

Signs of Mental Health



**Inside:
Sharing the Model**



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Office of Deaf Services
Alabama Department of Mental Health and Mental Retardation
P.O. Box 301410
Montgomery, Alabama 36130



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Signs of Mental Health
 ADMH/MR, Office of Deaf Services
 John M. Houston, Commissioner
 Steve Hamerdinger, Director
 P.O. Box 310410
 Montgomery, AL 36130
steve.hamerdinger@mh.alabama.gov

Editor's Notes:



What fun issue this has been! Between reporting on a project from BDU, recognizing the staff for their great work, sharing what we are doing here with other states and recapping all the various comings and goings, there is a lot in this issue.

The BDU gardening project has been phenomenal. We knew from reading about programs in other states that horticulture therapy was effective, but leave it to the communication team at BDU to find brand new tie-ins that turn it into a language development tool.

We had a group of officials from Georgia come and look at what we are doing. They seemed impressed. Our impression was that the more we talk about the underlying philosophy of all we do – deaf people thrive

in an ASL-rich environment – the more we become convinced that it is the only way to effectively provide mental health services. Interpreted services are not only ineffective, they are sometimes counter-therapeutic.

We are reprinting an article by Gardy Van Gils that we thought was interesting. It's both a cautionary tale and a pat on the back because DMHMR does indeed value professionals who are deaf—far more so than many state mental health authorities do. We are lucky that way indeed!

This issue also spotlights some significant staff achievements. Dawn Marren was named Interpreter of the Year by the Council of Organizations Serving Deaf Alabamians and Liz Hill was elected to the Board of Directors of the National Association of the Deaf. Congratulations are in order for both. See Notes and Notables on page 11 for more highlights.

MENTAL HEALTH SERVICES HIGH PRIORITY OF NAD

At its biennial convention in New Orleans this July, the National Association of the Deaf voted to make mental health services one of its top five priorities for the coming two years. The Council of Representatives, which is the legislative body of the Association, passed the motion on Friday, July 11th.

Founded in 1880, NAD is the oldest and largest grassroots organization of deaf people in the world. Its mission is to preserve, protect and promote the civil, human and linguistic rights of all deaf Americans. NAD published a position paper on mental health that can be accessed at

www.nad.org/mentalhealthposition

The motion read: “The [National Association of the Deaf] shall promote a national agenda for mental health, with emphasis on: a) services provided in ASL as a civil/human right, b) statewide coordination to ensure a continuum of services, c) a lifespan developmental approach to services delivery, and d) clearinghouse of resources on the NAD website.” It was introduced by Liz Hill and seconded by Judith Gilliam with unanimous backing of the southeast delegation (Region III). There was no dissent.

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ON THE COVER:

Dr. Eric Hedberg, Clinical Director at Greil and BDU's psychiatrist, shares "lessons learned" with officials from Georgia.

PLANT THERAPY TEACHES MANY LESSONS AT BDU

By DEB WALKER



Communication Specialist Amy Peterson showing off the consumers flowers and plants

Our Facility Director, Allen Stewart, had some creative ideas of his own. He remembered that there were two planters on the terrace out by the Recreation Department. He asked the director of that department, Estella Derico, if the Bailey Deaf Unit could use one of them as a pilot project. She agreed. (The planters were a project by an Eagle Scout and were donated to Greil several years ago. Each one is approximately 8 x 2 ½ ft, is on wheels and is lined to retain water.) Our planter was moved to Bailey Deaf Unit's terrace on June 12th.



Springtime always makes me itch to get my hands dirty in an attempt to beautify my corner of the world. Unfortunately, I'm known to have a blackish thumb so my initial beautification projects usually look like I spread weed seed. Still the desire to dig hits me seasonally and, although not lastingly successful, the therapy is well worth the effort. It was after enjoying a weekend of digging and planting that I noticed a neglected planter outside the Bailey Deaf Unit here at Greil and began chewing on the possibility of our patients having a form of "Gardening Therapy". I put the idea past our Clinical Director and the Facility Director, truly expecting to be told that it wasn't feasible. They both, though, liked the idea and responded positively. Yay! Ummm ... now what?

My, oh my, what a buzz it has created here on the unit! The day before it was moved, I spoke to the patients about the possibility and emphasized that good behavior was necessary of each participant. One and all enthusiastically volunteered to help. In fact, when it was time to paint it, nine of our ten patients and two staff were out there in the heat painting away. The hard work has provided the patients with a positive diversion and each finished project has brought them obvious satisfaction and pride. We have never had a behavioral problem while the patients are working;

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DEAF SERVICES
REGIONAL CENTERS

Region 1: Northern Alabama

Wendy Lozynsky

Mental Health Center of
Madison County
4040 South Memorial Pkwy
Huntsville, AL 35802
(256) 533-1970 (Voice)
(256) 533-1922 (TTY)

Region 2: Central Alabama

Shannon Reese, Coordinator

JBS Mental Health Center
956 Montclair Road, Suite 108
Birmingham, AL 35213
205-986-9213 (Voice)
205-591-2216 (TTY)

Region 3: Wiregrass Region

Liz Hill, Coordinator

Montgomery Area
Mental Health Authority
101 Coliseum Boulevard
Montgomery, AL 36109
(334) 279-7830 (Voice)
(334) 271-2855 (TTY)

Region 4: Southern Region

Vacant

AltaPointe Health Systems
2400 Gordon Smith Drive
Mobile, AL 36617
251-450-4353 (Voice)
251-450-4371 (TTY)



Office of
Deaf Services
Regions

GA DHR STUDIES ALABAMA'S OFFICE OF DEAF SERVICES

Four representatives from the Georgia Department of Human Services visited Alabama on June 26th to learn about Deaf Services in hopes of taking some of ideas back with them. The delegation included Dr. Denis Zavodny, Assistant Direct of Forensic Services, Charles Bliss, Adult Mental Health Program Specialist, Dr. Julie Oliver, Forensic Psychologist at Northwest Regional Hospital in Rome, GA and Patricia Ferreira, Language Access Coordinator.



Seated, clockwise: Dr. Denis Zavodny, Dr. Julie Oliver, Charles Bliss, Patricia Ferreira, and Dr. Eric Hedberg. Brian McKenny (standing) interprets.

The group met with both Office of Deaf Services and Bailey Deaf Unit Officials, spending the full day looking at all aspects for how services are delivered in Alabama. Steve Hamerdinger, ODS director, Dr. Eric Hedberg, Greil clinical director, Scott Staubach, Bailey Deaf Unit director and Charlene Crump, Mental Health Interpreter Coordinator all gave presentations. The group also spent time on the unit at BDU where various activities and program modifica-

tions that make BDU “culturally Deaf” where highlighted.

The group was especially interested in how Alabama modified hospital programming as the need for forensic services for deaf people is driving the effort in Georgia. The need to create a “Deaf Environment” was stressed. Charles Bliss said, “The greatest lesson learned was the need to develop “deaf friendly” services and not just adapt hearing services to

accommodate deaf needs.” After touring the unit and talking to the staff the group was better able to understand what was meant by this. They also noted the level of “teamwork” that makes BDU unique. Dr. Zavodny said, “As a student of leadership and organizations, I was very impressed by the organizational culture and climate of your administrative and hospital staff. Specifically, the morale and vision with focus on the mission of the staff were evident to me.”



CULTURE SHOCK

BY ERIC B. HEDBERG, MD



A decision was made to assign one psychiatrist to all of the Bailey Deaf Unit patients at Greil Psychiatric Hospital. I had previous experience with BDU patients when I worked part time in 2006. Like other physicians I saw the patients with the assistance of an interpreter only. I naively thought American Sign Language was a translation of English. After all, the interpreter spoke in fluent, grammatically correct English when I or the patient was speaking. **What a culture shock** to find out that American Sign Language is a language unto itself, and **not English!** I began to learn this by interviewing my patients with the help and presence of the entire treatment team.

I have begun to learn about the deaf culture. Things that hearing people do have drastically different meaning to a deaf or hard of hearing person. For example, the simple gesture of touching someone as hearing people do all the time can be alarming to deaf or hard of hearing people. I learned there are correct ways to get someone's attention and there are incorrect ways. Holding the hand or arm of a deaf or hard of hearing person is the same as someone putting their hand over my mouth to shut me up. I learned that “I'm not going to listen to you” is way easier for deaf or

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As I See It

Steve Hamendy



Recently a news story was aired in Springfield, Missouri chronicling the plight of a 22 year old deaf man named Sade, who was placed in a “residential facility (i.e. a nursing home) for no other reason than “there was no other option.” He didn’t need nursing care. He didn’t need incarceration. He really needed a place where he could be around others who could communicate with him. Instead, he was dumped. Warehoused where he would be out of sight, out of mind and forgotten.

The story (you can access it at <http://ozarksfirst.com/content/fulltext/?cid=43701>) showed a young man who is frustrated and demoralized as he sits, day after day, surrounded by people but without any way to connect with them. Without any friends. And this was called “good” by the authorities. “It’s not ideal, but it’s been okay, good for him because that’s what there was,” said Clay McGranahan of the Springfield Regional Office, which is part of the Missouri Department of Mental Health.

Reading the story is causing slow-building rage, fueled by life-long oppression and fanned by my own trauma. The initial, “it’s nothing new” reaction is slowly giving way to “How long must we endure?” Why is it “OK, good for us because that’s all there is,” for deaf people, but would be considered a violation of basic human rights for anyone else? “O God, how long shall the adversary reproach?” (Psalm 74:10)

Most readers know I came to Alabama after ten years of working as the Director of Deaf Services at the Missouri Department of Mental Health. I was often subtly and not so subtly informed that I was “uppity” because I dared to give voice to inconvenient truths. I was frequently told to remember my place and my place was at the back of line behind others who were better funded, had better lobbyists and were better connected to the powers that be.

I left Missouri with a mixture of relief that I was going to a place where some good could be done, but profound dread that the cracks through which Sade fell would become yet wider with the lack of advocacy. My heart was heavy for the consumers who were failed and those who would be failed. I wept for the staff who would have to carry on and who would be dismissed as irrelevant and, ultimately, let go.

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CAMPBELL SIGNS ON AS REGION II INTERPRETER



Sereta Campbell joined the Department of Mental Health/Mental Retardation Office of Deaf Services on August 1st of this year serving as the Region II Interpreter. She will be based at the Tuscaloosa complex (Bryce Hospital) and is expected to bring much needed relief to the interpreter shortage in that part of the state. She will also be coordinating interpreter coverage for the entire region.

Originally from Virginia, Sereta comes to Tuscaloosa, Alabama by way of Illinois with several stops along the way including Minnesota and Kentucky. Sereta spent the first part of her career working in post-secondary educational settings including New River Valley Community College in Virginia, Virginia Tech and the University of Minnesota.

For the past several years she has spent her time working in state government agencies serving the deaf population including the Minnesota Deaf and Hard of Hearing Services Division, the Office of Vocational Rehabilitation serving as the Interpreter Coordinator in Kentucky and the Kentucky Commission for the Deaf and Hard of Hearing serving as the Executive Staff Interpreter.

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FOCUS ON THE STAFF: **DAWN MARREN**



“Standing out” from the group by means of distinctive service is a manifest characteristic of Dawn Lackey Marren’s tenure as the Region I Interpreter for the Office of Deaf Services,” is how the citation for the 2008 Interpreter for the year award from the Council of Organizations Serving Deaf Alabamians reads. ODS Director Steve Hamerdinger was on hand to present the award.

Marren joined the Office of Deaf Services staff in May of 2005. She was previously in the role of interpreter at the Mental Health Center of Madison County before the position became a state position. In effect, she has been the mental health interpreter in Region I for more than 4 years. She is highly respected by those she works with and is the only member of the Office of Deaf Services staff to ever win the RESPECT Award, which is given annually by the consumers themselves and it is considered a tremendous honor by those of us who serve people with mental illness.

Hamerdinger called Marren “an emerging leader in the field of mental health interpreting.” She approaches her work with high level of positive energy and enthusiasm. “ I expect great things for Dawn in the years ahead,” he added. 

CAMPBELL SIGNS ON AS REGION II INTERPRETER

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Sereta is an approved Local Test Administrator (LTA) for RID and has spent the last few years administering the RID-NIC Written and Performance assessments to interpreters.

Sereta currently is RID CI/CT certified. She will be working on her QMHI certification. An avid runner, sports junkie and self-professed connoisseur of “chick flicks” , Sereta is married and has two sons, ages 12 and 8. 

ODS REPRESENTED AT NAD

The Office of Deaf Services had a very visible presence at the biennial convention of the National Association of the Deaf July 6 - 11, in New Orleans. Director Steve Hamerdinger and Region III coordinator Liz Hill, were in the Alabama delegation while BDU director Scott Staubach and Region I coordinator Wendy Lozynsky worked the exhibit booth.

Both Hill and Lozynsky were also presenters at the conference, which drew several thousands of deaf people from all over the country. Lozynsky spoke on the stigma of mental illness in the Deaf community and how it can be overcome. Hill talked about mental illness among deaf children and how services could be improved.

The ODS booth was well located near several highly popular exhibits for video relay services. This proved to be a blessing as many people were exposed to the services that the Alabama Department of Mental Health has. Alabama delegate Rann Gordon commented, “So many people told me how envious they were that Alabama had such good services.”



Wendy Lozynsky talks about Deaf Services at NAD

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SURDOPHOBIA!

FEAR OF DEAF PROFESSIONALS

By: GARDY VAN GILS

First printed in Dutch, in WOORD & GEBAAR, November 1997. yr 17, number 9. The original British spelling is retained. Reprinted with permission of author

"When a surdophobe must collaborate with deaf people on an equal footing, a fear mechanism is activated. Maybe it is the fear of having to render account to those whom you consider to be inferior." Thus states Gardy van Gils. Her presentation about surdophobia - fear of the deaf - had quite an impact recently at a conference on Mental Health and Deafness in Manchester UK. Below follows an integral version of her presentation.

I am thirty-one years old and I am deaf. I was raised bilingually by deaf parents and attended a school for the hard-of-hearing, which offered oral education. The last six years I have been working as a social worker specialised in support services for the deaf at GOUDT in Ede.

Last year I developed a training course for the staff of our institute, that provides support services for the deaf. The aim of that course was to closely examine collaboration between deaf and hearing people, in order to improve its quality. Experience had taught us that the collaboration within this organisation was not working well.

The discussions were fierce and many irritations were voiced like "When I am having a break, I don't want to sign for my deaf colleagues". At one point a woman at the end of the room stood up and said (in a tone of voice which implied - what are we talking about) "But the deaf are inferior to the hearing!"

A deadly silence followed. The hearing were all looking out of the windows, with a few exceptions, and the deaf participants, who were sit-

ting up front, looked at me, stupefied, indignant. I was completely taken aback. Such a remark in the nineties.... It could not be true. I thought it to be a very rude remark, and decided to ignore it.

However, her remark stayed with me. I thought that I had misjudged her statement, and should not have ignored it. She had the guts to say out loud what many hearing think but dare not say, although they do act like it.

While most hearing were thus staring out of the window, the woman looked me straight in the face and said, that she did not think much of me and my deaf colleagues, thus showing me the core of most hearing people's attitude: the deaf are inferior.

Similar scenes were flashing before my eyes. Fearful whites who were trying to exclude black students from an American university, even the army had to interfere. Whites who no longer dared go to the beach, because now it was open for black people.

Closer to home: men who for a long time denied women the right to vote, out of fear that those housewives would gain a voice in their important political affairs. Or women who were banned from authority in typically male professions, again out of fear that men would lose their power and status.

And even closer to home: the psychiatric aid to the deaf. You can spot it in the Netherlands and abroad in organisations where deaf people are minimally represented in the staff, and only work in functions that require little or no education. And that in organisations that provide services to deaf children, deaf adults and deaf elderly people!

"Usually it is mentioned in the official policy plan, that the organisation considers it of importance that there are deaf people employed. However, in practice that policy is not implemented. It is considered, but not executed."

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SIXTH MHIT A SMASH HIT

“MHIT is the single best and most comprehensive training I've ever attended. I cannot recommend this program strongly enough. It is an incredibly empowering and enlightening curriculum.”

The sixth annual Interpreter Institute of the Alabama Mental Health Interpreter Training project was conducted August 24 – 29 in Montgomery Alabama. Fifty-one interpreters attended the training at the Troy University at Montgomery campus as participants, including two deaf interpreters. The Interpreter Institute is 40-hour training.

This year's version was co-sponsored by Troy University, which is in the process of setting up Alabama's first four-year interpreter training program.

A stellar line up of speakers returned from last year, headlined by Dr. Robert Pollard and Robyn Dean of the University of Rochester Medical School and Roger Williams, Director of Services for Deaf and Hard of Hearing, South Carolina Department of Mental Health and Steve Hamerdinger, ODS Director. Several other Alabama DMH staff were on the faculty, including Carter English, PharmD., Charlene Crump, ODS Mental Health interpreter Coordi-



Rachel Naiman, attends to the discussion on how to interpret difficult concepts at the Deaf Interpreter's Roundtable.

nator, Brian McKenny and Deb Walker, Bailey Deaf Unit staff interpreters. A special program for deaf interpreters was conducted by Shannon Reese, Region II Coordinator and Amy Peterson, BDU Communication Specialist.

“Many experienced interpreters were part of this year's group, including several with significant mental health experience,” said Institute coordinator Charlene Crump. Carter English remarked that this was the best group he has had in his three years as an Institute instructor.

The participants were equally complimentary about the training. Dr. Laurel Standley of Huntsville, Alabama said, “MHIT is the single best and most comprehensive training I've ever attended. I cannot recommend this program strongly enough. It is an incredibly empowering and enlightening curriculum.” Thai Morris, from Atlanta Georgia, said, “This was the most beneficial and in-

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Robyn Dean discusses the Demand-Control Schema as Dawn Marren Interprets.

ON THE ODS BOOKSHELF



Hot Off the Presses: Important Articles You Must Read

(2008) Titus, Janet C., Schiller, James A., Guthmann, Debra. Characteristics of youths with hearing loss admitted to substance abuse treatment. *The Journal of Deaf Studies and Deaf Education* 13(3):336-350

The purpose of this study is to provide a profile of youths with hearing loss admitted to substance abuse treatment facilities. Intake data on 4,167 youths (28% female; 3% reporting a hearing loss) collected via the Global Appraisal of Individual Need-I assessment was used for the analyses. Information on demographics, environmental characteristics, substance use behaviors, and symptoms of co-occurring psychological problems for youths with and without a hearing loss was analyzed via Pearson chi-square tests and effect sizes. The groups reported similar backgrounds and comparable rates of marijuana and alcohol use. However, youths in the hearing loss group reported substance use behaviors indicative of a more severe level of involvement. Across all measures of co-occurring symptoms, youths with hearing loss reported greater levels of distress and were more often victims of abuse. Results of this study will help inform treatment needs of youths with hearing loss and define a baseline for future research.

(2008) Munro, L., Knox, M., Lowe, R. Exploring the potential of constructionist therapy: deaf clients, hearing therapists and a reflecting team. *The Journal of Deaf Studies and Deaf Education* 2008 13(3):307-323

This article explores the use of constructionist therapy with a reflecting team of hearing therapists seeing deaf clients. Using findings from two in-depth interviews, postsession reflections and a review of the literature, we propose that this model has the potential to cater to the diversity of the lived experiences of deaf people and also to address issues of power and tensions between medical, social, and cultural models of deafness. The interviews found there was real value in sharing multiple perspectives between the reflecting team of hearing therapists and these deaf clients. In addition, the clients reported feeling safe

and comfortable with this model of counseling. Other information that emerged from the interviews supports previous findings regarding consistency in interpreting and the importance of hearing therapists having an understanding of the distinctions between Deaf and hearing worlds. As the first investigation of its kind in Australia, this article provides a map for therapists to incorporate reflecting teams with interpreters, deaf clients, and hearing therapists. The value of this article also lies in providing a much needed platform for future research into counseling outcomes and the efficacy of this constructionist model of therapy.

Monzani D, Galeazzi GM, Genovese E, Marrara A, Martini A. Psychological profile and social behaviour of working adults with mild or moderate hearing loss. *Acta Otorhinolaryngol Ital.* 2008 Apr;28(2):61-6

In this study, an assessment was made of the global assumption that working adults with a mild to moderate sensorineural hearing loss experience more negative emotional reactions and socio-situational limitations than subjects with no hearing problems and that a deterioration of health-related quality of life on these specific domains would occur.



This feature highlights books that are being read by ODS and Deaf Services staff members around the state. Not all the books will be strictly about deafness and not all will be strictly about mental health, but all will help increase knowledge and understanding of how deaf people living with mental illness can be better served. Contributions are welcomed. Send your contributions to ODS in care of: steve.hamerdinger@mh.alabama.gov.

ODS, AIDB PARTNER FOR TRAINING

The Office of Deaf Services and the Alabama Institute for the Deaf and Blind collaborated to develop more teams in using the Signed Language Proficiency Interview in a three-day long training July 29 - 31 at the Montgomery Regional Center.

The training, which was designed to help the AIDB Regional Centers develop in-house evaluation teams, was conducted by ODS staff members Charlene Crump, Liz Hill and Amy Peterson. AIDB staff members attending were Benji Estes (Auburn), Cheryl Willis (Dothan), Linda Cole (Huntsville), Stacy Yarborough (Huntsville), Lisa Gould (Mobile), Ken Irving (Talladega) and Rosemary Guy (Talladega). Both AIDB and ALDMH make extensive use of SLPI in determining whether applicants have sufficient competency in American Sign Language to be effective in their jobs.

native-like signers. Since each SLPI candidate's performance is compared to this standard scale, not other candidates, the SLPI is a criterion referenced test. There are several possible levels or "grades" from "No Functional Skills" to Superior Plus. "Superior" generally means native-like or native signing skills.



Amy Peterson (Standing) and Liz Hill (seated) explain how to objectively evaluate sign language production.

“Since each SLPI candidate’s performance is compared to this standard scale, not other candidates, the SLPI is a criterion referenced test.”



Liz Hill (Standing) and Charlene Crump (seated left) conduct SLPI Training at AIDB Montgomery Regional Center.

This training was a project of the Mental Health Interpreter Training Project, which is funded by the Department of Mental Health pursuant the Bailey settlement. Funding is provided through the Mental Illness Planning Council.

The Sign Language Proficiency Interview (SLPI) Rating Scale is a standard scale for rating sign language communication skills that is based on highly skilled, knowledgeable





Liz Hill presents on children's services at NAD

ODS REPRESENTED AT NAD

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Hill was also elected to be one of the two people who represent the southeast United States on the Board of Directors of NAD. Region III encompasses Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virgin Islands, and Puerto Rico.

The Council of Representatives, essentially the legislative body of NAD, also voted to make mental health services for deaf people a top priority for 2009-2010. (See page 2.) *✍*

“Deaf people face such a tremendous gap in access to information.”

NAD APPROVES POSITION PAPERS

The National Association of the Deaf has approved two important position papers related to mental health services. Culturally and Linguistically Accessible Mental Health Services. Can be found at www.nad.org/atf/cf/%7bA2A94BC9-2744-4E84-852F-D8C3380D0B12%7d/Culturally%20Affirmative%20and%20Linguistically%20Accessible%20Mental%20Health%20Services.pdf. A new paper on services for deaf children can be found at www.nad.org/atf/cf/%7bA2A94BC9-2744-4E84-852F-D8C3380D0B12%7d/Mental%20Health%20Services%20for%20Children%20Position%20Statement.pdf.

NOTES AND NOTABLES

Region III Coordinator **Liz Hill** recently passed her test to become a licensed social worker. She is the first ODS staff person to become an LCSW. Congratulations! She joins **Dr. Frances Ralston** (psychology) and **Scott Staubach** (counseling) as licensed clinicians on the Office of Deaf Services staff.

Brian McKenny, staff interpreter at the Bailey Deaf Unit, passed his National Interpreter Certification test, the new combined NAD/RID testing system.

Last month **Judith Gilliam** became the first deaf QMHI. This month **Shannon Reese** passed the first part of her testing process to become a Certified Deaf Interpreter, putting her on track to become the second. We are excited to see more deaf people working toward QMHI status.

Steve Hamerding will give the Keynote Address at the NAMI Tennessee annual meeting on September 27th. He will address “What Deaf People With Mental Illness Need Now?”

CURRENT QUALIFIED MENTAL HEALTH INTERPRETERS

Becoming a *Qualified Mental Health Interpreter* in Alabama requires a rigorous course of study, practice, and examination that takes most people nearly a year to complete. It involves 40 hours of classroom time, 40 hours of supervised practice and a comprehensive examination covering all aspects of mental health interpreting.

- | | |
|-------------------------------|-----------------------------|
| Charlene Crump, Montgomery | Denise Zander, Wisconsin |
| Nancy Hayes, Hayden City | Brian McKenny, Montgomery |
| Dee Johnston, Oxford | Debra Walker, Montgomery |
| Lisa Gould, Mobile | Jill Farmer, Arley |
| Dawn Marren, Huntsville | Wendy Darling, Prattville |
| Pat Smartt, Sterrett | Lee Stoutamire, Mobile |
| Frances Smallwood, Huntsville | Cindy Camp, Jacksonville |
| Lynn Nakamoto, Hawaii | Roz Kia, Hawaii |
| Jamie Garrison, Wisconsin | Vanessa Less, Wisconsin |
| Kathleen Lamb, Wisconsin | Dawn Ruthe, Wisconsin |
| Paula Van Tyle, Kansas | Kathleen Bucher, Huntsville |
| Judith Gilliam, Talladega | Joy Menges, Ohio |
| Sandy Peplinski, Wisconsin | Stacy Lawrence, Florida |
| Linda Lonning, Wisconsin | |

POSITIONS AVAILABLE WITH DEAF SERVICES

OFFICE OF DEAF SERVICES

The Office of Deaf Services, Alabama Department of Mental Health and Mental Retardation, one of America's best mental health programs for Deaf and Hard of Hearing people, is recruiting for several key positions in both its community program and its inpatient program.

INTERPRETER,

Region III (Montgomery)

SALARY RANGE: 73 (\$33,241 - \$50,396)

QUALIFICATIONS: Combination of training and experience equivalent to a two-year degree plus three years of full-time experience interpreting in a variety of different settings. Must be licensed or eligible for licensure by the Alabama Licensure Board of Interpreters and Translators. Must be certified or eligible to receive certification as a QMHI (Qualified Mental Health Interpreter) or its equivalent. Certification must be obtained within 24 months of hire.

For more information on any of these positions, or for an application, please contact:

Steve Hamerdinger
Director, Office of Deaf Services

ADMH/MR

100 North Union Street

Montgomery, AL 36130

Steve.Hamerdinger@mh.alabama.gov

(334) 353-4701 (TTY)

(334)353-4703 (Voice)

DEAF SERVICES GROUP HOMES BIRMINGHAM

MENTAL HEALTH TECHNICIANS (Birmingham)

(\$16,242 to \$17,052 FULL TIME POSITIONS)

(\$7.80/hr PART TIME POSITIONS)

(\$7.00/hr RELIEF POSITIONS)

QUALIFICATIONS: High School Diploma or GED. Must have near intermediate plus signing skills in American Sign Language (ASL) as measured by a recognized screening process such as the SLPI and have a thorough knowledge of Deaf Culture. Must have a valid Alabama driver's license and car insurance.

For more information about the Birmingham positions, contact:

Malissa Cates, Program Director

JBS Mental Health/Mental Retardation Authority

956 Montclair Road, Suite 108

Birmingham, AL 35213

205-591-2212 (Voice)

205-591-2216 (TTY)

mcates@jbsmha.com

**MORE POSITIONS WILL BE ANNOUNCED SOON!
WATCH THIS SPACE.**

CULTURE SHOCK

Continued from page 4

hard of hearing patients than for the hearing. My BDU patients simply close their eyes when they don't like what I'm saying, and it is hard to pry eyes open!

Particularly shocking was the fact that simple psychiatric symptoms are not easy to discuss with deaf or hard of hearing patients. The concept of time, depression, mania and other symptoms that are relatively easy to discuss with hearing patients are often not easily translated or understood by deaf people.

One of the things I really love is the facial expressions and non-verbal body language used to communicate. It is not difficult to see what a deaf or hard of hearing person is feeling. They "act" it out when communicating. I heard/saw the director of BDU, Scott Staubach give a lecture recently. His non-verbal body language as he talked made the lecture much more interesting than the often monotone, straight faced talks hearing people give.



Scott Staubach (right) leads visitors through BDU as Charlene Crump (left) interprets.

I was asked to write about what I have learned as psychiatrist on the BDU. More accurate would be what I need to learn. At times I feel like a visitor in a foreign country. Fortunately, I have a tremendous staff to help educate me and it has been a wonderful life experience. I feel very fortunate to have this opportunity to know so much more about human communication and emotional expression.

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PLANT THERAPY TEACHES MANY LESSONS AT BDU

Continued from Page 4

they've always been extremely cooperative and calm while working with the plants.

Having the miniature garden has also lended itself to numerous educational tie-ins. Here are a few examples:

- A discussion of the voting process. Amy Peterson, our Communication Specialist, led the class in a vote to decide the colors the planter would be painted as well as the placement of the flowers. (The voting process is fairly unknown to our patients.) Amy led them through the process several times for several decisions that needed to be made.
- A discussion of the similarities between plants' transpiration and our respiration.
- Amy and I were also able to teach about the human lung and diaphragm, even making a "lung in a bottle" that demonstrated the breathing process. Amy later added classes that further explored the respiration theme with "A Smokers' Body", etc.
- A discussion of the similarities between plants' digestive system and ours. Amy and I were able to show the patients what animals and insects depend on nectar for food, explain how honey is created, etc.

Amy found a book called "My Garden Book" in which the patients

- have documented the changes in the flowers, measured them periodically,

etc. They have kept these booklets for over a month, keeping track of "their plant" (as they have a friendly competition going about whose plant will grow the fastest and biggest).

- Still planned are lessons that will discuss the similarities between plants' circulatory system and ours and one that compares the bloom of the flower in its complexity and diversity to the patients and how beautiful they are. (Part of that bulletin board will be an unbreakable mirror.)

The patients are very conscientious about watering and caring for the flowers. Every morning during Therapeutic Community Meeting there's a "Watering Responsibility Assignment" for the day. As the staff walk onto the unit every morning, we usually get a report from the patients on what bug was on what flower and what new bloom is opening. The patients have truly taken ownership of their miniature garden. They take pride in its growth, colors and beauty; they all are concerned about broken stems as well as new growth. When someone comes down and compliments the garden, they glow. Ask us how our garden grows over on BDU ... our patients would be thrilled to show you. *✍*



The daily records kept by the patients teach them several important skills, including math.

"The patients are very conscientious about watering and caring for the flowers. Every morning during Therapeutic Community Meeting there's a "Watering Responsibility Assignment" for the day.



Homemade visual aid that the communication team uses to teach respiration. Above left: inflated (inspiration). Right: deflated (expiration)

MENTAL HEALTH HIGH PRIORITY AT NAD

Continued from Page 2

A critical point is the expectation that services be provided in ASL. NAD's position is that this means direct therapy not through interpreters only. The Office of Deaf Services has traditionally been providing this through its regional offices.

According to the NAD Mental Health Position Paper, "These services should be provided by culturally and linguistically competent providers using appropriate support services." It goes on to define what this means.

The skills of culturally and linguistically competent providers, whether hearing, deaf or hard of hearing include:

Ability to communicate directly with deaf and hard of hearing individuals, frequently requiring fluency in American Sign Language, but may include other modes of signed or visual communication systems used by deaf and hard of hearing people, and;

Appropriate use of services and adaptive technology as is best identified and utilized by the consumer and his/her family members, including qualified and certified interpreters, assistive listening devices and real-time captioning services, and;

Intensive and extensive awareness of the cultural and linguistic differences, and psychosocial impact associated with hearing loss.

NAD's position paper was developed by a committee of experts in mental health and deafness from across the United States. The Department of Mental Health and Mental Retardation had input in its development.



CONSUMER LOOKS TO HOOK SPONSORSHIPS



David Giudice holds a seven pound bass caught recently. He is hoping to parlay a passion into a Pro Anglers career

David Giudice, one of the deaf consumers at the Madison County Mental Health Center has a passion. He is looking to fish on the Pro-Am Bassmasters circuit.

Giudice, who dreams of being a professional bass angler, has hooked sponsorship of the Mental Health Center of Madison County and looking to net additional sponsorships as well. The Office of Deaf Services is also playing a small role in helping him toward this dream.

Giudice is scheduled to appear in two events already, the Bassmasters Weekend Series September 12, at Lake Guntersville and then again at the Bassmasters Open, beginning October 13.

"I'm doing this to increase awareness of the need of more programs and services for the deaf," Giudice said. He is one of the few deaf people with mental illness who is active on the circuit. If you are interested in helping him achieve his drive write to him at Giudiced@yahoo.com.



"These services should be provided by culturally and linguistically competent providers using appropriate support services."

Surdophobia

Continued From Page 7

Whenever I ask the management why there are so few professional deaf people, they give me these plausible arguments. Usually it is mentioned in the official policy plan, that the organisation considers it of importance that there are deaf people employed. However, in practice that policy is not implemented. It is considered, but not executed.

There is more than meets the eye. This has to do with fear. You can smell their fear when you ask the managers why they don't adhere to their policy plans as formulated. This fear I call *surdophobia* - which means fear of the deaf.

As long as surdophobes come into contact with deaf people as clients, patients or pupils there is nothing to worry about. S/he can do her or his job, and exert his professional power. Just like the whites could tolerate the blacks as workers on their cotton plantations or as domestics - but they could not join them on the beach.

The moment a surdophobe must collaborate with deaf people on an equal footing, a fear mechanism is activated. Maybe it is the fear of having to render account to those whom you consider to be inferior.

I can see you thinking: Surdophobia - where does Van Gils get it? Well, maybe this is her answer to the diagnosis of surdophrenia of a couple of years back, which was coined to describe the supposedly aberrant personality structure of deaf people, which is so popular in mental health circles.

Are you still with me?

Let us consider the criteria for Surdophobia that I successfully submitted to the American Psychiatric Association. They have decided to integrate my classification in the next D5M edition. For those unfamiliar with this term: D5M-IV is a psychiatric classification system,

used by professionals in mental health to support the research into psychopathological and psychiatric disorders.

Surdophobia belongs to the so-called Anxiety Disorders. The diagnosis can be given when four of the following criteria are met:

- A. The person suffers from a clear and lasting fear of situations in which s/he must function on an equal level with deaf people, or must act in the company of the deaf or be judged by deaf people.
- B. The person has a discriminating, incorrigible bias toward the deaf: they are inferior people.
- C. The person has no insight into his own fear of the deaf.
- D. The person will try his utmost to avoid the abovementioned confrontation. This avoidance behaviour is manifested by rationalisation and denial.
- E. The person tried to infest his environment with his own fear that the deaf may become a danger if treated as equals. The invention of a psychiatric disease like 'surdophrenia' is clear proof of this.
- F. The person has a bloated sense of self-esteem when confronted with a deaf person in need of help.
- G. The person shows this behaviour minimally for six months and is incorrigible even when confronted with information about deafness or with deaf people who do not need help.

I think I am getting even closer to home now. I think I am almost inside, even almost on your lap. For those of you who are getting all warm and sweaty and who cannot bear my tale: please do not give in to

“As long as surdophobes come into contact with deaf people as clients, patients or pupils there is nothing to worry about. S/he can do her or his job, and exert his professional power. Just like the whites could tolerate the blacks as workers on their cotton plantations or as domestics.”

Next page please

evasive behaviour, do not run away – there is more to come.

There is hope for surdophobes!

I will be realistic. For those chronic surdophobes among us – and I mean those of you who have had this disorder for five years or longer – you have a long way to go, but a cure is not impossible.

The first step to health is *awareness*. That is the first, biggest and most difficult step. This step must be taken with a hearing therapist. The therapist should help the client to become aware of his disorder surdophobia. Contact with a deaf professional would seriously lessen the chance of success, since the fears of the surdophobe would increase and the patient would probably stop the treatment prematurely.

Once the client is aware of his surdophobia, he should work on how to handle his fears for the deaf according to the rules of behavioural therapy.

A behavioural therapist can tell you more about this than I can, but naturally a confrontation with a deaf person in an equal setting will be part of the treatment.

For instance, locking the client in an elevator with a deaf co-professional and subsequently shut it off for a couple of hours. The client must think of a plan, together with the deaf person, how to escape from this nasty situation. Of course there are other therapeutic treatments possible.

To be perfectly clear: everything you have just learned about surdophobia is completely fictitious – I made it all up. But – and I want to emphasize this – that does not mean that the phenomenon that I just described does not exist. The woman I quoted at the beginning of this article, articulated a bias of society as a whole. She said: “In the end the deaf are inferior to the hearing”. People think it and act upon it, but don’t say it. That, I think is the core of the problem. That is why there are so few deaf professionals active in mental health settings for the deaf.

With this presentation I hope to raise your awareness. Surdophobia is a sick mentality with a century old tradition, a psychiatric disorder that nowadays needs to be recognized and treated. In the meantime, I trust that in the near future more deaf people will be working within your organizations.



As I See It

Continued From Page 5

Sade’s story is not unique, of course. In fact, it is the norm, not the exception. Even here in Alabama, Sade would probably have “fallen through the cracks.” The continuum of options in Alabama for deaf people with mental illness is still pitifully small. Better than most, that’s true enough, but small all the same.

Everywhere, Deaf people languish in nursing homes and boarding houses, alone, afraid, and forgotten, because “that’s all there is.” They are denied culturally and linguistically appropriate placements because they “don’t fit the admission criteria.” They are dumped in cheap rooming house, squalid motels or on the street because “they are no longer psychotic” but there is no place for them to go where they can be around other deaf people. They are warehoused if they are passive. If they are assertive they are drugged up and restrained so as not to be a burden to the staff. Isolated and held incommunicado with no one and nothing to occupy their time except whatever world they have created in their own minds. And this “treatment” is called, “OK, good for us because that’s all there is.”

With a tightening economy and lean budget years coming up, it would be unrealistic to expect that all this will magically change. It would be irresponsible for me to suggest that there are easy solutions that will satisfy everyone. But we can do better. We can be sure that gains, hard won, are not lost. We can be quick to seize opportunities that arise that may be “different” and creative.

Being creative means stretching. It means thinking outside the box, to use an overused cliché. It means being willing to try something new. It’s past time to recognize that deaf services have to be approached differently. We are square pegs. We will never fit nicely in round holes. As I See it, it’s maybe it’s time to stop trying to make us fit



**St. Louis is the site of the exciting *Weaving Common Threads of Diversity*
Among Deaf and Hard of Hearing Adolescents Conference,**

October 5-8, 2008.

See: www.adara.org/pages/Adolescent_Conf/Call%20for%20Presentations%202008.pdf

INTERPRETER INSTITUTE A HIT

Continued from page 8



Roger Williams leads a role play activity that gave participants to apply theory to practice. Standing left to right: Roger Williams, Deborah Kunschik, June Walatkiewicz, Lee Stoutamire, Liz Hill

tense training I have ever experienced.” Charlene Edwards, of Godfrey, II, said, “For those who have never experienced MHIT, I would highly suggest you go!! [ODS is a] great organization with big hearts for those in our community.”

The training consisted of lecture, role play and experiential activities. The overall goal is to help interpreters move from a technical view



Debriefing after the “Hearing Voices” activity. This gave the participants a simulation of what people who have auditory hallucinations experience. Kathy Seifried (standing center) led the exercise.

of the profession of interpreting to a practice professional view, which is a necessary adjustment to make in mental health settings. To this end there was much focus on the Demand-Control Schema of interpreting and how to apply it mental health work. “MHIT was one of the most intensive and most organized trainings I have attended. The wealth of information and resources I gained from MHIT will definitely allow me to work in mental health settings with a solid knowledge of what to expect while working with clients and clinicians,” said Sereta Campbell of Alabama.

A highlight is the “Hearing Voices” activity, which simulates what consumers with auditory hallucinations experience. The goal of the activity is help professionals develop better understanding of the challenges that people with mental illness face. The participants were impressed. One participant remarked that she would never again assume a person with mental illness was “just being difficult.” “I get it now!” was a common reaction.

For deaf interpreters, the CDI Roundtable gave them a chance to exchange ideas and techniques. Deaf interpreting is a highly specialized subset of Sign Language interpreting. Native signers, who are usually deaf themselves, are trained with work with language deprived deaf people using a visual gestural mode. All of the participants in that session were experienced working as deaf interpreters, so the session was a brainstorming session. Nevertheless, out of state participants were impressed with the work done in Alabama.

The Interpreter Institute is made possible by a grant from the Mental Illness Planning Council and is considered one of the crown jewels of the Office of Deaf Services. The Mental Health Interpreter Training Project also conducts periodic training events throughout the year, including training for deaf interpreters.

“The wealth of information and resources I gained from MHIT will definitely allow me to work in mental health settings with a solid knowledge of what to expect while working with clients and clinicians.”



Addressing

the Needs of Students

Labeled Deaf & Low Functioning,
At-Risk or Deafblind

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DARS, Division of Rehabilitation Services
Office for Deaf and Hard of Hearing Services (DHHS)



Session ID: 317357

The "Addressing the Needs of Students Labeled Deaf and Low Functioning, At-Risk or Deafblind" Conference is scheduled for November 20-22, 2008 in Houston, Texas. It will be located at the Intercontinental Houston Hotel next door to the beautiful Galleria and hundreds of beautiful shops, restaurants and tourist attractions. This conference will be the fifth such conference which brings people together from across the nation to address the unique needs of persons who are deaf or deafblind and have additional challenges to reaching their life goals.

With an expected 500 attendees coming to this event, it will be an opportunity to learn from those who work directly with this population, to network and exchange ideas, strategies and resources with others and to acquire new skills. Presenters will include Dr. Bobbie Beth Scoggins, Dr. Greg Long, Dr. Neil Glickman and Dr. Mike Kemp.

Registration materials are available and can be obtained by contacting Theresa Johnson at tjohnson@esc4.net. Come to Houston to learn, shop for the holidays and network with others.