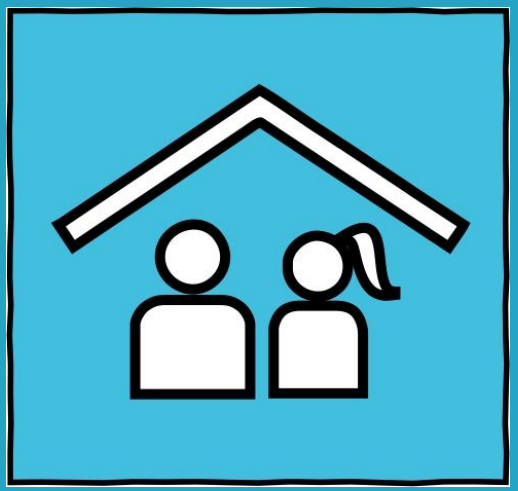
USING INTERPRETERS WITH THOSE EXPERIENCING MULTIPLE DISADVANTAGE



City of Westminster

Groundswell
Out of homelessness

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Introduction
Good communication is essential to safe and ethical practice, particularly when working with adults experiencing multiple disadvantage such as homelessness, trauma, migration, substance use, and mental ill health.

Many services support people who do not speak English as their first language, have limited English, or feel unable to discuss sensitive issues in English. In these situations, staff may need to use an interpreter to complete assessments, explain care or support, discuss risk, or obtain informed consent.

When there is a language barrier, important changes can be missed. Deterioration, cognitive difficulties, and safeguarding concerns may not be recognised, which can lead to unsafe decisions or delayed support.

Although interpreters are often used to bridge this gap, many staff have had little training in how to work with them. Communication can still break down, and the person's needs may not be fully understood. This toolkit provides practical guidance on working with interpreters in a psychologically informed way to support engagement, understanding, and safe decision-making.

Relational dynamics in interpreted conversations
Using an interpreter is sometimes essential, but it changes how conversations work and requires extra planning.

Interpreted conversations take longer. Workers need time to explain clearly, check understanding, and allow complete translation. Rushing increases the risk of misunderstanding.

The client / interpreter relationship
Clients who need interpreters may have experiences of trauma, migration stress, or discrimination, which can affect trust. An interpreter's gender, age, dialect, or community background can influence what a client feels safe to share. Concerns about confidentiality, particularly if an interpreter is from the same local community, may lead to brief answers or apparent agreement. Offering choice where possible helps build safety and trust.

The interpreter's human presence
Interpreters are not neutral machines. They sit within the emotional space of the conversation, often hearing distressing or sensitive information while also navigating cultural nuance. Their own emotional responses, assumptions, and beliefs can influence how meaning is conveyed, especially in complex or high-risk discussions.

As with all professionals, interpreters may hold conscious or unconscious biases. Frontline experience indicates that this can be more commonly felt by clients who identify as LGBTQ+ or who are from Roma communities. Bias may not be explicit; it can appear subtly through tone, body language, discomfort with certain topics, omissions, or softened or altered translations. Where this occurs, it can significantly affect trust, safety, and a client's willingness to speak openly.

A brief pre-conversation check-in helps set expectations, clarify the purpose of the session, and reduce the risk of unintentional distortion. This includes reinforcing the importance of verbatim interpretation and encouraging interpreters to flag any difficulties or concerns as they arise (discussed in more detail later).

Reflecting on Dynamics

With three people in the room, relational dynamics become more complex. All participants bring assumptions, emotional responses, and power differences that shape communication.

It is helpful for staff to reflect on:

- **What might the client assume about you, the professional?**
  How might your role, authority, or identity, influence what they disclose?
- **How might power differences affect communication?**
  Clients may minimise risks, agree quickly, avoid eye contact, or tell you what they think you want to hear.
- **Who is the client speaking to, you or the interpreter?**
  Clients may direct their attention differently depending on trust, comfort, or cultural norms.
- **What themes might be playing out in the interaction?**
  For example: fear, shame, compliance, avoidance, testing trust, or trying not to burden others.
- **How do language, culture, trauma, and social position intersect?**
  These factors shape not only what is said but how safe the client feels saying it.
  Understanding these dynamics supports trauma informed, culturally sensitive, and relationally attuned practice, ensuring that interpreted conversations remain safe, respectful, and accurate for all involved.

Understanding communication barriers

People experiencing multiple disadvantage commonly face communication needs, whether linked to trauma, neurodivergence, mental ill health, learning disability, brain injury, substance use, or disrupted education. These needs are often invisible, fluctuating, or masked by distress, behaviour, or housing insecurity, which is why it's important to actively hold communication in mind rather than assume understanding.

Safe practice starts with recognising whether communication difficulties arise primarily from a language difference or from an underlying clinical communication need. This distinction matters. It shapes your assessment of risk, informs the interpreting or communication support you put in place, and determines how you adapt your approach. Language differences may be addressed through interpretation or translation, while clinical communication needs require adjustments

such as simplifying information, pacing conversations, using visual supports, or checking understanding in non-verbal ways. Getting this right reduces the risk of misunderstanding, exclusion, and unsafe decision-making.

1. Language difference vs clinical communication need

Language difference

The person and worker do not share a language. With an appropriate interpreter, communication *should* become clearer and more accurate.

Clinical communication need

The person is difficult to understand even in their own language (and across all languages they use). This may reflect:

- Learning disability
- Autism or other neurodivergent communication profiles
- Brain injury or cognitive impairment
- Fluctuating mental health (e.g., disorganisation, thought disorder)
- Trauma responses (dissociation, freeze, hypervigilance)
- Substance-related effects

Quick test for staff:
"If this person were fluent in English, would I still struggle to understand them?"
If yes, plan for a clinical communication need. An interpreter alone will not resolve it—adapt the format and your approach.

2. Interpreter format is a safety decision

- Choosing telephone, video, or face-to-face interpreting is a clinical safety decision:
- Telephone removes visual cues, flattens tone, and can mask or distort:
- Disorganised thinking, unusual speech, or slowed processing, signs of distress, dissociation, or cognitive difficulty. These can be misread as "language issues."
- Video restores nonverbal cues and allows grounding, pacing, and better turn taking.
- Face-to-face is often safest where there are trauma histories, neurodiversity, brain injury, mental health crises, or fluctuating capacity.

Practice principles:

- If one format isn't working, change it. Do not persist with a failing method.
- Under the Equality Act 2010, interpreting format can be a *reasonable adjustment*.
- "An interpreter is present" doesn't equal "communication needs are met." The support must be appropriate to the person and the risk.

3. Do not assume non-engagement, assume complexity

Minimal, inconsistent, or confusing communication often reflects hidden needs, not "refusal" or "non-compliance."

Before concluding disengagement, consider:

- Overwhelm, shame or fear
- Dissociation, mistrust of services, previous harm
- Cognitive or neurodivergent processing differences
- Substance effects or withdrawal
- Power dynamics and cultural safety with the interpreter
- Time pressure and information load

Staff reflection:
What might be affecting communication today?
What format gives us the best chance of mutual understanding and safety?

4. Barriers that affect communication (even with an interpreter)

Relational & cultural:

- Interpreter-client gender, age, community ties, religion, or dialect.
- Fear of local community visibility or confidentiality breaches.
- Power differences between client-interpreter-worker.
- The interpreter's bias towards the client.

Clinical & contextual:

- Trauma, neurodiversity, brain injury, cognitive impairment.
- Mental health crises; thought disorder; memory or attention difficulties.
- Substance-related effects.
- Rushed appointments; multiple staff in the room; complex agendas.

5. Communication Difficulty Is Clinical Information

Barriers may present as:

- Apparent agreement without understanding.
- Short, guarded answers or withdrawal.
- Topic loss, contradictions, or speech where a person goes off-topic and does not return to the original point or question. Their responses may be loosely related or drift further away, making it difficult to follow the conversation or obtain clear answers.

Repeated misunderstanding, is safety-critical data. It may indicate:

- Deterioration or acute mental health need.
- Hidden disability or reduced capacity.
- Safeguarding concerns or coercion.
- Mismatch of interpreting format or skill.

You will need to take action if understanding remains limited, this could include any of the following:

- Change the format (e.g., phone → video/face-to-face).
- Slow down; reduce agenda; use shorter turns and plain language.
- Add visual supports (pictures, timelines, objects, diagrams).
- Brief and debrief the interpreter for clinical cues (disorganisation, memory, topic maintenance).
- Record what worked/what didn't and escalate if risks persist.

Key safety message: Repeated misunderstanding is a risk issue and not a performance issue. *E.g. when communication keeps breaking down, the problem is not about how well a worker is doing their job or how cooperative a client is being. Instead, repeated misunderstanding is a sign of risk that needs attention.*

6. Barrier checklist

#	Practice Checklist	Y/N
1	Have I distinguished language difference from clinical communication need?	
2	Is the interpreting format (phone, video, face to face) appropriate for clinical risk?	
3	Do cultural, gender, community or dialect factors affect safety or disclosure?	
4	Am I noticing signs of disorganisation, memory problems, dissociation or distress?	
5	If this were the person's first language, would communication still be difficult?	
6	Have I changed the interpreting format or approach when understanding was limited?	
7	Have I recorded what worked, what didn't, and what adaptations are needed next time?	

Preparing clients to talk to an interpreter

People experiencing multiple disadvantage may refuse an interpreter for understandable reasons, such as fear, shame, wanting to stay in control, past negative experiences, or ways they have learned to keep themselves safe.

Text below provides a practical conversation guide for staff to help them discuss why using an interpreter is needed with the aim of de-shaming the experience.

Start by explaining your role and responsibility

Do not imply the person's English is the problem.
Frame the interpreter as something ***you need in order to do your job safely.***

You can say:

- *"I want to make sure I understand you correctly."*
- *"I don't want to get anything wrong about your situation."*
- *"This helps me do my job safely."*
- *"It's for important or legal information so we both know we understood each other."*
- *"I don't speak Danish, so a Danish interpreter will help me at the meeting."*
- *"Because this affects your health and rights, I need to be completely sure we understood each other. That's why I need an interpreter today."*

Reassure about confidentiality and safety

Many refusals relate to fear rather than language. People may worry about authorities, benefits, debt, or controlling individuals. They may also not wish to share information with an interpreter within a particular culture or religious beliefs. They refuse because of trust, fear, dignity, and control. The goal is not to *convince* the person to accept an interpreter. The goal is to **make communication feel safe enough that they agree to one.**

You can say:
"The interpreter's job is only to help us understand each other."
"You stay in charge of the conversation. The interpreter is just helping."

Explain early:

- The interpreter is confidential.
- The interpreter is not connected to immigration, the police, or the person's community.
- The interpreter does not make decisions.
- The interpreter will repeat exactly what each of you says.
- The interpreter is professionally bound to confidentiality.
- You can stop the session.
- You can correct the interpreter, if they misinterpret something you say.

Ask that they tell you their preferences (these will need to be passed on to the interpreter when you make the booking):

- a male or female interpreter
- ask the client's preferences for interpreter's language/dialect, nationality or religion. They can refuse an interpreter from a specific culture or religion if they would prefer.

Recognise and validate concerns
Acknowledge that hesitation is understandable.
Say:
"Some people don't want an interpreter because they've had a bad experience before, or they worry someone will judge them. If that applies to you, I want to know."

When someone says "My English is fine"
Do not argue, test their English, or correct them.
The aim is to avoid a power struggle and protect the person's dignity.
Instead, reassure them that the interpreter is about **accuracy**, not ability.
You can say:

- *"Your English is good. I still use interpreters for important conversations so nothing serious is misunderstood."*
- *"This isn't about how well you speak. It's about making sure nothing important gets lost."*
- *"We may use legal or medical words, so I want us both to be certain we understand."*
- *"I need the interpreter in case there are important or legal terms."*

If the person refuses to use an interpreter
Do not immediately push harder.
Instead:

1. Ask their reason.
2. Problem-solve the barrier.
3. Offer alternatives (different gender interpreter, different dialect, video/face-to-face instead of phone, or a short session first).
4. Say *"We can try for ten minutes and stop if you don't like it."*

Booking the interpreter

An interpreter can be booked for a health appointment by **informing the GP surgery, hospital, or clinic as soon as the appointment is booked**. Everyone has the right to have a trained interpreter provided free of charge, and the responsibility lies with the healthcare provider to arrange it.

If an interpreter is needed for translation in supported accommodation or outreach, then the service supporting the individual will probably need to provide this. Read section on **Using non-professional support appropriately** if you do not use a professional interpreter.

- When booking the interpreter, let them know the client's preferences (male/female, language/dialect, nationality or religion).
- You can let an NHS interpreter know you would like to use the same interpreter in future sessions to ensure continuity. This is especially useful over the phone and if the client engages successfully with a particular interpreter.
- You are advised to book in at least 15 minutes to brief the interpreter before the session and at least 15 minutes after the session.

- Tell them what model of interpreting you would like. e.g., the linguistic mode, is where the interpreter tries to interpret word-for-word and adopts a neutral and distanced position. Another model includes psychotherapeutic where meaning/feeling of the words is more important.

Before session, briefing interpreters

Effective interpreting begins *before* the client arrives. A well-structured pre-session briefing ensures the interpreter understands the clinical context, communication risks, and their role in supporting safety. Wherever possible, book at least **15 minutes** for this discussion.

1. Start with known or suspected clinical factors

Begin with the information that most effects communication and risk. Starting with this primes the interpreter to listen clinically, not just linguistically. These factors can strongly influence the client's pace and clarity of speech, their memory, concentration and understanding, their ability to stay on topic, their responses to stress, and the presence of disorganised or unusual communication.

Brief the interpreter on any relevant concerns such as:

- Shouting.
- Mental health needs.
- Trauma history (only where appropriate to share).
- Substance use.
- Explain whether the clients has possible autism, learning disability, brain injury, or cognitive impairment with dependent drinkers and direct them to the toolkits.

2. Share specific communication concerns

Then describe what you've observed so far:

- *Does the person struggle with long or complex sentences? Or struggle with how and why questions?*
- *Do they lose focus, jump between topics, or appear confused?*
- *Are you noticing memory or thought-processing difficulties?*

Explain what you need from the interpreter to help navigate these challenges and how you will support them if communication becomes difficult.

3. Explain the purpose and roles

- Clarify your role and the aim of the session.
- Specify exactly how you want them to interpret.
    - e.g., **verbatim**, or whether brief clarifying questions are permitted.
- Emphasise that this is a **clinical**, risk sensitive conversation, not casual translation.

4. Explore cultural considerations

Then ask the interpreter about cultural factors that may affect communication:

- Eye contact norms.

- Power or hierarchy differences (age, gender, community roles).
- Words/phrases that shift meaning across languages (PTSD, Trauma).
- Cultural factors that might influence shame, fear, or withdrawal. The client may not want to have an interpreter from their hometown due to trust.

5. Practical instructions to the interpreter

Finally, outline what you need them to do during the session:
Ask interpreters to:

- During the meeting, the client may only look at you and reply in English. Warn the interpreter if this may happen and agree a plan to respond. You may for example say, "And now say in Danish for the interpreter Frederick."
- **Flag concerns** if communication becomes disorganised or inconsistent.
- **Alert you** if they cannot interpret meaning or sense-check the client's responses.
- **Ask you questions** if needed to clarify.

Suggested safety focused question

"If you notice anything about the person's communication that could suggest cognitive, neurodevelopmental, or mental health needs, please let us know immediately."
This signals that you welcome their clinical observations and reinforces interpreting as part of a safeguarding process.

During the session - communication tips

The member of support staff will need to chair the meeting. Make sure you have pen and paper available or a way to record points from the meeting as you will need to accurately record what it is said. Tips include:

- **Use pictures, diagrams, or objects.**
  These can be understood by many people and work across different languages and communication needs.
- **Keep the conversation simple.**
  Focus on one main topic at a time. Don't use specialist terminology. If more needs to be discussed, book another meeting.
- **Have fewer people in the room.**
  This helps the person feel calmer and reduces interruptions.
- **Go slowly.**
  When more than one language is being used, things can get confusing. Take your time.
- **One person speaks at a time.**
  This makes it easier for the interpreter, and the client, to follow what is being said.
- **Use short, clear sentences.**
  This improves understanding for everyone.
- **Use cognitively easier questions -** WHY and HOW questions are harder to answer.
- **You can use translation apps, with caution.**
  Apps like Google Translate can help with simple words or short sentences.

After the session

After the meeting with the client, meet the interpreter for a debrief and ask for their impressions of the client's communication.

It might help if you ask about:

- The vocabulary the client used, was this as expected or did it seem limited in some way?
- Was it easy to understand the speech of the client? Did the client appear to struggle to speak in some way?
- Could the interpreter follow the sentences the client used?
- Did the client stay on topic?
- Did it appear that the client followed the discussion?
- Did the client seem to remember what was being discussed throughout the meeting?

The answers to these questions may help you think about whether there are other communication issues rather than language difference.

Understanding may take multiple contacts

Appointments involving interpreters may require additional time. **NHS England guidance.**

Good practice includes:

- Building a picture over time.
- Recording what worked and what didn't.
- Noting differences between interpreter formats.
- Gathering reflections from staff and interpreters.
- Considering continuity of interpreter where possible.
- Taking cultural context seriously.

Alternatives to phone interpretation

Communication conducted only by telephone can create clinical risk. Unusual, unclear, or inconsistent speech may be assumed to be a language barrier when it could instead indicate a health, cognitive, or safeguarding concern. Without visual contact, staff may miss important cues such as confusion, distress, injury, or reduced capacity.

For this reason, **telephone interpreting should not be treated as sufficient where communication is unclear**.

Staff must actively adapt communication methods rather than persisting with an approach that is not working. If understanding is limited, the method should be changed.
Appropriate alternatives include:

- Face-to-face interpreting.
- Video interpreting.

- Written translation tools, such as Google Translate (use cautiously due to potential errors).
- Spoken translation apps (use cautiously due to potential errors).
- Pictures, symbols, diagrams, objects, or other visual aids.

Where possible, face-to-face or video communication should be prioritised, as it allows staff to observe the person directly and better determine whether the issue is linguistic or clinical.

If a communication method proves ineffective, this must be recorded in the client's notes and shared with the wider team, so the same unsuccessful approach is not repeated. Equally, if a method works well, this should also be recorded and shared so it can be used again consistently.

Using non-professional support appropriately

In some situations, a **non-professional interpreter** (for example, another worker in the organisation) may help communication by building trust, offering reassurance, or supporting engagement.

This might include:

- Another worker in the organisation.
- A peer advocate.
- A specialist community group that speaks the required language.

However, non-professional interpreters **must not be used alone** for:

- Consent discussions.
- Capacity assessments or decisions.
- Safeguarding disclosures.

When involving non-professional support, staff must consider:

- Power dynamics and safety.
- The person's comfort, choice, and consent.
- Whether their presence may limit what the person feels safe to say.

Non-professional support can enhance communication, but it **cannot replace a trained interpreter** for any clinical, legal, or safeguarding task.

Safety red flags, slow down and escalate

Take extra care if:

Communication suddenly deteriorates.

- Interpreters repeatedly report confusion.
- The person appears to agree but later contradicts key information.
- Engagement varies dramatically by interpreter type.
- Staff feel "something doesn't add up".
- Let management know, and your safeguarding lead, if you have concerns.
- A safeguarding referral to Westminster Social Care may be *needed if you are worried about someone's safety*. Section 42 of the Care Act 2014 states that each local authority must make enquiries, or ensure others do so, if it believes an adult is, or is at risk of, abuse or neglect.

- To make a safeguarding referral to Westminster City Council, contact Adult Social Care at 020 7641 2176 (9am-5pm weekdays), email adultsocialcare@westminster.gov.uk, or complete the online Westminster Adult Social Care referral form. For immediate risk or out-of-hours, call 020 7641 6000.

Mental capacity concerns:

When engagement is inconsistent or decisions appear unwise, it is important to consider whether the Mental Capacity Act 2005 applies.

Key Principles

- Decision-specific and time-specific: The MCA provides a framework for assessing whether a person has the capacity to make a particular decision at a given time.
- Fluctuating capacity: Capacity is not fixed; it may change depending on circumstances, health, or environment.
- Support first: Always support individuals to make their own choices wherever possible, using clear communication and appropriate adjustments.
- Best interests: If a person is found to lack capacity, any decision made on their behalf must be in their best interests, taking into account their values, wishes, feelings, and past experiences.
- Balancing duties: Applying the MCA helps staff respect autonomy while fulfilling safeguarding responsibilities.

Practical Guidance

- Observe patterns of engagement and decision-making.
- Use the MCA screening tool to guide your assessment of capacity.
- Document your observations and decisions clearly, ensuring transparency and accountability.
- Involve family members, advocates, or other professionals where appropriate to ensure decisions reflect the person's values and preferences.

If you need to complain

If you used a private interpretation company, you need to complain via their complaint service.

To complain about interpretation service via the NHS, you will need to contact the PALS (Patient Advice and Liaison Service) of the NHS organisation that provided the care (the hospital, mental health team, or clinic). The NHS service is legally responsible for providing appropriate communication support. You can find the PALS contact details for each NHS service here.

PALS can arrange a different interpreter, contact the clinical team and record a safety concern.

What to say

"I want to raise a concern about interpreting/translation support. The communication support provided was not appropriate and affected safe understanding and care."

Include:

- Date and place of appointment.
- Language requested.
- Phone / video / face-to-face interpreter.
- What went wrong.
- The impact (misunderstanding, consent issues, discharge, safeguarding risk etc.)
- If urgent, say: “This is a patient safety concern.”

Appendix 1: Checklist for working with interpreters

1. Before Booking the Interpreter

☐ I have distinguished language difference from a clinical communication need.

☐ I have considered whether telephone interpreting is clinically safe, or whether video/face-to-face is necessary.

☐ I have checked for safeguarding, mental capacity, cognitive, or mental health concerns.

☐ I have validated any client concerns about shame, fear, confidentiality, or past experiences.

☐ I have reassured the client about confidentiality, neutrality, and control.

☐ I have explored reluctance and problem-solved alternatives (format, gender, dialect, trial session).

☐ I have obtained client preferences for gender, dialect, nationality, religion, or communities to avoid.

2. Booking the Interpreter

☐ I have chosen the safest interpreting format (phone / video / face-to-face).

☐ I have passed on all client preferences.

☐ I have booked 15 minutes before and after for briefing/debriefing.

☐ I have considered continuity of interpreter.

☐ I have specified the interpreting mode (verbatim / meaning-focused).

3. Briefing the Interpreter (Before the Session)

☐ I have explained relevant clinical factors (trauma, mental health, brain injury, autism/LD, substance use).

☐ I have explained communication concerns (topic drift, disorganisation, memory issues).

☐ I have clarified roles, purpose, and expectations.

☐ I have instructed the interpreter to flag concerns or ask clarifying questions.

☐ We have discussed relevant cultural considerations.

4. During the Session

☐ I have chaired the conversation clearly.

☐ I have used short sentences, plain language, and one speaker at a time.

☐ I have used visual supports where helpful.

☐ I have avoided WHY/HOW questions unless essential.

☐ I have monitored for red flags (confusion, contradiction, disorganisation).

☐ I have changed the interpreting method if communication wasn't working.

☐ If non-professional support was used, I ensured it wasn't for consent, capacity, legal, or safeguarding discussions.

5. After the Session – Interpreter Debrief

☐ I asked about vocabulary (typical vs limited).

☐ I asked about speech clarity.

☐ I asked about whether the client could keep to topic being discussed.
☐ I asked about understanding and memory.

6. Recording & Next Steps

☐ I have documented what worked and what didn't.
☐ I have recorded capacity, cognitive, mental health, or safeguarding concerns.
☐ I have escalated any safety issues to management.
☐ I have considered whether a Mental Capacity Assessment is required.
☐ I have documented concerns about interpretation quality and initiated complaints/escalation if needed.

Appendix 2: NHS Guidance

NHS England guidance states that interpreting and translation services must be high-quality, timely, appropriate to the individual's needs, and free at the point of use.

"Appropriate" does not mean one standard approach; the mode, timing and interpreter skill set must match the person and the level of risk. If communication is still failing, the duty to meet communication needs has not been met, even if an interpreter is technically present. Repeated misunderstanding is a clinical safety risk, not a performance issue; escalate and change the communication plan.

In high-risk situations, **using an interpreter is not the same as communicating safely**.

NHS England – *Guidance for Commissioners: Interpreting and Translation Services in Primary Care*: https://www.england.nhs.uk/publication/guidance-for-commissioners-interpreting-and-translation-services-in-primary-care/ [bmehf.org.uk]
GOV.UK (OHID) – *Language interpreting and translation: migrant health guide*: https://www.gov.uk/guidance/language-interpretation-migrant-health-guide [saeb.org.uk]

Appendix 4: Extra reading

https://www.bps.org.uk/guideline/working-interpreters-online-or-telephone

https://www.england.nhs.uk/interpreting/improving-the-quality-of-interpreting-in-primary-care/

https://www.england.nhs.uk/publication/guidance-for-commissioners-interpreting-and-translation-services-in-primary-care/

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