

State Licensing of Sign Language Interpreters

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Brief Overview of LB 87

On March 16, 2006, Governor Dave Heineman approved LB 87 that requires sign language interpreters to obtain a license by June 30, 2007 (*LB 87-2006, Neb. Statutes 20-150 to 20-159*) which mandates the use of licensed interpreters in all state settings (20-150.7), courts and probation officials. Issuing and maintaining licenses for interpreters is the responsibility of the Nebraska Commission for the Deaf and Hard of Hearing (NCDHH). An eight member Interpreter Review Board promulgated regulations that interpreters have “minimum levels of competencies”. The Board established four types of licenses: interpreter or transliterate license, specialty license (Deaf interpreters, Legal), provisional licenses and limited practice license. The Board maintains that licensees will meet specific requirements including: be 18 years of age, have a high school degree, hold a current valid certification, attend Continuing Education activities and submit the required Continuing Educational Units necessary to maintain licensure.

Public school districts and educational units shall appoint “qualified” educational interpreters and licensing is not required for educational interpreters. The Nebraska Commission for the Deaf and Hard of Hearing and the Nebraska Department of Education work jointly to assure “qualified” interpreters work in classrooms for Nebraska children across the state and that continued training opportunities are available.

The Nebraska Commission for the Deaf and Hard of Hearing maintains a directory of interpreters qualified to provide appropriate interpreting services and can be accessed via their website: www.ncdhh.ne.gov or by contacting their office at (402) 471-3593.

Historical Perspective of Interpreting

A historic workshop for rehabilitation personnel, educators and interpreters held at Ball State Teacher’s College in Muncie, Indiana, June 14-17, 1964, pioneered the field of interpreting (Frishberg, 1995). Those interpreters, from across the United States, came together and recognized the need to establish a “list” of qualified interpreters nationally (*Beard, 1976*). This “List” was the beginning of The Registry of Interpreters for the Deaf (RID). With federal funding from Rehabilitative Services, the RID established their national office and work began on testing and certification for interpreters. Sign language interpreters throughout the United States, Canada, Europe, Australia and New Zealand joined the RID since this was the first interpreting organization in the world (*Humphrey & Alcorn, 1995*). The advent of the RID helped to establish sign language interpreters as professionals providing bilingual bicultural communication. The role of interpreters as “helper” is forever changed.

Previously, deaf and hard of hearing people used their own social networks for interpreting and support such as hearing teachers that taught at schools for the deaf,

hearing children of the family or other hearing family members, and clergy. Written communication was commonly used when a “signer/helper” was not available, which puts the livelihood; health and well-being of persons that are deaf or hard of hearing are in the hands of another person. Deaf and hard of hearing persons were often frustrated and embarrassed when they realized their words were misinterpreted or the intent of meaning was not clear.

Mental Health and Substance Abuse Counseling and the Use of an Interpreter

The intent of LB 87 is for people who are deaf and hard of hearing to have effective communication when accessing services with state agencies, courts and probation. Licensed interpreters will have to meet the minimum levels of competencies within their disciplines. It would make sense for counselors, therapists, psychologists and physicians to use licensed interpreters in the therapeutic setting to ensure appropriate communication and equal access to services. Historically this has not been the case.

Until the 1960's, people who were deaf and hard of hearing rarely used mental health or social services, at least on a voluntary basis, because of lack of access to interpreters and fears of being misunderstood. Therapist and counselors were not as open to working with this population because they found the process frustrating and laborious. Training and research into treatment was not available and many individuals that did access services found themselves misdiagnosed as mentally retarded and/or mentally ill. Forced institutionalization by professionals and family members were common and some deaf and hard of hearing people spent their entire lives in those institutions (Myers, 1995). People who are deaf or hard of hearing are demanding rights to equal access of services. They want to have choices where they can access care within agencies that provide mental health, education, medical, social, organizational and legal services.

Current research continues to show that no matter what the approach used in a therapeutic setting rapport is important to successful outcomes. Understandably, in order to establish rapport, communication is vital. A person accessing mental health and substance abuse services needs to know they are being “heard” and to be able to understand the provider of services. A “qualified” interpreter serves as a bridge for communication and facilitates understanding.

Trust and confidentiality are equally important when establishing rapport. People who are deaf and hard of hearing seeking services will need to know their rights to privacy (HIPPA, informed consent and release of information) and understand the ethical codes followed by the interpreter. Allow for pre and post session with an interpreter to discuss information that will be helpful in the therapy process and to discuss communication issues that arise in the session. Always explain to the person who is deaf or hard of hearing the purpose of the pre and post sessions and allow them to be part of the process if desired.

The role of the interpreter in therapy is to provide effective communication. Guidelines worth mentioning are; always use the same interpreter if possible for ongoing sessions, make sure the person is comfortable with the interpreter and they are a good “fit”. Speak to the person and not to the interpreter avoiding directions such as “tell her/him”. Do not ask the interpreter questions about the person who is deaf or hard of hearing. Interpreters do not offer advice, give opinions or counsel other than that which relates to providing communication. The interpreter must stay true to the intent of all

parties, matching tone and affect via voice inflection and signing. When the therapist leaves the room it is suggested the interpreter may leave as well. The purpose is so the client/consumer will not feel compelled to disclose counseling information to the interpreter. Resources on using interpreters in various settings are available at the Nebraska Commission for the Deaf and Hard of Hearing.

Conclusion

LB 87 is an exciting piece of legislation for interpreters and persons who are deaf and hard of hearing. The challenge to the field of mental health and substance abuse counseling is to provide the best quality of care for people who are deaf and hard of hearing and the use of licensed interpreters is a step closer to making that happen.

References

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