

Mental Health Interpreting

Training, Standards, and Certification

THE AMERICANS With Disabilities Act (ADA) sets the benchmark standard for the qualifications of an interpreter. The standard set forth, according to the ADA is as follows: “A qualified interpreter is one that is able to communicate, expressively, and receptively, using any specialized vocabulary” (Americans With Disability Act, 1990).

The Southern District Court in Florida ruled in *Tugg v. Towey* that providing mental health services through an interpreter was not providing equal access. The court went on to order the Florida Department of Health and Rehabilitation Services to provide mental health services to the Deaf using signing clinicians (*Tugg v. Towey*, 1994). The landmark *Tugg* case notwithstanding, a significant segment of mental health services are still provided by primary care physicians or mental health therapists who are not Deaf and are also nonsigners with rudimentary knowledge of or, more often, no experience at all in working with Deaf individuals. Exacerbating the obvious problem this creates, these clinicians are often paired with interpreters who have limited or no experience working in mental health settings.

Mental health interpreting is a unique and highly specialized field in which technical vocabulary and words in general carry great weight. Pollard and Dean (2003) explain that “Psychiatry is unique among the medical fields in that most of the symptoms are conveyed by or through communication, and communication also is the primary method and nature of treatment.” No one seriously disputes the view that therapeutic services provided directly by a practitioner sharing the same linguistic and cultural framework is preferable. It is axiomatic that “something is lost in the translation.” The work of therapy in a counseling session using an interpreter

will never be the same as work that is done when both the therapist and the client speak the same language (Hamerdinger & Karlin, 2003).

Traditional interpreter training and historical relationship dynamics between interpreters and members of the Deaf community have not adequately prepared either interpreters or consumers for the overt and covert challenges of providing effective access in mental health environments. Some of the challenges that are present for interpreters include alliances, technical vocabulary, working as a member of a clinical team, unusual or unexpected behavior, stress caused by secondary or vicarious trauma, and working with consumers who may have extreme language dysfluency. Such dysfluency may be a result of singular or multiple causes, including developmental delays, mental illness, medical or neurological complications that may also have been a contributing factor to the cause of deafness, or a combination of the aforementioned reasons. Treatment methodologies vary according to a multitude of factors, including the diagnosis of the consumer, discipline, the practitioner's clinical orientation, and even the funding stream that renders payment for the services. Interpreters who are not knowledgeable about these factors may be less effective and even countertherapeutic in the clinical milieu.

Currently there is no nationally based certification for sign language interpreters working in mental health. Only within the past two decades has the interpreting field begun to specialize as more and more people have come to understand the uniqueness of interpreting in various clinical/professional realms. The Registry of Interpreters for the Deaf (RID) has established a specialty certification for legal interpreting. Some states have addressed certification for medical interpreting, but it is mostly from the perspective of spoken-language interpreters. The need for in-depth training in mental health interpreting remains particularly acute.

In addition, there are also currently no nationally based program-level certificates for sign-language interpreters working in mental health. A number of states and programs have attempted to address the need for training in highly specialized fields, including mental health interpreting. With the exception of Alabama's Mental Health Interpreter Training project, most attempts have consisted of a series of ad hoc workshops, not a systemic approach guided by specific standards, learning objectives, and learning outcomes. In 2007 RID published a practice paper for mental

health interpreting, which serves as a standard of best practices, but the recommendations are not tied to any specific activities that need to be pursued to achieve measurable outcomes. The lack of standards generally means that there are no guidelines for what should or should not be included in any training. This results in interpreters' having widely divergent concepts of what "mental health interpreting" is, even those who have attended various training opportunities.

Clinicians who are not used to working with Deaf people have little concept of just how differently one interpreter works from another. These clinicians are unaware of the impact of divergent interpreters' thought worlds on their behavioral and linguistic output. Thought worlds are the interpreters' own perspectives based on the sum of their own life experiences. These perceptions, or thought worlds, are brought into the mental health setting. Interpreters who have witnessed or experienced trauma or abuse themselves will bring their subconscious reactions and defenses to that experience and consequently may over- or undercompensate.

In one scenario, for example, an interpreter grew up with deaf parents (such a child is often referred to as a child of deaf adults, coda) and, as a child, had been sexually abused by a neighbor. This interpreter contracted for a forensic-based assignment where a Deaf male consumer accused of sexual predation was being interviewed for a court-ordered evaluation. The Deaf person started the session by discreetly asking the interpreter whether she was a coda. He stated that she must be a coda because she signed so well. She nodded affirmatively. This set the stage for alliances in the session. None of this information was voiced to the clinician as the interpreter viewed it as typical introductory relationship building and identification. Before long, the Deaf consumer again started a side conversation with the interpreter and stated that she was pretty and suggested that the two of them go out on a date. The interpreter started explaining to the Deaf consumer that she did not want to date him. Within a few seconds, the two of them were having a conversation that not only did not include the clinician but was pertinent to the evaluation.

In another example, after a therapy session the male Deaf consumer asked the interpreter whether she was a CODA. When she said no, he replied, "That's why I didn't understand you." Indications through dialogue and responses were that the consumer had indeed understood the

interpreter. However, at the next appointment, a coda was utilized. After the assignment, the Deaf consumer asked this interpreter, too, whether she was a coda. When she said yes, the consumer replied, "Odd. I wonder why I didn't understand you." Indications through dialogue and response again implied that the consumer had indeed understood the interpreter. Several other interpreters were subsequently hired to work for his appointments with similar outcomes. This occurred at a time in his therapy when he was beginning to reveal childhood sexual abuse and was attempting to avoid discussing these issues. The conversations with the interpreters were happening outside of the therapy session. None of the interpreters realized what had transpired prior to their involvement, and the therapist was not privy to the conversations that were occurring after the session.

Sometimes the examples are not as explicit. An interpreter may have had previous experiences in which a Deaf consumer misunderstood questions or suffered consequences because the interpreter's decision was based on insufficient knowledge. This interpreter may work to ensure that Deaf consumers are fully aware of their options and the intrinsic meanings of question. Instead of asking, "What is the date?" an interpreter may ask "TODAY WHAT?" which may still be too vague. The interpreter might therefore expand on the question in this manner: "TODAY MONDAY, TUESDAY, WEDNESDAY, WHAT?" This is, however, probably more directive and specific than the clinician wanted.

Many interpreters have come to believe that when there is a communication problem, the source is poor skills on the part of the interpreter. This is connected to the idea that "the consumer is always right" (or always fluent) and also to a desire to present Deaf people in their best light. This makes interpreters reluctant to reveal language or social problems. Interpreters may fear that, when the Deaf person is not presented in the best possible light or when the outcome is an undesirable one, they will be blamed by the Deaf person and, by word of mouth, the Deaf community for their perceived lack of skills or inappropriate attitude.

An interpreter's personality can also impact the establishment and subsequent measurement of baselines unless the interpreter and therapist are aware of this phenomenon and take steps to ensure that the interpreter's own individuality is filtered. Simply put, one interpreter whose natural personality is bubbly and gregarious could make a Deaf person seem to

be exhibiting manic symptomology, whereas the next interpreter, whose innate tendency is to be reticent, could make the same Deaf person sound flat, if not depressed, especially when compared to the previous baseline. This change in interpreters can confound diagnosis or medication monitoring.

The effect is not limited to how the clinician views the Deaf consumer. How the clinician and the interpreter view each other's work is also highly dependent on who was exposed to what information. Interpreters do not understand what clinicians are trying to do, and clinicians do not understand the mental gymnastics interpreters are required to perform. The lack of exposure to the demands on the other may cause each professional to misperceive and misconstrue variances. Thus, trust is not readily forthcoming, and professional collaboration between interpreters and clinicians is not as common as it is among psychiatrists and social workers.

In an attempt to improve this situation, the state of Alabama has codified standards for mental health interpreting that outline the qualifications for state certification as "qualified" (Alabama Department of Mental Health and Mental Retardation Administrative Code, 2003). The standards were developed as part of a settlement to a lawsuit filed by the Alabama Association of the Deaf and Verna Bailey. Bailey alleged that her son had been inappropriately served for several years by programs funded by the Alabama Department of Mental Health. Among other charges, the lawsuit stated that the Department of Mental Health (DMH) failed to "provide qualified interpreters, and physicians, psychologists, social workers, caseworkers, nurses, and support staff who are fluent in American Sign Language and .by failing to provide adequate culturally and linguistically appropriate mental health services" (Bailey v. Alabama Department of Mental Health, 2002).

The lawsuit, which was settled in 2002, resulted in the establishment of the Office of Deaf Services within the Division for Mental Illness. As a part of the settlement, DMH agreed to develop training and standards for interpreters working with Deaf people with mental illness. This gave rise to the Alabama Mental Health Interpreter Training (MHIT) Program.

The program is based on the preliminary work by Steve Hamerdinger, Wayne Elrod, Jay Wolfe, Kelley Clark, and Ben Karlin while they were working for the Missouri Department of Mental Health (Hamerdinger, Karlin, & Clark, 2000). Borrowing from that model, the Alabama Depart-

ment of Mental Health proposed rules to codify standards describing the necessary skill set, which would be quantified and measured in an objective way. This would enable the establishment of required training and a formal process for certification. The DMH held a series of stakeholder meetings with the Interpreter Licensure Board, the state chapter of RID, and the Alabama Association of the Deaf. The goal of these meetings was to seek input to establish minimum competencies for interpreters working in mental health settings.

The new standards, which define what constitutes a “qualified mental health interpreter,” were entered into the Administrative Code of Alabama as section 580-3-24 in December 2003. This became the basis for both the curriculum of MHIT and the certification of Qualified Mental Health Interpreter (QMHI).

A portion of the definitions included in these standards, which outline competencies and knowledge, is listed in appendix A. Additional competencies are listed in the following section.

PROFESSIONAL COMPETENCIES/KNOWLEDGE

In order to effectively provide interpretation from one language to another in mental health settings, certain levels of fluency and knowledge are necessary. The interpreter shall demonstrate professional competencies/knowledge and the level indicated.

1. Sign language interpreters must be licensed as interpreters in Alabama or otherwise eligible to work at an equivalent level as set forth in the Administrative Code of Alabama (34-16-5-10). The interpreter must demonstrate understanding of mentoring and supervision.
2. Interpreters working in other languages shall hold an appropriate certification in their field, if one is available. If no certification is available for the language(s) the interpreter is working in, it is expected that the interpreter will successfully pass a screening test approved by the Office of Deaf Services.
3. Interpreters must demonstrate interpreting methods and appropriate use of simultaneous (first-person and third-person), consecutive (first-person and third-person), and narrative (third-person) interpreting.

4. Interpreters must demonstrate familiarity with mental health issues and treatment options in Alabama.
 - a. Mental illness services
 1. The interpreter must be able to accurately interpret specialized vocabulary used in psychiatric settings in both the source and the target languages.
 2. The interpreter must be aware of psychopathologies, including knowledge of the names of the major mental illnesses treated by the Department of Mental Health in both the target and source languages and familiarity with symptomology of major mental illnesses experienced by the consumers of services provided by the Department of Mental Health as presented within the psycholinguistic context of the target language group.
 3. The interpreter must demonstrate familiarity with assessment methods and understanding of the impact of interpretation when interpreting assessments.
 4. The interpreter must have exposure to treatment approaches and demonstrate awareness of how cultural influences might impact treatment.
 - b. Substance abuse services
 1. The interpreter must be able to accurately interpret specialized vocabulary used in addiction treatment in both the source and the target languages.
 2. The interpreter must have familiarity with addiction theory and issues involving addiction.
 3. The interpreter must have familiarity with assessment methods and how cultural influences might impact assessment.
 4. The interpreter must have exposure to treatment approaches and demonstrate awareness of how cultural influences might impact treatment.
5. The interpreter must be familiar with inpatient settings, with the various staff that will be working in those settings, and how interpreting and cultural differences can influence therapeutic relationships in those settings.
6. The interpreter must be familiar with outpatient settings, with self-help and support groups, the specialized vocabulary used in those groups,

and how interpreting and cultural differences can influence therapeutic relationships in those settings.

c. Mental retardation services

1. The interpreter must have exposure to issues involving mental retardation and developmental disability and the role culture and language play in providing services to people with mental retardation.
2. The interpreter shall be aware of the difference between interpreting and communication assistance/language intervention.
7. The interpreter shall be able to identify care providers, identify mental health disciplines, and be familiar with milieus and settings.
8. The interpreter must be able to explain the role of an interpreter as a professional consultant.
9. The interpreter must understand professional boundaries and must be able to explain confidentiality and privilege, including, at a minimum, abuse reporting, the duty to warn, and protections specific to Alabama statute.

CULTURAL COMPETENCIES/KNOWLEDGE

The interpreter must demonstrate cross-cultural competencies.

1. The interpreter must be able to explain the impact of stereotypes on mental health service delivery.
2. The interpreter must understand cultural views of mental illness, mental retardation, and addiction specific to the populations the interpreter works with and must be aware of various constructs of Deafness and hearing loss relative to majority/minority cultures and pathological models.
3. The interpreter must demonstrate understanding of the sociological impact of cross-cultural mental health service provision and the impact of an interpreter on the therapeutic dyad.

CONDUCT COMPETENCIES/KNOWLEDGE

1. The interpreter must demonstrate knowledge of personal safety issues, including an understanding of at-risk conduct and personal boundaries as they apply to mental health interpreting work and an awareness of de-escalation techniques and universal precautions.

2. The interpreter must demonstrate professional boundaries and judgment particularly in professional collaboration through pre- and post-conferencing.
3. The interpreter must demonstrate the ability to assess effectiveness of communication.
 - a. The interpreter must demonstrate the ability to appropriately match the interpreting method with the consumer and the setting and must understand the impact of emotionally charged language.
 - b. The interpreter must demonstrate the ability to discuss unusual or changed word or sign selection.
 - c. The interpreter must demonstrate the ability to discuss linguistic dysfluency or any marked change in linguistic fluency within a psycholinguistic context.
 1. The interpreter must demonstrate the ability to convey information without alteration, emotional language without escalation, and ambiguous or emotionless language.
 2. The interpreter must demonstrate the ability to isolate peculiar features of eccentric or dysfluent language use.
4. The interpreter must demonstrate the ability to read consumer case documentation and record appropriate documentation of linguistic significance.
 - a. The interpreter must demonstrate knowledge of confidentiality as defined by state and federal law.
 - b. The interpreter must understand the difference between personal records and records shared with other interpreters and other professionals. The interpreter must understand the ramifications of keeping personal records and must demonstrate knowledge of what records may and may not be kept pertaining to consumers.
5. The interpreter must be aware of personal mental health issues and maintenance.
 - a. The interpreter must understand how personal issues may impact the interpreting process.
 - b. The interpreter must be aware of counter-transference in the interpreter and must be familiar with transference to the clinician or to the interpreter.

Having codified minimum competencies for interpreters, DMH developed the training curriculum based on these standards, which, in turn, is

being used at the annual Mental Health Interpreter Institute. The forty-hour training offered at the institute focuses primarily on mental illness and the unique dynamics that are present when Deafness and interpreting intersect.

The annual training provides foundational mental health skills to highly skilled interpreters who have already obtained national interpreting certification status through RID. The training includes lectures, demonstrations, exercises, evaluation, and discussions to enhance interpreters' knowledge, skills, and resources. Additionally, participants take a pre- and posttest to demonstrate what they have learned and the impact of the training. The core of the curriculum includes topics such as the following:

- Mental health systems and treatment approaches
- Diagnostic criteria and disorder types according to the DSM-IV
- Sources of language dysfluency and techniques for interpreting
- Interpreting as a practice profession
- Demand Control Schema in mental health settings
- Confidentiality and collegiality
- Secondary trauma stress/vicarious trauma, self-care, and safety
- Psychopharmacology
- Simulation of auditory hallucinations
- Certified deaf interpreters working in mental health settings
- Clinician's panel on the clinician and interpreter working relationship

In developing and conducting the training, DMH sought leaders in the field of mental health interpreter training as instructors. Robert Pollard, Robyn Dean, Roger Williams, Steve Hamerdinger, Charlene Crump, Brian McKenny, Shannon Reese, and others have been longtime instructors in the program. The program is rounded out by a pharmacist, a substance abuse specialist, and clinicians who work regularly with interpreters (such as psychiatrists, psychologists, and social workers).

The curriculum is not static. Each year it is carefully reviewed, and new technology, techniques, and practices are incorporated in the training. Since the faculty members are leaders in the field of mental health interpreting, the Interpreter Institute is often the first place new ideas are introduced. The most recent revision to the curriculum included the topics of "what clinicians expect from competent mental health interpreters," "specialty settings," and "sources of dysfluency," and previously taught courses are continually updated. Because of the frequent revisions that

occur within the curriculum, around 10% of any given class consists of people who have taken the training before.

Interpreters are screened for acceptance into the training based on a combination of criteria, including educational status, certification level, years of experience, involvement in mental health settings, and previous training in the field. The purpose of the screening is to ensure a cohort of participants who are able to both understand the material presented and to create a synergistic discussion of issues in the field. A maximum of 50 interpreters are accepted annually. The limited class size provides each interpreter an opportunity to receive individualized attention and creates a manageable group for various activities and discussions.

Since its inception in 2003, 342 interpreters from 48 states and two foreign countries have been trained. In 2010, 26 states were represented. Additionally in the same year, two students from the state's Interpreter Training Program participated as student representatives. These students, along with five others, are being supported by full financial scholarships from the Alabama Department of Mental Health. Since these students will be working in mental health settings upon graduation, having access to this specialty training allows them to apply this information early in their academic course of study.

The training package has two parts: the classroom work and a 40-hour field practicum. Each interpreter who completes the classroom work is eligible to participate in the supervised practicum, which can take place at a specialized psychiatric hospital unit serving Deaf people and in community mental health settings. During the practicum, interpreters are given an opportunity to work with not only consumers who are Deaf and have mental illness but also Deaf professionals who work in those environments. Alabama requires that the practicum be completed within 1 year of completion of the 40 hours of classroom instruction in order to ensure application of the most current practices without retaking the entire sequence.

The practicum has two parts: observation and fieldwork. Upon scheduling the practicum, the interpreter is responsible for conducting 10 hours of observation in the interpreter's own state, writing case studies for each event using an environmental, interpersonal, paralinguistic, and intrapersonal (EIPI) perspective based on the observation supervision and demand control models developed by Robyn Dean and Robert Pollard (Dean &

Pollard, 2004a). The case studies are submitted to the practicum supervisor for discussion. Once the case studies have been completed, the supervisor begins a dialogic process with the practicum interpreter. The discussion examines the dynamics of the case studies to prepare the practicum interpreter for the experiences, which will be encountered on-site, and to assist the interpreter in developing a greater synthesis of mental health settings. The resulting discussion initially focuses on the practicum interpreter's identification of demands and controls and subsequent demands. The supervisor then leads the practicum interpreter to identify additional areas that have not been noted. This process is designed to broaden and strengthen the practicum interpreter's ability to critically analyze interactions. It also helps the interpreter to begin actually putting into practice the concepts of interpreting as a practice profession (Dean & Pollard, 2004b).

Supervision supplements experiential opportunities with reflection on case studies and dialogue with the practicum supervisor. The qualifications of the practicum supervisor are defined by the practicum guidelines (Alabama Department of Mental Health and Mental Retardation Administrative Code, 2003, Alabama Department of Mental Health, 2010), which state that an approved supervisor is a staff interpreter who is assigned to the Office of Deaf Services or a DMH facility and who is certified as a Qualified Mental Health Interpreter, a QMHI with extensive experience in mental health interpreting, or an interpreter or Deaf professional who also has a terminal degree in psychology, clinical social work, psychiatry, or counseling and has participated in MHIT. Additionally, all supervisors must complete training in Robyn Dean's observation-supervision method of guidance and mentoring.

Practicum sites must be primarily clinical in nature and are approved by the DMH practicum coordinator, who is different from the practicum supervisor. Acceptable assignments at a given site include counseling, testing, group therapy, treatment team meetings, emergency room intake, and psychosocial education classes. Because clinically based settings are used, the practicum helps to ensure that principles and practices taught in the classroom are reinforced in the field. Moreover, the work is expected to be direct clinical interpreting work and not social or interactive time. With prior approval, a practicum experience can include some 12-step groups. Unacceptable assignments include platform interpreting for

workshops, interpreting professional-level meetings that are not directly related to treatment planning, social activities, or interpreting assignments that are primarily educational in nature, with the exception of psychosocial education.

The practicum provides a way to apply academic understanding, analysis, and an approach on which to base and validate the interpreter's work product. Case studies are a vital part of the practicum experience because they allow interpreters to learn not only how to focus on the content of the message but also how to usefully analyze discourse situations. Subsequent discussions with the supervisor help the interpreter to encompass a clinical perspective in addition to a Deafness worldview. Interpreters leave the program with more awareness of the clinical thought world, and they are better able to collaborate with the clinical team than they would otherwise have been. They are able to predict functional linguistic and behavioral outcomes based on diagnostic criteria. They also learn to empower the clinician to make more effective determinations and to enhance treatment. In short, they learn to align with the treatment process rather than with the Deaf consumer.

Feedback is important in the development of skills. Guided by rubrics developed by the MHIT staff, it covers a variety of settings and situations that include professional conduct, chart review, live and remote interpreting, clinical meetings, working with various disciplines, interpreting for sign-fluent professionals and consumers who are not fluent in sign, interpreting with a team, interpreting with a Deaf interpreter team, communication assessments, and other situations. Guiding all of the feedback is the desire to produce interpreters who are comfortable in clinical settings and who can operate with a clinician's perspective while respecting and communicating what is happening in the consumers' point of view.

THE PRACTICUM EXPERIENCE

Mental health interpreters learn that approaches to interpreting must match the diagnostic and linguistic or communication profile of the Deaf consumer and also be an appropriate match for the clinical techniques being used. Since consumers, both providers and individuals with mental

illness, are extremely heterogeneous, interpreters need to be forearmed with as much background information as possible. As such, one element of the practicum has the interpreters review consumer/patient files to become familiar with the information in them before meeting with the consumers. They and their supervisor discuss how to use this knowledge to guide and shape interpreting (linguistic, behavioral, relationship, etc.) choices. The interpreter is provided the following list of questions to consider when examining each file:

- Where was the patient educated? For how long?
- How might the age of the consumer impact communication abilities and socialization as well as impact interpreting style/choices?
- What relationship does the consumer have with family members? How might this impact the consumer's ability to communicate and socialize?
- Are there any language notes regarding unusual language exhibited by the consumer?
- What do we know about the consumer's current or previous language usage?
- What fund of knowledge deficits might be present?
- Does the consumer have any known cognitive deficits?
- What is the etiology of Deafness, and how can this impact language?
- What are the current diagnosis and course of treatment? What is known about this diagnosis (symptoms, language impact, etc.)?
- What is the consumer's level of familiarity with this environment and the other individuals?
- What current medications is the consumer taking? Are there any potential issues regarding language (blurry vision, shaky hands, involuntary movements, lethargy, etc.)?
- Are there any medical conditions that might hamper the consumer's ability to communicate effectively (diabetes, vision problems, stroke, cerebral palsy, Parkinson's, etc.)?
- Are there any personal issues that may arise for the interpreter working with this consumer related to specific issues (victim of domestic violence, substance abuse issues, death in the family, personal/moral beliefs, family history/personal history with mental illness, etc.)?

- Are there any professional issues that may arise for the interpreter when working with this consumer (boundary issues, interpreter's previous relationship with consumer, male/female relationships, etc.)?
- Who are the other professionals working with this case? Who might the interpreter expect to be working with, and what issues would be pertinent?
- Have there been cases of incident reports, medication interventions (used to control behavior), seclusions or restraints that might occur and hinder communication? Are there indicators that signal when the consumer might be escalating? What should the interpreter do in situations if an escalation occurs? What is the communication policy in these cases?
- Is there a communication assessment completed on the consumer? How can this benefit the interpreter?

COMMUNICATION ASSESSMENT

The communication assessment is such an important tool in working with Deaf consumers that it is now part of the program standards for all mental health service providers in Alabama. The report is conducted by a trained staff member such as an interpreter, communication specialist, or clinician. Assessments of consumers who have atypical or dysfluent language are often administered by a team. The report considers the following elements:

Hearing Loss

- What is the extent of the hearing loss, and how was the information obtained? What observations were made in regard to the consumer's hearing loss and communication abilities? What impact can the etiology of hearing loss have on language use, treatment, and functioning level?

Educational Status

- Describe the consumer's educational achievements and communication strategies used/not used during school. How can this impact the con-

sumer's fund of knowledge and language use? How can the educational status impact the consumer's ability to understand the current clinical environment?

Communication with Family/Friends

- Describe the consumer's communication strategies used with family/friends. How can this impact treatment or daily communication? What type of linguistic support system does the consumer have?

Literacy

- Describe the consumer's ability to use written English. What is the approximate reading level (grade level)? How can written English be utilized/not utilized in treatment or daily communication? Would there be negative clinical consequences if these were used inappropriately? To what extent?

Auditory/Verbal/Speechreading Ability

- What usable/functioning auditory, verbal, or speechreading ability does the consumer seem to have? To what extent can this be utilized/not utilized in treatment or daily communication? Would there be negative clinical consequences if these were used inappropriately? To what extent?

Use of Sign Language

- What usable/functioning sign language ability does the consumer seem to have? What strengths and weaknesses does the consumer exhibit? How fluent in sign language is the consumer? To what extent can this be utilized in treatment or daily communication?
- How well does the consumer communicate directly? With an interpreter?
- Are there any uses of dysfluent or idiosyncratic language?
- Are there any expressive or receptive differences?
- Are there any physical or mental complications related to language?

- At what age did the consumer learn to sign?
- What type of grammar is identified within the consumer's language?

Recommendations

- Preferred communication modality of the consumer
- Modifications for treatment related to language (direct therapy by a signing therapist, one-on-one communication, eye contact, confirmation of information, interpreter, certified deaf interpreter, or visual-gestural communication specialist, etc.)
- Environmental considerations
- Ability to use modifications or accommodations
- Additional considerations

When possible, practicum interpreters are given an opportunity to complete a communication assessment profile on consumers. This allows them to develop familiarity with the communication assessment profile and gain experience in applying the information to the work.

The practicum interpreters also maintain a communication log, which is used to document the consumers' language use. In addition, interpreters are also required to utilize a checklist to document linguistic behaviors to address during treatment-team or postsession meetings with clinicians or the communication team. In Alabama, this information becomes part of the consumer's clinical record. Although not a universally accepted practice, it is becoming increasingly recognized as a critical part of the consumer's chart.

Practicum interpreters are provided documents to help them develop a portfolio that can be utilized as a resource for future interpreting assignments. They are encouraged to tailor the information to their specific needs and develop additional materials that best fit the local circumstances. This portfolio includes the following:

- The interpreter's credentials
- State law and policies
- Lawsuits related to mental health and deafness
- Federal laws and policies
- Professional competencies, ethics, and position statements
- Interpreter resources while working in mental health settings
- Contact information

- Therapist resources when working with individuals who are Deaf
- Materials for dysfluent consumers

EXAMINATION

After an interpreter successfully completes the practicum segment, based on the practicum supervisor's evaluation and the recommendation of the practicum committee, the interpreter moves to the next phase, which is the comprehensive examination. This test examines the interpreter's knowledge of material presented in the training and the practicum experience, as well as the interpreter's ability to apply the information to test-case scenarios. The written examination, which takes 4–6 hours to complete, is designed to assess the interpreter's comprehension and ability to synthesize and apply knowledge of mental health interpreting. Examples of questions that a candidate might encounter are the following:

1. Describe transference and countertransference within a therapeutic setting and how this is complicated by the presence of a third party (i.e., interpreter).
2. Compare and contrast how you approach interpreting for a Deaf consumer exhibiting each of the following:
 - a. Extremely dysfluent language
 - b. Deficit in consumer's fund of knowledge
 - c. Presence of atypical nonmanual markers
 - d. Bizarre language content
3. Discuss the challenges of interpreting family or group therapy.
4. Explain the presence and manifestations of auditory hallucinations in a prelingually Deaf adult.

The preceding examples can have more than one right answer. The interpreter must not only be able to give a solution (and sometimes more than one) but also be able to defend that solution using a demand-control framework.

Passing this test results in the award of certification as a Qualified Mental Health Interpreter. In Alabama, this certification is tied to a higher rate of compensation for contract interpreters and is a job requirement for staff interpreters working in mental health.

Once an interpreter successfully passes the comprehensive written examination and is recognized as a Qualified Mental Health Interpreter, 40 hours of continuing education and work experience annually in mental health are required to maintain the QMHI certification status. This ensures that the QMHI will spend at least 1 hour a week, on the average, in mental health work or training. Most QMHIs greatly exceed this amount as demonstrated by documentation submitted at renewal time.

Ongoing training is also recommended for interpreters to continue to develop their understanding of specialized settings in mental health. They are encouraged not only to expand their knowledge of elements of the core curriculum but also to acquire a sufficient knowledge base in areas not covered extensively during the 40-hour training period, areas such as interpreting in competency-based settings with language-dysfluent consumers, domestic violence, interpreting in play therapy, and interpreting in emergency responder situations. Quarterly training sessions are recommended for more in-depth learning opportunities. To facilitate such instruction, DMH provides training for interpreters online, which is thus also accessible to interpreters who do not live in Alabama.

Training interpreters in mental health is only one part of maximizing services for Deaf individuals who are mentally ill. A service-delivery system must also consider the working relationship of the therapist and the interpreter. This includes clinicians who are sign fluent and those who are not. Working through a third person is very different from working one-on-one with a client (Hamerdinger & Karlin, 2003). Interpreters and clinicians must not only be trained in their respective fields and have cross-training in or at least a base knowledge of each other's field but also have instruction in how to work together effectively. Additionally, administrators who oversee clinical programs and frontline staff who work with Deaf consumers must also be trained in the unique needs of Deaf individuals seeking mental health services.

Interpreters who are Deaf, often referred to as Deaf interpreters (DI) or certified deaf interpreters (CDI), must also be trained beyond MHIT on the unique role of functioning as a Deaf interpreter in mental health. At times, the CDI may be hired in what is considered the typical role of a CDI and at other times as a language coach or consultant. Hearing and Deaf interpreter teams also need instruction in working together to collaborate

effectively in mental health settings, including dealing with more than the usual expectation of transparency during the process.

In a typical setting involving a hearing interpreter and a CDI, the hearing interpreter will translate a spoken message to ASL, and the CDI will break the message down to a language that is more readily understood by the consumer. The message may be delivered through atypical signs and gestures, in shorter segments, or through connections based on intimate knowledge, for example. Once the consumer responds, the CDI will formulate a response in ASL, and the hearing interpreter will interpret the message in spoken English. The clinician is interested in how the consumer uses language in order to draw appropriate conclusions regarding issues like mental status, competence, language competence, fund of information, or thought processes. As such, how the question is arrived at and how the response is formulated are integral parts of the session. In the typical scenario just described, hearing interpreters are often silent while the CDI is working, which deprives the clinician of critical information. Alabama's training program prepares interpreters to accommodate this need by techniques such as providing a third-person narrative of the interpreted process between the CDI and the deaf consumer.

The addition of two interpreters may change the dynamic into something clinicians are very unprepared to deal with. Issues of alliances, transference, and countertransference will arise. The clinician and both interpreters must be aware of these challenges and be prepared to address them honestly and openly and without hidden agendas or issues of control. Acknowledging the tenuous balance of power between the interpreters and the "us vs. them" dynamics at play, both the "Deaf vs. hearing" dynamic and the "signing vs. non-signing" one will be vital to ensuring that the sessions are therapeutic for the consumer.

The following is a case in point of how an interpreter's alliance can be detrimental in mental health settings. A certified interpreter, untrained in mental health work, contracted with a hospital that provided interpreting services for consumers with mental illness. The patient was a consumer in extended care. Whenever the treatment team met to assess the consumer's care, the interpreter would spend time arguing with the team, stating that "they didn't understand Deaf people" and "they were against Deaf people." When the treatment team met and recommended that the patient cease

smoking and cut down on sweets (concerns related to the patient's severe medical needs), the interpreter, who disagreed with the decision on "human rights" grounds, regularly purchased candy and cartons of cigarettes, gave them to the patient, and instructed the patient to hide them in his room. While this may be an extreme example, interpreters without training are more apt to side with the Deaf consumer, which can disrupt the therapy.

In their evaluative reports, interpreters who have completed this extensive certification program report that they become more comfortable in dealing with dysfluent language by understanding the various roles of mental health professionals, common diagnosis, interview questions, and clinical objectives and by using various interpreting techniques, such as third-person descriptive interpreting. Trained interpreters are less likely to be defensive when questioned and also less likely to explain away unusual behaviors or language and more likely to align with the program of therapy.

In addition, QMHIs are more apt to cooperate with the therapeutic process in order to focus on the consumer's recovery. This, in turn, means better outcomes for the consumer, a therapist who feels better about the therapy process, and interpreters who feel their contributions to the therapy were effective.

The cadre of interpreters who are qualified to work alongside clinicians provides services that are conducive to the therapeutic environment. Clinicians have commented in consumer satisfaction surveys that interpreters who are trained and certified to work in this setting are better prepared to match the goals of therapy and to be able to dialogue about what is occurring within the communication arena by capturing critical clinical information.

Further studies are needed to determine the efficacy of Mental Health Interpreter Certification, including evidence-based practices, consumer recovery, and clinical effectiveness.

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APPENDIX A: DEFINITIONS

Definitions included in the standards outlining competencies and knowledge are the following:

Exposure: having some knowledge of a field's existence and its place in the setting and possibly some of the vocabulary used in the field

Demonstration (or compliance): showing that a skill has been learned and incorporated into the interpreter's practice

Familiarity: having actual experience with a field and/or practitioners in that field

Awareness: insight that goes beyond familiarity in that it includes beginning to internalize information about a field and to grasp how it affects one's professional and personal behavior. It does not necessarily include having resolved particular issues.

Understanding: having sufficient knowledge of a field to be able to explain the discipline, including its limits and its relationship to other disciplines