NCIEC
National Consortium of Interpreter Education Centers

DEAF INTERPRETER-HEARING INTERPRETER TEAMS

Unit 3- Assessing the Need for a DI-HI Team

Introduction Assessing the need for a DI-HI team typically falls on the shoulders of the hearing interpreter assigned to a particular job because they are often the first on the scene in an interpreted setting. This means that the hearing interpreter is usually the person responsible for first assessing the needs required to successfully interpret in a particular setting. However, it is important for anyone assessing these communication needs to look at several different factors in order to determine if a DI-HI team is required to ensure the D/deaf person's rights to full linguistic and communicative access are provided. Two of the primary factors to consider will be explored in this unit - the Deaf consumers of the interpreting service and the setting in which these services are to be provided. Though DI-HI teams may be required or beneficial for any consumer or setting, this unit focuses on 7 of these categories of consumers and 3 settings. Possible consumers that often require the use of a DI-HI team are divided into the following 7 categories: semi-lingual/alingual, foreign-born, users of International Sign, DeafBlind individuals, those consumers with physical and/or cognitive disabilities (i.e. Deaf Plus), minors, and persons under the influence or experiencing a traumatic event. The 3 settings covered in this unit are: educational, social services, and medical. These settings were chosen because of their complexity combined with their potential for life-altering outcomes all of which are heavily dependent on linguistic presence and full access. In summary, this unit includes a brief discussion on the important impact that a HI's own skills can have on the need for a DI-HI team as well as a summary of the importance of this assessment.

I) Possible Consumers Deaf individuals have a variety of language experiences, backgrounds, and skills. When assessing the need for a DI-HI interpreting team, it is essential that an interpreter have familiarity with the variety of possible consumers who may require the use of a DI-HI team in order to ensure their rights to equal access are preserved. In this unit, a variety of possible consumers are briefly discussed, for more in depth information on the topic, please see the resources listed at the end of the unit. It is important to note that the categories listed here are not mutually exclusive as it is possible to have one consumer with multiple factors impacting their language use.

A. Semi-lingual/alingual: Bienvenu and Colonomos (1992) define these consumers as "…deaf people (alingual) who have not been exposed to any natural language and have devised a limited vocabulary to

Copyright © 2013-2016 by the National Consortium of Interpreter Education Centers (NCIEC).
This NCIEC product was developed by the National Interpreter Education Center (NIEC) at Northeastern University. Permission is granted to copy and disseminate these materials, in whole or in part, for educational, non-commercial purposes, provided that NCIEC is credited as the source and referenced appropriately on any such copies.

express their thoughts… Other D/deaf people (semi-lingual) have learned some signs, but their language acquisition was so delayed, or the language input so scarce, that they are not able to express themselves freely, with the depth and precision of natural language" (p. 71). According to the NCIEC Deaf Interpreter Work Team (2010), Deaf interpreters work most frequently with this consumer population. Other labels sometimes used to describe these consumers include Minimal Language Skill (MLS), highly visual, monolingual, low functioning, Limited English Proficiency (LEP), etc. Though these terms may be used in various contexts, the preferred and more appropriate terms are alingual or semi-lingual.

B. Foreign-born: Some Deaf people have immigrated to the US from foreign countries and therefore may have a fluent and native signed language other than ASL as their native language. These potential consumers could also be in the process of acquiring ASL, or they may have no foundation in a signed language whatsoever.

C. Users of International Sign: International Sign (IS) is a system of signs created by a committee of the World Federation of the Deaf (WFD) in 1973. It is a system of signs based on choices of the most easily understood signs from a diverse variety of signed languages (NCIEC Deaf Interpreter Work Team, 2012). Previously called Gestuno, International Sign is now the preferred term used to describe this created, non-natural signed communication system (Boudreault, 2005). Some possible deaf consumers of interpreting services may be international travelers who have a fluent and native language other than ASL, but may also have an understanding of, and ability to use, International Sign.

D. DeafBlind: DeafBlind consumers can include people with a spectrum of hearing and vision abilities who need specific accommodations in order to access signed language (e.g. tactile interpreting, close or far interpreting, tracking, etc). More information on communication needs and preferences for DeafBlind individuals can be found at http://aadb.org/factsheets/db_communications.html.

E. Deaf Plus: This category of possible consumers would include any Deaf or Hard of Hearing persons who have cognitive and/or physical disabilities that impact their language expression or comprehension such as autism or down syndrome. This category would also include individuals with conditions such as Cerebral Palsy or Muscular

Copyright © 2013-2016 by the National Consortium of Interpreter Education Centers (NCIEC).
This NCIEC product was developed by the National Interpreter Education Center (NIEC) at Northeastern University. Permission is granted to copy and disseminate these materials, in whole or in part, for educational, non-commercial purposes, provided that NCIEC is credited as the source and referenced appropriately on any such copies.

Dystrophy, which may impact their ability to produce signs, and may therefore necessitate a DI-HI team.

Certain mental illnesses may impact a Deaf person's ability to produce and comprehend typical ASL and would benefit from a DI-HI team. An example of this would be a Deaf person who experiences hallucinations. There may be very subtle language cues and changes that indicate whether the deaf consumer is signing to their hallucinations or directly to the addressee. This distinction is critical as a misinterpretation may lead to a misdiagnosis.

F. Minors: This includes anyone under the age of 18. Depending on their language environments, education level/background, and age, minors may have varying levels of language competency.

G. Persons under the influence or experiencing a traumatic event: There may be some Deaf persons who would not typically require the services of a DI-HI team, but for a particular event or setting a DI-HI team would be the best provision of services. Examples include Deaf persons who are heavily under the influence of an intoxicating substance that is impacting their ability to produce and comprehend typical ASL. Or a Deaf person that has experienced a traumatic or excessively stressful event (i.e. physical or sexual assault, the loss of a loved one, etc.) that is impacting their ability to communicate effectively.

II) Various Settings

This following information pertains to how DI-HI teams work in three specific settings; educational, social services, and medical.

1. Educational Interpreting

Education is a vital part in the development of young people and adults alike. Access to education becomes even more important for people with needs for accommodations. The Individuals with Disabilities Education Act of 1975, amended 2004, along with the Americans with Disabilities Act, section 504 of the Rehabilitation Act of 1973, require that accommodations be made for people who are Deaf and Hard of Hearing in K-12 and higher education settings.

The educational environments that interpreters work within span a vast range of ages, settings, and content. An interpreter needs to have the awareness and ability to assess each educational setting in order to identify the best communication and

Copyright © 2013-2016 by the National Consortium of Interpreter Education Centers (NCIEC).
This NCIEC product was developed by the National Interpreter Education Center (NIEC) at Northeastern University. Permission is granted to copy and disseminate these materials, in whole or in part, for educational, non-commercial purposes, provided that NCIEC is credited as the source and referenced appropriately on any such copies.

interpreting provisions for each situation. In the US, students are more often educated in mainstream environments than in deaf residential schools (Gallaudet Research Institute, 2011). Many of these deaf children are in mainstream settings without any deaf peers, deaf role models, or deaf language models (Oliva, 2004), and in these settings the role of the interpreter in providing appropriate access and language modeling becomes that much more imperative. There may be times when an ASL-English interpreter is not best suited for providing access to a consumer in an educational setting and may make the decision to include a DI on the interpreting team.

Any educational setting in which interpreters work could potentially require a DI-HI team depending on the consumers' needs. These settings include, but are not limited to, birth-to-three programs, pre-k programs, K-12 programs, vocational training, undergraduate and graduate programs, etc. In the settings where there is a hearing student with Deaf family members, services may be required for the Deaf parents or family members attending school functions, educational planning meetings, etc. It is also possible that Deaf family members will necessitate a DI-HI team.

2. Social Services

Social Service programs include, but are not limited to: Vocational Rehabilitation, Social Security, Medicaid, Medicare, Child Protective Services, utility assistance programs, food banks, low cost clinics, and housing agencies. There are forms, criteria, and regulations that determine a person's eligibility for social services. These forms and regulations are not only vast but they can be quite complex. Understanding what is expected of the social service participant is paramount; services will be denied or delayed if forms are not properly filled out or regulations, rules, or criteria are not satisfied. With few laws that mandate the use of an interpreter in social service settings (Humphrey & Alcorn, 2001) access to these services can be difficult, further marginalizing Deaf communities. To add to the complexity, social service settings often include legal and mental health interpreting. Child Protective Services, for example, could begin with a routine home visit that turns into legal questioning or mental health counseling the Deaf parents and/or the child who may be under emotional duress. Due to the complexity and serious nature of these settings, combined with their potential for life-altering outcomes if services are denied, delayed, or inappropriately given, interpreters working in social service settings should consider utilizing a DI-HI team.

3. Medical Interpreting

In the United States, Deaf individuals are granted equal access to health care services through both the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973. While we would expect that these two laws have allowed

Copyright © 2013-2016 by the National Consortium of Interpreter Education Centers (NCIEC).
This NCIEC product was developed by the National Interpreter Education Center (NIEC) at Northeastern University. Permission is granted to copy and disseminate these materials, in whole or in part, for educational, non-commercial purposes, provided that NCIEC is credited as the source and referenced appropriately on any such copies.

for improved access and a greater understanding of health care issues, studies have shown that this is not the case (Steinberg, Wiggins, Barmada, and Sullivan, 2002). A study conducted in 2002 examined Deaf women's health care experiences and found that there was a general lack of health knowledge, little understanding or value of common screenings, purposes of prescribed medications or procedures, and negative experiences with insensitive health care providers. Subjects in this particular study reported more "positive experiences and increased access to health information" with medical practitioners who provided qualified interpreters (Steinberg, et al, 2002, p. 729). Moore and Swabey (2007) discuss several other studies which mirror the experiences of women in Steinberg et al.'s study. The Registry of Interpreters for the Deaf (RID) Standard Practice Paper *Interpreting in Health Care Settings* (2007) lists eight settings "in which the information to be exchanged requires effective communication." These same settings may require the use of a DI-HI team in order to ensure effective communication and include, but is not limited to: taking a patient's medical history, giving diagnoses, performing medical procedures, explaining treatment planning, explaining medicine prescription and regimen, providing patient education or counseling, describing discharge and follow up plans, and admitting to emergency departments/urgent care. Specific medical settings and situations will have distinct ramifications on communication and will present specific challenges to interpreting procedures. Most often, problems that arise in the medical setting are "due to differing cultural norms, and the onus falls to the interpreter to make the adjustments required for accurate communication" (Moore and Swabey, 2007, p. 24). DI-HI teams are better equipped at handling these differing cultural norms.

Although three particular setting where DI-HI teams often work are described in this unit, it is also important to recognize that DI-HI teams work in a number of additional settings. These setting include, but are not limited to: mental health interpreting, legal, public events settings, and national/international interpreting and/or Deafness-related conferences.

III) HI Self-Skill Assessment and Summary for Unit 3 HIs may acquire fluency in ASL and may be viewed as holding partial membership in the Deaf community, however, they often do not have the same level of native fluency and insider acceptance in the Deaf community as DIs. Though a HI could perhaps justify the need for a DI on every interpreting assignment, the practicality of following such an ideal is not realistic. For that reason, HIs must continually assess their skills against the demands of the job to determine when a DI should be included as part of the interpreting team. The NAD/RID Code of Professional Conduct (2005) states that interpreters must assess "the consumers' needs and the interpreting situation before and during the assignment and make necessary adjustments as needed," and furthermore, to "request support (e.g., certified deaf interpreters, team members,

Copyright © 2013-2016 by the National Consortium of Interpreter Education Centers (NCIEC).
This NCIEC product was developed by the National Interpreter Education Center (NIEC) at Northeastern University. Permission is granted to copy and disseminate these materials, in whole or in part, for educational, non-commercial purposes, provided that NCIEC is credited as the source and referenced appropriately on any such copies.

language facilitators) when needed to fully convey the message or to address exceptional communication challenges." Typically, it is the HI who is first called in to interpret and therefore they possess the power of deciding whether or not they are able to meet the needs of the consumer involved in a particular setting. For this reason, continual self-assessment to determine suitability for an interpreting assignment is imperative. The mark of a true professional is evidenced by their acknowledgment of the ethical and professional obligation they have to ensure that effective communication access is achieved and in doing so continually assess their strengths and abilities against the demands of the interpreting job. Recognizing that a DI-HI team is needed and taking steps to secure such a team is the sign of a professional, ethical interpreter.

References

American Association of the Deaf-Blind. (2009, February 11). How do Deaf-Blind people communicate?. Retrieved from http://aadb.org/factsheets/db_communications.html.

Bienvenu, M., & B. Colonomos (1992). Relay interpreting in the 90′s. In L. Swabey (Ed.), Proceedings from Eighth National Convention of the Conference of Interpreter Trainers: *The Challenge of the 90′s: New Standards in Interpreter Education* (pp. 69-80). Pomona, CA: Conference of Interpreter Trainers. Retrieved from http://www.diinstitute.org/wp-content/uploads/2012/07/Bienvenu.pdf.

Boudreault, P. (2005). Deaf interpreters. In T. Janzen (Ed.) *Topics in Signed Language Interpreting: Theory and Practice* (pp. 323-355). Philadelphia, PA: John Benjamins.

National Consortium of Interpreter Education Centers. (2010). *Toward effective practice: Competencies of the Deaf Interpreter*. Boston, MA: NCIEC Deaf Interpreter Work Team. Retrieved from http://www.diinstitute.org/wp-content/uploads/2012/07/DC_Final_Final.pdf.

Registry of Interpreters for the Deaf, Inc. (2005). NAD-RID Code of professional conduct. Retrieved fromhttp://rid.org/UserFiles/File/NAD_RID_ETHICS.pdf.

<u>Educational Interpreting</u>

Gallaudet Research Institute. (April 2011).*Regional and national summary report of data from the 2009-10 annual survey of Deaf and Hard of Hearing children and youth.*Washington, DC: GRI, Gallaudet University.

Oliva, G. A. (2004). *Alone in the mainstream: a deaf woman remembers public school*. Washington, D.C.: Gallaudet University Press.

Copyright © 2013-2016 by the National Consortium of Interpreter Education Centers (NCIEC).
This NCIEC product was developed by the National Interpreter Education Center (NIEC) at Northeastern University. Permission is granted to copy and disseminate these materials, in whole or in part, for educational, non-commercial purposes, provided that NCIEC is credited as the source and referenced appropriately on any such copies.

Social Services
Humphrey, J. H., & Alcorn, B. J. (1995). *So you want to be an interpreter?*. Amarillo, TX: H&H Publishers.

Medical Interpreting
Moore, J., & Swabey, L. (2007 – Draft). Medical interpreting: A review of the literature. CATIE, College of St. Catherine/NCIEC.

Registry of Interpreters for the Deaf. (2007). Standard practice paper: Interpreting in health care settings. Retrieved from http://www.rid.org/UserFiles/File/pdfs/Standard_Practice_Papers/Drafts_June_2006/Health_Care_Settings_SPP.pdf.

Steinberg, A. G., Wiggins, E. A., Barmada, C. H., & Sullivan, V. J. (2002). Deaf women: Experiences and perceptions of healthcare system access. *Journal of Women's Health, 11*, 729-741.

Suggested Resources

Burns, T. J. (1999). Who needs a Deaf interpreter? I do!. *RID VIEWS, 16*(10), 7.

Egnatovitch, R. (1999). Certified Deaf Interpreter WHY. *RID VIEWS, 16*(10), 1;6.
Educational Interpreting
Registry of Interpreters for the Deaf. (1997). Standard practice paper: Use of a Certified Deaf Interpreter.Retrieved https://drive.google.com/file/d/0B3DKvZMflFLdbXFLVVFsbmRzTVU/view.

Registry of Interpreters for the Deaf. (2010). Standard practice paper: An overview of K-12 educational interpreting. Retrieved from https://drive.google.com/file/d/0B3DKvZMflFLdcFE2N25NM1NkaGs/view.

Copyright © 2013-2016 by the National Consortium of Interpreter Education Centers (NCIEC).
This NCIEC product was developed by the National Interpreter Education Center (NIEC) at Northeastern University. Permission is granted to copy and disseminate these materials, in whole or in part, for educational, non-commercial purposes, provided that NCIEC is credited as the source and referenced appropriately on any such copies.