A Pilot Consultation Group for Medical and Mental Health Interpreters
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July 2012

Overview of presentation
- Need for consultation group
- How established
- Structure and logistics
- Content of sessions
- Lessons learned
- Future directions

What is this group?
- Facilitated monthly case conferencing, for contracted interpreters providing medical and/or mental health interpreting
- Using Dean and Pollard’s DCCRD
  (Demand → Control → Consequence → Resulting Demand)

Why?
- Interpreters in these settings usually work alone
- Dealing with complex interactions, potentially strong emotion, serious outcomes
- Potential for burnout or vicarious trauma is high
- Medical and mental health may overlap

New understanding in our field
- Dean and Pollard: interpreting as a practice profession
- Use of Observation-Supervision with mental health interpreters
- Co-construction of meaning: interpreters no longer viewed as invisible (e.g., Wilcox and Shaffer, 2005; Janzen and Shaffer, 2008)

An idea whose time has come
- Robyn Dean and Bob Pollard: New York
- Arlyn Anderson: Minnesota
- Ali Hetherington: England
- Kendra Keller: California
How?

- Well Being Program (WBP)
  - and Deaf-Blind consumers throughout BC
- Medical Interpreting Services (MIS)
  - Provides interpreters for Deaf, Hard of Hearing and Deaf-Blind consumers throughout BC

- Each has a part-time staff interpreter, but mostly use roster of contracted interpreters
- MIS: screening
- WBP: series of workshops, mentoring
- No established structure for debriefing

How, con’t.

- Approached both with proposal
- Outlined benefits:
  - Increased quality of service for consumers
  - Increased loyalty to working for these organizations
  - Reducing threat of burn out

Structure of consultation group

- Monthly meetings
- Evenings, 6 - 8 pm
- Week night varies (Monday - Thursday)
- Central location, close to transit (with thanks to Douglas College Dept. of Sign Language Interpretation)
- Email notice sent to eligible interpreters with follow up reminders, request to RSVP
- Use of Skype, Oovoo

Consultation format

- Review of how group came to be
- Clarification re reporting responsibility to funders
- Limits of discussion
- Discussion re confidentiality
- Agreement to respect contributions of each
- Quick overview of DCCRD, and the liberal-conservative spectrum of ethical decision making
Use of DCCRD
- Some interpreters familiar with it
- New for others
- Reading sent out prior to first meeting:
  Dean and Pollard: Context-based Ethical Reasoning in Interpreting

Case conferencing
- Participants identify who has a case to discuss
- Participant speaks, facilitator writes on board using DCCRD
- Other interpreters add comments, ask questions

Examples of cases
- Home care instructions for patient who lives alone. Patient declines home nurse. Interpreter not sure if patient understood instructions and consequences could be severe.
- Deaf patient reveals disordered thinking to interpreter when they are alone, but not to clinician.

Participant responses to mid-point survey
- What has been most useful?
- Hearing the perspectives from people I don’t normally go to for discussion
- Being able to debrief and discuss with my colleagues
- Sharing experiences and our approaches with each other, and analyzing the situation as a group together using DC5 model.
- Realizing others struggle with the same dilemmas

Considerations for future meetings
- More instruction needed for those unfamiliar with DCCRD
- Establishing trust
- Discussion topics in addition to case conferencing?
- Ways to entice those who never attend
- If people pay, do they have more of a commitment?

Establishing a consultation group
- Funding
- Location and timing
- Facilitator familiar with DCCRD and respected in community
- Open to any community work? More restricted?
Conclusion

- Thank you to WBP (Patti Dobie) and MIS (Janice Lyons) for their support of this initiative.
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