social Care Research which funded the original study. PPIE is an active partnership where patients, carers and members of the public work alongside researchers to shape the design, conduct and dissemination of studies, rather than just participating as subjects.
8. Meta-commentary is a secondary text or thought process that runs alongside the main point being made. So, in the context of interpreting, an interpreter may provide a meta-comment on the interpretation they have just provided.
9. Some of the quotes featured are quite long. We felt it was important to reflect the way in which the interpreters in particular expressed themselves in some detail as it highlights the difficulty they have in talking about and describing these issues and shows a marked contrast with the list of discordant communication features presented earlier.
10. A 'word salad' refers to a confused, incoherent mixture of seemingly random words or phrases that lacks any discernible meaning. While the words might be grammatically strung together, they fail to convey a logical thought. In clinical settings, the term has a distinct meaning: it describes highly disorganised speech that is a symptom of a neurological or

severe mental health disorder, such as schizophrenia. Also known as *schizophasia* or *formal thought disorder*, the speaker often lacks the ability to organise thoughts into coherent sentences. (Cambridge Dictionary). This is recognised by the American Psychological Association as 'severely disorganised and virtually incomprehensible speech or writing, marked by severe loosening of associations' (https://dictionary.apa.org/word-salad).

11. See: https://sites.manchester.ac.uk/informhaa/.

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References

Berthold, S. M., & Fischman, Y. (2014). Social work with trauma survivors: Collaboration with interpreters. *Social Work*, *59*(2), 103–110. https://doi.org/10.1093/sw/swu011

Bot, H. (2005). *Dialogue interpreting in mental health*. Rodopi.

BPS. (2026). *Working with interpreters: Guidelines for psychologists*. The British Psychological Society. Available: https://www.bps.org.uk/guideline/working-interpreters-guidelines-psychologists

Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide*. Sage.

Brijnath, B., Cavuoto, M. G., Markusevska, S., Gilbert, A., Antoniades, J., Garcia, E. G., Hlavac, J., Low, L. F., LoGiudice, D., Woodward-Kron, R., & Enticott, J. (2024). Improving interpreting for dementia assessments: Results from the MINDSET trial. *Alzheimer's & Dementia*, *20*(S3), e085823. https://doi.org/10.1002/alz.085823

Brijnath, B., Gonzalez, E., Hlavac, J., Enticott, J., Woodward-Kron, R., LoGiudice, D., Low, L. F., Antoniades, J., White, J., Hwang, K., & Lin, X. (2022). The impact of training on communication quality during interpreter-mediated cognitive assessments: Study protocol for a randomized controlled trial. *Alzheimer's & Dementia: Translational Research & Clinical Interventions*, *8*(1), e12349. https://doi.org/10.1002/trc2.12349

Brijnath, B., Markusevska, S., Enticott, J., Sethi, P., Gilbert, A. S., Gonzalez, E., Hlavac, J., Low, L. F., LoGiudice, D., Woodward-Kron, R., & Antoniades, J. (2025). Interpreter communication quality in cognitive assessments for dementia. *JAMA Network Open*, *8*(2), e2458069–e2458069. https://doi.org/10.1001/jamanetworkopen.2024.58069

Cornes, A., & Napier, J. (2005). Challenges of mental health interpreting when working with deaf patients. *Australasian Psychiatry*, *13*(4), 403–407. https://doi.org/10.1080/j.1440-1665.2005.02218.x

Costa, B. (2017). Team effort – training therapists to work with interpreters as a collaborative team. *International Journal for the Advancement of Counselling*, *39*(1), 56–69. https://doi.org/10.1007/s10447-016-9282-7

Crump, C., & Glickman, N. (2011). Mental health interpreting with language dysfluent deaf clients. *Journal of Interpretation*, *21*(1), 21–36. https://digitalcommons.unf.edu/joi/vol21/iss1/3

De Cotret, F. R., & Leanza, Y. (2023). Typology of healthcare interpreter positionings as applied to family medicine. *Patient Education and Counseling*, *113*, 1–6. https://doi.org/10.1016/j.pec.2023.107773

Dean, R., & Pollard, R. Q. (2014). *The demand control schema: Interpreting as a practice profession*. CreateSpace.

Department of Health. (2015). Mental health act code of practice, Department of Health, London.

Doherty, S. M., MacIntyre, A. M., & Wyne, T. (2010). How does it feel foryou? The emotional impact and specific challenges of mental health interpreting. *Mental Health Review Journal*, *15*(3), 31–44. https://doi.org/10.5042/mhrj.2010.0657

Elvevåg, B. (2023). Reflections on measuring disordered thoughts as expressed via language. *Psychiatry Research*, *322*, 1–4. https://doi.org/10.1016/j.psychres.2023.115098

Fine, J. (2008). *Language in psychiatry: A handbook of clinical practice*. Equinox.

Gallagher, C., Melluish, S., & Löfgren, S. (2017). Exploring the experience of Polish interpreters who interpret for mental health clinicians in the UK: An interpretative phenomenological analysis. *International Journal of Culture and Mental Health*, *10*(3), 338–346. https://doi.org/10.1080/17542863.2017.1317280

Gentzler, E. (2003). Interdisciplinary connections. *Perspectives*, *11*(1), 11–24. https://doi.org/10.1080/0907676X.2003.9961458

Gieshoff, A. C., & Albl-Mikasa, M. (2022). Interpreting accuracy revisited: A refined approach to interpreting performance analysis. *Perspectives*, *32*(2), 210–228. https://doi.org/10.1080/0907676X.2022.2088296

Gilbert, A. S., Antoniades, J., Hwang, K., Gonzalez, E., Hlavac, J., Enticott, J., Lin, X., Woodward-Kron, R., Low, L. F., LoGiudice, D., & White, J. (2023). The MINDSET study: Co-designing training for interpreters in dementia and cognitive assessments. *Dementia (Basel, Switzerland)*, *22*(7), 1604–1625. https://doi.org/10.1177/14713012231190578

Green, H., Sperlinger, D., & Carswell, K. (2012). Too close to home? Experiences of Kurdish refugee interpreters working in UK mental health services. *Journal of Mental Health*, *21*(3), 227–235. https://doi.org/10.3109/09638237.2011.651659

Hall, P. (2017). Mental Health Act Assessments – professional narratives on alternatives to hospital admission. *Journal of Social Work Practice*, *31*(4), 445–459. https://doi.org/10.1080/02650533.2017.1394825

Hanft-Robert, S., Emch-Fassnacht, L., Higgen, S., Pohontsch, N., Breitsprecher, C., Müller, M., Mueller, J. T., & Mösko, M. (2023). Training service providers to work effectively with interpreters through educational videos. *Interpreting, International Journal of Research and Practice in Interpreting*, *25*(2), 274–300. https://doi.org/10.1075/intp.00090.han

Henner, J., & Robinson, O. (2023). Unsettling languages, unruly bodyminds: A crip linguistics Manifesto. *Journal of Critical Study of Communication and Disability*, *1*(1), 7–37. https://doi.org/10.18061/jcscd.7119

Hlavac, J. (2017). *Mental health guidelines for interpreters*. Monash University. Available: https://ausit.org/wp-content/uploads/2020/02/Mental_Health_Interpreting_Guidelines_for_Interpreters.pdf

Hlavac, J., & Harrison, C. (2021). Interpreter-mediated doctor-patient interactions: Interprofessional education in the training of future interpreters and doctors. *Perspectives*, *29*(4), 572–590. https://doi.org/10.1080/0907676X.2021.1873397

Karasek, R. (1979). Job demands, job decision latitude, and mental strain: Implications for job redesign. *Administrative Science Quarterly*, *24*(2), 285–308.

Lesch, H. M., & Saulse, B. (2013). Revisiting the interpreting service in the healthcare sector: A descriptive overview. *Perspectives*, *22*(3), 332–348. https://doi.org/10.1080/0907676X.2013.822008

Manolakelli, A. (2022). *Inter, multi, cross, trans, & intra-disciplinary: What is the difference and why is it important?* Available: https://www.archpsych.co.uk/post/disciplinarities-definitions

Mapson, R., & Major, G. (2021). Interpreters, rapport, and the role of familiarity. *Journal of Pragmatics*, *176*, 63–75. https://doi.org/10.1016/j.pragma.2021.01.020

McCay, V., & Miller, K. (2001). Interpreting in mental health settings: Issues and concerns. *American Annals of the Deaf*, *146*(5), 429–434. https://doi.org/10.1353/aad.2012.0200

Mellinger, C. (2020). Positionality in public service interpreting research. *FITISPos International Journal*, *7*(1), 92–109. https://doi.org/10.37536/FITISPos-IJ.2020.7.1.250

Napier, J. (2002). *Sign language interpreting: Linguistic coping strategies*. Douglas McLean.

Resera, E., Tribe, R., & Lane, P. (2015). Interpreting in mental health, roles and dynamics in practice. *International Journal of Culture and Mental Health*, *8*(2), 192–206. https://doi.org/10.1080/17542863.2014.921207

Rodriguez, N. V., Napier, J., & De Pedro Ricoy, R. (2021). Dialogue interpreting and person-centred care in a clinical mental healthcare setting. In C. Wang, & B. Zheng (Eds.), *Empirical studies in translation and interpreting: The post-structuralist approach* (pp. 29–48). Routledge.

Rodriguez, N. V., Young, A., Vicary, S., Napier, J., Tipton, R., & Hulme, C. (2024). A scoping review of interpreter-mediated assessments under the Mental Health Act (1983) and international equivalents. *Interpreting and Society: An Interdisciplinary Journal*, *4*(2), 1–37.

Schouten, B., Lázaro Gutiérrez, R., & Krystallidou, D. (2022). Language and cultural discordance between practitioners and refugees in mental healthcare consultations: Developing a promising European intervention to break down barriers. *Patient Education and Counseling*, *105*(10), 3171–3172. https://doi.org/10.1016/j.pec.2022.08.003

Tipton, R., Napier, J., Rodriguez Vicente, N., Young, A., Vicary, S., & Hulme, C. (in preparation). I might be doing something which I wouldn't do otherwise': Investigating Approved Mental Health Professionals' (AMHP) talk about interpreter mediation in Mental Health Act assessments.

Tipton, R., Napier, J., Rodriguez, N. V., Young, A., Vicary, S., & Hulme, C. (2025). 'Just interpret'. *Interpreting. International Journal of Research and Practice in Interpreting*, 221–251. https://doi.org/10.1075/intp.00120.tip

Topçu, M. T., & Mösko, M. (2025). Building trust and relationship across language barriers: A qualitative study of interpreter-mediated psychotherapy with therapists, interpreters and patients. *International Journal for Equity in Health*, *24*(1), 1–16. https://doi.org/10.1186/s12939-025-02718-6

Tribe, R. (2009). Working with interpreters in mental health. *International Journal of Culture and Mental Health*, *2*(2), 92–101. https://doi.org/10.1080/17542860903115976

Tribe, R., & Thompson, K. (2011). Developing guidelines on working with interpreters in mental health: Opening up an international dialogue? *International Journal of Culture and Mental Health*, *4*(2), 81–90. https://doi.org/10.1080/17542863.2010.503365

Tribe, R., Thompson, K., & Raval, H. (2026). *Working with Interpreters in Mental Health (2nd Ed.)*. Routledge.

Vicary, S., Young, A., Tipton, R., Rodriguez Vicente, N., Napier, J., & Hulme, C. (2024). *The luxury of time: A reflexive thematic analysis of omnipresence, contradiction, and passivity in interpreter-mediated Mental Health Act assessments*. *Qualitative Social Work*.

Vranjes, J., & Bot, H. (2021). Optimizing turn-taking in interpreter-mediated therapy: On the importance of the interpreter's speaking space. *The International Journal of Translation and Interpreting Research*, *13*(1), 101–117. https://doi.org/10.12807/ti.113201.2021.a06

Young, A., Vicary, S., Napier, J., Tipton, R., Rodriguez Vicente, N., & Hulme, C. (2023). Mental Health Professionals (AMHPs) perspectives on interpreter-mediated Mental Health Act assessments. *Journal of Social Work*, *24*(2), 219–239. https://doi.org/10.1177/14680173231197987

Zendedel, R., Schouten, B. C., van Weert, J. C. M., & van den Putte, B. (2016). Informal interpreting in general practice: Comparing the perspectives of general practitioners, migrant patients and family interpreters. *Patient Education and Counseling*, *99*(6), 981–987. https://doi.org/10.1016/j.pec.2015.12.021

Zhang, C. X., Crawford, E., Marshall, J., Bernard, A., & Walker-Smith, K. (2021). Developing interprofessional collaboration between clinicians, interpreters, and translators in healthcare settings: Outcomes from face-to-face training. *Journal of Interprofessional Care*, *35*(4), 521–531. https://doi.org/10.1080/13561820.2020.1786360

Zimányi, K. (2013). "Somebody has to be in charge of a session". *Translation and Interpreting Studies*, *8*(1), 94–111. https://doi.org/10.1075/tis.8.1.05zim

Appendix: Topic guides

(1) Interpreter interviews

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

(2) SUC interviews

What do you think is important for interviewers like me to understand about the Mental Health Act Assessment?
In your experience did everyone in an assessment introduce themselves and explain what their role was clearly?
Were there any points in your assessment where you did not understand what was going on?
How do you think the professionals doing the assessment communicated with you in the assessment and with each other?
Do you think enough time was given to understanding your cultural background in the assessment?
Did you feel respected as a person with rights and feelings?
What has it been like talking to me today about your experiences?
Have you accessed services outside of the mental health service setting through interpreters in the past?
Have friends or family interpreted for you in the past? Is this something you feel comfortable with?
Can you talk about what it is like to access a service through an interpreter that you have never met before?
What do you think are the biggest challenges for service users to communicate how they are feeling in a mental health act assessment?
Did you feel included in the conversation when an interpreter was involved? Did you ever feel people were talking about you rather than to you in the assessment?
Did you feel able to communicate how you were feeling in the assessment?
Was the same interpreter present in different stages of your initial assessment (including transport to services)? Was this / Would it have been important to you for this to be the case?
How do you think your experience could have been improved?

(3) AMHP interviews

What do you recall of your initial AMHP training about doing assessments with interpreters?
Are you offered any ongoing development in doing assessments with interpreters?
How well prepared did you feel when you undertook your first interpreter-mediated assessment?
What do recall taking away from your early experiences that you felt you needed to work on further?
What, if any, adjustments have you made over time to your approach when an interpreter is involved?
How do you view the interpreter in an assessment (i.e. part of the team)? What are your general expectations of their role?
What sort of ethical challenges do you think interpreters face in assessments? Do you factor these into your approach (e.g. in the pre- assessment work, during an assessment and afterwards)?
If you have a pre-assessment briefing with an interpreter, how do you structure it?
Have you experienced assessments where an individual is able to or attempts to bypass the interpreter and communicate directly with limited English?
During assessments, how do you try to build rapport and establish a clear basis of understanding about what an assessment is?
Are there any particular aspects of the language of assessments that you have found to be challenging for interpreters? How have you handled this?
If there is disagreement between professionals about a particular course of action, is the interpreter asked to interpret everything to the person being assessed (i.e. including side conversations)? Would you expect them to do this automatically?
When making a judgement about whether an interpreter is needed, what factors influence this and do you feel able to consult others in a timely manner?
If you are multilingual and use your language skills to do assessments, to what extent have these personal experiences shaped your approach to working with interpreters?
If an interpreter-mediated assessment has gone particularly well, can you recall what you or the interpreter did that worked effectively?
How do you respond to situations where you are working with an interpreter who has had very limited training (e.g. because they speak a so-called 'rare' language) and experience, before, during and after the assessment?
If an interpreter seems out of their depth in an assessment or distressed, what action have you / might you take(n)?
What approach do you take to record keeping and report writing where interpreters are involved?