

Signs of Mental Health

4 Planes
17 Time Zones
15,399 KM

Yes, It Was Worth It!

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



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HOLD THE DATES!

2013 Interpreter Institute Dates Announced

August 5–9, 2013

Montgomery, Alabama

Details will be announced as available at:

www.mhit.org

Register Now!

The past two classes have all filled up by April 1st. If you are planning to attend, get your registration in ASAP.

Registration form will be posted on the website

Editor's Notes



Sometimes, issues write themselves. Other times it is hard to come up with interesting stories. This time, the stories fell into our laps with two great contributions from friends of ODS. Minnesota state coordinator of Deaf Services, John Gournaris, contributed the story on developing an ASL-based peer support curriculum that appears on page 4.

His Kentucky counterpart, Michelle Niehaus, who was also on the faculty of MHIT last year, contributed a piece about developing peer-mentoring groups for mental health interpreters.

Nicole Maher, from Melbourne, Australia came to MHIT last year. She was impressed with the training and wrote to tell us about it. We were glad to have her!

Speaking of MHIT, by the time you get this the 2013 Interpreter Institute brochure will be up and ready for you to download. Go to www.mhit.org and look for the link there.

Finally, we want to wish all our readers a blessed Holiday Season and a wonderful new year. Join our next edition when we celebrate our 10th birthday! ✂

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On The Cover:

On the Cover: Left to Right: Beverly Johnson of the Department of Mental Health and Nicole Maher, an Australian Sign Language (Auslan) Interpreter from Melbourne, Australia, take part in the "Hearing Voices" Activity at the 2012 Interpreter Institute. Maher's story can be found on page 8



National Association of the Deaf Releases Foster Care Position Paper

The National Association of the Deaf (NAD) formally adopted a new *Position Statement on Quality Foster Care Services Continuum for Deaf Children*, at their 2012 conference in Louisville, Kentucky in July.

Deaf children require foster care that is both linguistically and culturally accessible, including appropriate medical, psychological, educational and mental health services. This position paper is intended to provide a road map for all professionals and agents who work within the foster care system to ensure the appropriate provision of referral and care services to deaf children.

The purpose of this Position Statement is to underscore the importance and need for quality foster care services for children who are deaf. This includes effective communication, awareness of cultural issues, and best practices in the delivery of foster care services to this unique population.

NAD recognizes that foster care placement is an essential service for children who are abused and neglected. Foster care for deaf children entails a comprehensive approach that addresses their physical, cognitive, socio-emotional, cultural, language and communication needs within a supportive family setting until the family can be reunited or adoption can occur.

Like most children, deaf children who are abused, abandoned or removed from their families or caregivers may experience deep emotional scarring, uncontrollable anger, trust issues and attachment disorders. Compassionate, accessible and highly specialized services are needed for children who are deaf and for those who may also have other disabilities such as visual impairment or blindness, cognitive disabilities, learning disabilities, autism spectrum disorders, emotional disturbances, physical disabilities or a combination of several disabilities.

The NAD firmly believes that foster care providers and professionals must understand the language and cultural issues of these children in order to effectively address their unique needs. Such understanding is necessary to identify whether or not children who are deaf may be suffering from chronic depression, feelings of despair and hopelessness, suicidal tendencies, and attraction to gangs, drugs, or other criminal activity that may result in homelessness, juvenile detention, jail, or prison (Vernon, 2010).

The NAD urges that foster care providers and professionals follow ten specific guidelines to provide an accessible and appropriate foster care placement for deaf children. Along with the ten guidelines above, foster care providers and professionals must be attentive to certain potential risk factors, such as high rates of sexual, physical and emotional abuse, language deprivation, and poorer school attendance.

For More Information:

[Access the full document, go here](#)

[See also the NAD position paper on Mental Health Interpreting](#)

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Alabama Peer Support Specialist Boosts ASL Peer Support Curriculum

By John Gournaris, Ph.D. (With additional reportage from SOMH editorial staff)

Michelle Williams, a deaf Alabamian who is a Certified Peer Support Specialist, participated in a two-day instructional design task force group working to develop a curriculum taught in American Sign Language on September 17 and 18, 2012 in St. Paul, Minnesota. The event was hosted by John Gournaris, the Director of Minnesota Department of Human Services, Deaf and Hard of Hearing Services Division (DHHS) Mental Health Program, who co-lead the task force with [ZenMation](#) owner and president, Peter Zenner.



Michelle Williams being recorded telling her recovery story which will be used in the ASL Peer Support Training curriculum.

Williams currently works in the Civitan House in Clanton, Alabama (see page 4 of the [spring edition of the Signs of Mental Health, volume 9, issue 1](#)). In addition to Williams, Terrell Jacques, who works as a full-time Certified Peer Support Specialist with the South Carolina Department of Mental Health was also on hand. Several other individuals were invited to participate. Michelle Niehaus, Mental Health Program Administrator and ADARA President-Elect from Kentucky, was invited to participate due to her interest in creating a culturally affirmative curriculum for peer support in her state. The instructional designers staffed by ZenMation, Patty Gordon and Margaret Endres, were also part of this group. Trudy Suggs of T.S. Writing Services was contracted by ZenMation to provide ASL translation services for videos.

There are several training programs and curriculums across the United States specializing in Peer Support Services that teach individuals in recovery to become peer support specialists. After these individuals complete intensive training



Peter Zenner, owner and president of ZenMation, a Minneapolis based multi-media company, described how the use of various technologies will be incorporated into the curriculum.

and pass approved competency tests they will become Certified Peer Support Specialists and are then able to seek employment providing recovery education and peer support in various community mental health programs.

However, the available training curriculums are not designed to accommodate the unique training needs of individuals who are deaf, deafblind, and hard of hearing and whose preferred language is American Sign Language (ASL). Nor are they able to capture the unique lived experiences of this community. As a result, there are only a handful of deaf individuals who have undergone Peer Support Services training to date despite the increased attention to peer



Deaf Certified Peer Support Specialists, Michelle Williams and Terrell Jacques (left), consulted the task force group on how the curriculum can be more tailored for deaf persons based on their personal experiences. (Patty Gordon, pictured right).

support services at the national level. Two of these deaf individuals are from Alabama. (The other is Lonnie Wright, profiled on page three of the fall edition of [Signs of Mental Health, volume 8, number 4.](#))

The pioneering group of Certified Peer Specialists had the added burden of trying to "fit" into the existing, audiocentric training programs. These individuals had to go through five days using interpreters, an exhausting process that is hard on the eyes and the mind. As part of the training curriculum, they also interacted with hearing peers during groups and breakout sessions, during which they were expected to share their thoughts, feelings, and recovery stories. A common reaction from deaf individuals was that they often felt out of place in those discussions as their experiences were so different.

ACG training curriculum, the purpose of this task force meeting was to preserve ACG's training model and to adapt it into a culturally affirmative curriculum using relevant deaf-related materials including recovery stories about deaf individuals. This task force meeting also helped to determine how the blended learning approach should look for this curriculum and to maximize the use of technology. Deciding which training materials to keep, adapt or add and determining which training materials to be put in ASL videos were also discussed. The blended learning approach for this curriculum will be a combination of ASL videos, reading, and group discussions via videoconferencing with a live facilitator. Upon the completion of this training, participants will be eligible to test for certification in their own states.



Front row (from left to right): Michelle Niehaus, Trudy Suggs, John Gournaris, Michelle Williams, and Terrell Jacques.
Back row (from left to right): Peter Zenner, Patty Gordon and Margaret Endres.

The [Appalachian Consulting Group](#) (ACG) has given DHHS permission to adapt their Peer Support Training curriculum and its training materials into ASL. The adapted curriculum will have videos in ASL with captions and voice-over audio. The course modules and its materials also will include English text as a means of accessing the information in another format. The goal is to build a web-based online course. The ultimate goal is to develop a national curriculum to train individuals who are deaf, deafblind, or hard of hearing who also have psychiatric diagnoses and currently in recovery to become Certified Peer Support Specialists with minimal traveling. It is believed that an ASL curriculum will benefit this group because it will be customized to fit their needs, language, and learning styles - a culturally affirmative curriculum. This approach will provide an opportunity for participants to create a network of other deaf Certified Peer Support Specialists.

Because this adapted curriculum will be modeled after the

Considering the cultural issues of this population group, a specialized curriculum that trains deaf, deafblind, and hard of hearing individuals who are in recovery must be delivered primarily in ASL. During the two-day meeting, Terrell Jacques and Michelle Williams not only shared their experiences of going through all-hearing ACG training but also were filmed telling their recovery stories which will be used in the curriculum.

While this curriculum is currently in the preliminary stage as of this writing, it is hoped that this project will be completed no later than March 30, 2013. This curriculum holds great promise in bringing the peer support movement into the Deaf Community by producing more deaf Certified Peer Support Specialists in their home states. This would help to achieve one of the [34 research priorities](#) developed by the NASMHPD Consensus Planning Group: creating peer support programs for deaf persons throughout the United States and evaluating these programs for their outcomes.

Helpful Hints for Developing Peer Consultation Groups in Your State!

By Michelle Niehaus, LCSW

After our discussion at MHIT, I thought of many things I wish I'd shared during the workshop. Here are some helpful hints for establishing and maintaining peer consultation groups in your home state.

1. Building trust does take time!

Several of you had valid concerns about confidentiality and being judged by your peers. This kind of work does require a paradigm shift and changing how we think and talk about ourselves and others. In Kentucky, we started with general workshops about interpreting. Many focused on the concepts taught by Pollard, Dean, and Williams. We then did "speed mentoring," a concept by Karin Lewis, PhD, a Kentucky interpreter. Participants rotated through dyadic discussions about ethical dilemmas in common interpreting scenarios. Offering this workshop several times allowed people to begin thinking about their fellow interpreters as potential mentors and brought home the concept that we all have things to teach and learn from one another; it doesn't have to be hierarchical. By the time we got to offering peer consultation groups, people tended to have started the process of the paradigm shift and could talk about their work in a different way.

2. Consider inviting a mental health professional to join.

My training is in social work. I bring that perspective along with the ability to facilitate the group. Having the provider perspective sometimes contributed to the range of demands and controls considered when sharing cases. It can also build mutual understanding and enhance the relationships between providers and interpreters rather than allowing adversarial relationships to perpetuate.

Your group can be composed of whoever you wish. The composition of members will change the dynamics and you may decide to have an "open" group where attendance fluctuates or a "closed" group where members commit to attendance and new entries are not permitted. Each has its pros and cons.

3. Consider the level of expertise and experience desired.

Our original preference was to have interpreters skilled in mental health work and experienced in using the demand-control schema. Most often we get a mixture of some people newer to the field and some more seasoned. Some know about DCS and some do not. The mixture allows for rich discussion about different ways of seeing things and, hopefully, is a gentle way to continue bringing about the paradigm shift. Seasoned interpreters do need to be mindful of their perceived power and recognize that their opinions will carry more weight with newer professionals. In these situations, it's hard to stay in the process of examining controls and not giving solutions or "shoulds." Remember it's your job to listen and guide, not to solve or tell.

4. Ask for state or other support.

We are able to provide free CEU's for each peer consultation group in Kentucky. Work with your local state agencies (OVR, Mental Health, Education, etc) to see if they can provide CEUs for you. Kentucky Registry of Interpreters for the Deaf also works with our department to give an annual rate for which we can provide as many trainings as we want. This partnership has benefitted everyone!

5. Establish ground rules and stick to them.

It is vital to have trust. Establishing ground rules about how you refer to individuals, what is expected when one interpreter knows who you are talking about, and even developing reminders or cues can help. For example, find ways to redirect with humor or gentleness when others start to "should" all over each other. We are not seeking right and wrong; this process involves "living in the questions" and practicing how to use uncertainty and complicated situations to grow as professionals and to enhance service delivery.

6. Keep the conversation productive and uplifting.

If used as venting session, peer consultation can easily become an "Us vs. Them" situation. That is not the goal. Likewise, interpreters can feel vulnerable sharing situations where they feel like they may have made a mistake or wrong choice. Peer consultation is about affirmation and skill building; use the strengths

perspective to see how you can use feedback to build on what an interpreter is already doing well.

If a particular agency or provider continually gets “called out” or discovered based on the discussion, consider how you could work together to address the issue rather than bad-mouthing and not acting. This would, admittedly, be a more liberal control! Hopefully it would be more productive than complaining and not resolving. Learning how to live with the many dimensions of your work can also be a benefit to peer consultation.

At the same time, mental health work can be emotionally draining. If someone needs to debrief and get support, the group could (with mutual agreement) be a safe environment to have that discussion. Self care is critical for sustaining practice professionals. Modeling this could also be done by a member / facilitator who is a mental health professional.

7. Evaluate the process and adapt as needed.

Not every group will be the same. Allow for that. Take time at the end of each session not just to do the required RID evaluation but to discuss with one another what did and didn't work about the process. If you are using a certain format, be willing to adapt it to fit your changing needs. Just as interpreting is a practice profession, so too is the process of consultation! ✍

Michelle Niehaus, (shown here leading a session at the 2012 Interpreter Institute) is the Statewide Coordinator/Program Administrator for Deaf and Hard of Hearing Services with the KY Department of Behavioral Health, Developmental, and Intellectual Disabilities. She provided direct mental health services at Deaf Network in Indiana and Seven Counties Services in Louisville, KY. She serves as a Commissioner with the Kentucky Commission on the Deaf and Hard of Hearing and on several statewide committees to improve Deaf and Hard of Hearing Services. Michelle also teaches an online course on Culturally Affirmative Behavioral Healthcare through the Eastern Kentucky University psychology department. Education and advocacy to grow and improve services are her passions.



Statewide Needs Assessment Includes Deaf Consumers Turns Up Interesting Results

The Department of Mental Health has been undertaking a statewide needs assessment for substance abuse as part of its strategic planning. That's not unusual.

What's unusual is the lengths to which the department, and its consultant, Collaborative Research, have gone to be sure that deaf and hard of hearing people, as well as people with limited English proficiency, are included in the survey.

Early on, Collaborative made the decision to hire surveyors who were themselves deaf to go into the deaf community. This is consistent with known best practice in minority research (Pollard, 1992). Surveys were conducted at various deaf community events around the state over a three-month period of time. This methodology produced some very surprising findings.

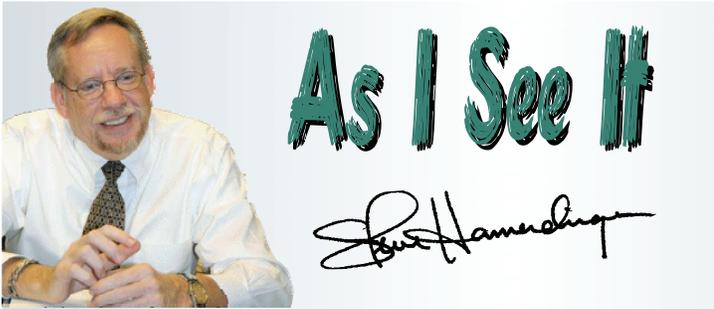
The first surprise was how forthcoming deaf people were when the interviewers were deaf. This resulted in a high rate of return. A much larger percentage of deaf people responded to the survey compared to the total population of deaf people served than any other group surveyed, including English-speaking hearing people.

The second surprise was how often American Sign Language was mentioned as primary language of the home among all respondents of the survey: 1.1%. Since the prevalence of deaf people being served by ADMH programs is no greater than the prevalence of deaf people in the nation at large (1.9 per 1,000) this was very surprising. Why this is awaits further analysis.

Another big surprise was how aware of mental health services the deaf community was. Far more so than any other non-English speaking group and, in most cases, the deaf respondents were also more aware of services than English-speaking hearing respondents. Whether this is a result of sample bias or higher than usual saturation of community education efforts, this finding has no precedent in any previous research.

Some of the results reported so far have reinforced other research. Co-occurring substance abuse and mental illness was reported by over 60% of the respondents. Very high use (and preference for) ASL fluent clinicians was reported. The respondents named the lack of specialty services as the

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Random thoughts developed for a speech no one will remember given at a conference attended by too few people who able or in a position to do anything about those thoughts. Nevertheless, play along at home...

- What if isolating deaf or other non-English speaking consumers in programs where they had limited or no contact with others who speak their language were considered a human rights violation by the Center for Medicaid Services and the federal Department of Education?
- What if the strongest language models (i.e. deaf teachers who are themselves deaf, and master interpreters) worked with kindergarten and first grade deaf children instead of high school academic stars?
- What if program certification for mental health services were contingent on recognizing that interpreters were not equal to providers fluent in the language a particular consumer preferred to use and providing interpreters only for part of the time a consumer was "receiving services" was considered *prima facie* evidence of discriminatory treatment?
- What if state schools for the deaf embraced the mission of providing residential treatment services instead of pretending that there are no deaf kids with serious emotional or behavioral disturbances on their campuses? While we are at it, what if state schools for the deaf were magnet programs instead of dumping grounds?
- What if failure to provide linguistically accessible services *at the same level and for the same amount of time* as provided to English-speaking people were considered to be "mistreatment" and/or neglect?

Continued on page 14)

Aussie Sign Language Interpreter Describes Her Experiences at MHIT



*Nicole Maher Professional
Auslan Interpreter
NAATI Level 3*

Fifteen thousand three hundred and ninety nine kilometers, four planes and 17 time zones later, I arrived in Montgomery, Alabama for the 10th Mental Health Interpreter Training (MHIT) and somehow I lost a Saturday!

A learned colleague sent me the website and I was beyond excited as there is nothing on offer in Australia like this course.

The course program was extensive and surpassed all of my expectations. It challenged, enlightened and confirmed my own current practice.

In particular it highlighted the importance of a Multi Disciplinary Team approach when working with consumers. As this approach results in optimal outcomes for both service users and professional alike.

Charlene Crump introduced me to the term 'Dysfluent'; etiological considerations of deafness and the implications both may have on the interpreting process. This information was new to me and has made me reassess my interpreting in a range of settings, including Mental Health.

Group role play unpacked Robyn Dean's and Bob Pollard's 'Demand Control Schema', an informative tool which helps prepare you for the unknown during assignments, by outlining possibilities into four categories before hand, namely the 'EIPI' demands. I recently used this tool with a colleague experienced in DCS, which resulted in more confidence, reportedly a clearer interpretation whilst decreasing the occurrence of the unknown.

Bob Pollard clearly demonstrated the importance for the interpreter to report all linguistic information present to the medical professional, inclusive of changes in eye gaze, eyebrow raises and all other linguistic information that at times only the interpreter will notice. This is imperative for the medical professional to make an appropriate mental health diagnosis.

Robyn Dean's suggestion of Community Interpreters aligning themselves away from the confines of the technical Conference Interpreter and more towards the model of

(Continued on page 10)



Important Articles You Must Read

Cabral L, Muhr K, Savageau J. (2012) Perspectives of People Who Are Deaf and Hard of Hearing on Mental Health, Recovery, and Peer Support. *Community Mental Health J.* 2012 Nov 13

This qualitative study sought to better understand the experiences of deaf and hard of hearing individuals with accessing recovery-oriented mental health services and peer support via a focus group and interviews. Cultural brokers were used to facilitate culturally-sensitive communication with study participants. Findings indicate that access to adequate mental health services, not just recovery-oriented and peer support services, is not widely available for this population, largely due to communication barriers. Feelings of isolation and stigma are high among this population. Public mental health systems need to adapt and expand services for various cultural groups to insure recovery.

Embree, J. (2011). *Wright State University-Suicidal Behavior, Language Acquisition, and Deafness: Evaluating the potential relationship between age of language acquisition and prevalence of suicidal behavior in a Deaf population with co-occurring substance use disorder.* Applied Behavioral Science: Criminal Justice and Social Problems (thesis paper)

<http://etd.ohiolink.edu/view.cgi/Embree%20Jared%20A.pdf?wright1310159367>

Since 2008, the Deaf Off Drugs and Alcohol (DODA) Program has provided culturally appropriate cessation and recovery support services via e-therapy to Deaf/HH individuals with a clinically diagnosed substance use disorder (SUD). The information collected by the DODA program presented an opportunity to study the relationship between delayed language acquisition and suicidal ideation and attempts in a population that has historically been understudied, yet has increased prevalence in both suicidal behavior and significantly delayed language acquisition compared to the general population. Of the 107 prelingually Deaf consumers in the program, 18 reported language acquisition later than age ten. This study proposed that manifestations of this delay may contribute to known risk factors for suicidal behavior as well as adaptive communication in the form of suicidal gestures and parasuicide. As hypothesized, the lifetime prevalence of suicide attempts increased with substance use

disorder or mental illness. Suicide attempts were also higher in this sample than studies suggest with comorbidity of substance use disorder and co-occurring mental illness. Each of these factors was amplified among those participants with significantly delayed language acquisition. Although caution should be exercised when comparing these results with the hearing population, they underscore the need for increased attention and further inquiry.

Gournaris, J., Hamerdinger, S., and Williams, R. (2010). Promising Practices of Statewide Mental Health Models Serving Deaf Consumers: How to Advocate For Your Model in Your Home State. *Journal of the American Deafness & Rehabilitation Association.* 43 (3), 152-182.

This article provides comprehensive information on how to develop a successful statewide mental health model serving deaf consumers. The article also covers three different statewide models currently in operation in Minnesota, South Carolina, and Alabama, including information about how each program was implemented. The successes, similarities, and differences of each model are analyzed and the information on how to establish and advocate for a statewide mental health model in your home state is discussed.

Gournaris, J. (2009). Preparation for the Delivery of Telemental Health Services with Individuals who are Deaf: Informed Consent and Provider Procedure Guidelines. *Journal of the American Deafness & Rehabilitation Association.* Vol. 43(1): 34-51.

Telemental health continues to emerge as the new wave of the modern health care delivery system, and psychotherapy sessions will routinely take place with geographically distant therapists and clients who are deaf or hard of hearing. Consequently, there is a critical need for best practices for such services including the development of informed consent and provider procedure guidelines for the telemental health delivery system serving this population. Sample informed consent forms and telemental health service guidelines are provided.

Brunnberg, E., Boström, M., and Berglund, M. (2008). Self-Rated Mental Health, School Adjustment, and Substance Use in Hard-of-Hearing Adolescents. *Journal of Deaf Studies and Deaf Education.* 13:324-335.

This survey, "Life and Health—Young People 2005," included all 15/16-year-old adolescents in mainstream schools in the county of Örebro, Sweden. Just students with a slight/mild or moderate hearing loss were included.

(Continued on page 10)

Aussie Sign Language Interpreter Describes Her Experiences at MHIT

(Continued from page 8)

'Practice Professionals' was thought provoking, whilst emphasizing that both are of equal validity however practice professionals deal with humans which depends on how well you interrelate with people and engage in the process.

I have barely covered my experience at MHIT as there was simply too much to cover in a few words. I look forward to informing my colleagues via a workshop imparting some of what I have learnt and will definitely encourage Australian interpreters to make the long journey to Alabama as the training was invaluable and the hospitality afforded to me as a visitor made it equally worthwhile. ✂

Ed. Note: Nicole is from Melbourne, Australia. We were thrilled to have her

The Lighter Side...

Hearing People Cant Stand Silence, so we learn in this [Daily Mail article](#). The longest that anyone has survived in the 'anechoic chamber' at Orfield Laboratories in South Minneapolis is just 45 minutes.

It's 99.99 per cent sound absorbent and holds the Guinness World Record for the world's quietest place, but stay there too long and you may start hallucinating.

'When it's quiet, ears will adapt. The quieter the room, the more things you hear. You'll hear your heart beating, sometimes you can hear your lungs, hear your stomach gurgling loudly. Obviously, this experiment was not conducted using deaf people! We don't think it would bother us a bit. ✂

On the ODS Bookshelf

(Continued from page 9)

There were 56 (1.9%) "hard-of-hearing (HH) students with multiple disabilities," 93 (3.1%) students who were "just HH," 282 (9.7%) students with some "other disability than HH," and 2,488 (85.2%) students with "no disability." "HH with multiple disabilities" reported considerably higher scores for mental symptoms, substance use, and school problems than the "no disability" group. Those with "just HH" and those with "other disability than HH" had more mental symptoms and school problems than the "no disability" group but no significant differences in substance use. In conclusion, the combination of a hearing loss and some other disability strongly increases the risk for mental symptoms, school problems, and substance use. This group, thus, is an important target for preventive measures.

Turner, O., Windfuhr, K., and Kapur, N. (2007). Suicide in deaf populations: a literature review. *Annals of General Psychiatry*. 6:26.

Studies have found that deaf individuals have higher rates of psychiatric disorder than those who are hearing, while at the same time encountering difficulties in accessing mental health services. These factors might increase the risk of suicide. However, the burden of suicidal behavior in deaf people is currently unknown. The aim of the present review was to provide a summary of literature on suicidal behavior with specific reference to deaf individuals. The objectives of the review were to establish the incidence and prevalence of suicidal behavior in deaf populations; describe risk factors for suicidal behavior in deaf populations; describe approaches to intervention and suicide prevention that have been used in deaf populations.

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 practica and a comprehensive examination covering all aspects of mental health interpreting. (Alabama licensed interpreter are in Italics)

Charlene Crump, Montgomery
Denise Zander, Wisconsin
Nancy Hayes, Remlap
Brian McKenny, Montgomery
Dee Johnston, Talladega
Debra Walker, Georgia
Lisa Gould, Mobile
Gail Schenfisch, Wyoming
Dawn Vanzo, Huntsville
Wendy Darling, Prattville
Pat Smartt, Sterrett
Lee Stoutamire, Mobile
Frances Smallwood, Huntsville
Cindy Camp, Piedmont
Lynn Nakamoto, Hawaii
Roz Kia, Hawaii
Jamie Garrison, Wisconsin

Vanessa Lacey, Wisconsin
Kathleen Lamb, Wisconsin
Dawn Ruthe, Wisconsin
Paula Van Tyle, Kansas
Joy Thompson, Ohio
Judith Gilliam, Talladega
Stacy Lawrence, Florida
Sandy Peplinski, Wisconsin
Katherine Block, Wisconsin
Steve Smart, Wisconsin
Stephanie Kerkvliet, Wisconsin
Nicole Kulick, South Carolina
Rocky DeBuano, Arizona
Janet Whitlock, Georgia
Sereta Campbell, Tuscaloosa
Thai Morris, Georgia
Lynne Lumsden, Washington

Tim Mumm, Wisconsin
Patrick Galasso, Vermont
Kendra Keller, California
June Walatkiewicz, Michigan
Teresa Powers, Colorado
Melanie Blechl, Wisconsin
Sara Miller, Wisconsin
Jenn Ulschak, Tennessee
Kathleen Lanker, California
Debra Barash, Wisconsin
Tera Vorpal, Wisconsin
Bridget Bange, Missouri
Julayne Feilbach, Wisconsin
Sue Gudenkauf, Wisconsin
Tamera Fuerst, Wisconsin

Positions Available In Deaf Services

DEAF CARE WORKER (Tuscaloosa) SALARY RANGE: 50 (\$21,722.40 - \$30,724.80)

Works primarily in a specialized psychiatric unit providing care, habilitation, and rehabilitation of deaf and hard of hearing (D/HH) patients with co-occurring disorders of mental illness and chemical dependency in a state mental health hospital. Performs basic nursing care and assist patients with personal hygiene and activities of daily living. Observes patients closely and documents patients' physical and mental condition. Maintains the security of patients. Accompanies patients off unit to hospital activities, functions, and off hospital grounds to medical appointments and field trips. Communicates with D/HH patients in sign language. Performs assigned work under supervision of professional nurses and LPNs with instructions from physicians. Performs related work as required.

NECESSARY SPECIAL REQUIREMENTS: Must be 18 years of age. Graduation from a standard high school or GED equivalent. Possession of a valid Alabama Driver's License. Proficiency in American Sign Language (ASL) at "native" or near "native fluency" level of signing skills as measured by a recognized screening process, such as SLPI/SCPI at the "Advanced" level or higher.

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

Steve Hamerdinger, Director, Office of Deaf Services
Alabama Department of Mental Health
100 North Union Street
Montgomery, AL 36130
Steve.hamerdinger@mh.alabama.gov
(334) 239-3558 (Voice/VP)

Deaf Services Group Homes

MENTAL HEALTH TECHNICIANS (Birmingham area) (\$8.00/hr Part-Time \$7.50/hr Relief)

QUALIFICATIONS: High School Diploma or GED. Must have 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 Galliher, MACN
Director of Deaf Services
JBS Mental Health Authority
604 27th Street South
Birmingham, AL 35233
205-380-4367(Voice)
205-623-0361(TTY)
mgalliher@jbsmha.com

MENTAL HEALTH TECHNICIANS *Deaf Services Group Home (Clanton, AL)* SALARY RANGE: Competitive

Positions Available: On Day, Evening, and Night Shifts
Candidates must possess proficiency in American Sign Language

Duties:

Provide personal, direct care for consumers with mental illness diagnosis who are also deaf or hard-of-hearing.

1. Pass medications under the direction of a Medical Assistance LPN.
2. Provide transportation to day habilitation and/or consumer appointments.
3. Provide basic living skills training and assistance.
4. Provide communication assistance to the consumers through the use of Sign Language or language of the consumer's preference. Ensure that consumers have access to assistance by a qualified interpreter.
5. Maintain policy of confidentiality.

Qualifications:

- High School Diploma or equivalent required
- Current AL Driver License and safe driving record
- **Fluent in Sign Language as demonstrated through the Sign Language Proficiency Interview. A score of Intermediate Plus level or greater is required.**
- Prior experience serving clients who are deaf or hard-of-hearing preferred.
- Prior experience working with clients with mental illness or intellectual disabilities preferred.
- Excellent customer service skills and professionalism required.

For more information go to [application webpage](#) or contact

Lori Redding, MHA
Director of Human Resources
Chilton-Shelby Mental Health Center
lredding@chiltonshelby.org
office: 205/668-4308
cell: 205/310-6706



**Alabama Department of Mental Health-Office of Deaf Services
ADARA and Gallaudet University Regional Center Southeast presents**

Currently eligible certified mental health professionals, Nurses
Social Workers, Counselors, Drug/Alcohol Counselors, Case Managers,
Psychologists, Domestic Violence Providers, MH and SA Providers
Interpreters in Mental Health, Community Interpreters, Educational Interpreters, etc.



**The Impact of Trauma Informed Care:
Communication Barriers and Vulnerabilities
in the Deaf Population**

February 21 2013

**9:30 am to 4:00 pm
(Deaf/Signing providers)**

February 22, 2013

**10:00 am to 3:30 pm
(Hearing/Non-Signing Providers)**

**Lunch on your own*



**Alabama Public Library
6030 Monticello Drive, Montgomery, AL
Registration Fee: Thursday \$50 / Friday \$20**

Presenter

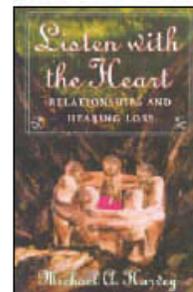
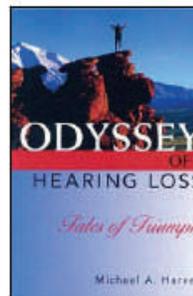
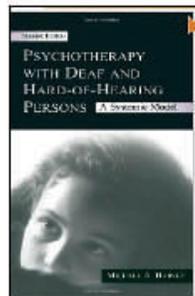
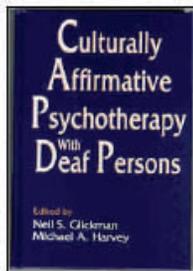
Michael A. Harvey, Ph.D., A.B.P.P.

Dr. Harvey provides training and consultation on deafness/hearing loss and mental health issues in the deaf community. He is internationally recognized for his work on trauma and trauma care, generally and with deaf people specifically. In addition to a private practice in Framingham, Mass., he was an adjunct faculty at Boston University and is a consultant faculty at Salus University where he has taught on-line courses relating to the psychosocial aspects of hearing loss. Dr. Harvey writes a regular column, "What's On Your Mind?" in Hearing Loss, the journal for Self Help for the Hard-of-Hearing. In addition to over 40 articles, his publications include The Odyssey of Hearing Loss: Tales of Triumph, Psychotherapy with Deaf and Hard of Hearing Persons: A Systemic Model (second addition), and a co-edited book entitled Culturally Affirmative Psychotherapy with Deaf Persons. His most recent book is Listen with the Heart: Relationships and Hearing Loss. Dr. Harvey is Co-Director of a private, non-profit organization, Dialogue Toward Change, dedicated to providing research, training and consultation services to alleviate the potentially negative impact of witnessing trauma and oppression.



Pre-registration is strongly encouraged.

Dr. Michael Harvey is the author of these great books:



Clinical CES for Psychologists, Social Workers, Counselors, SA Providers, and Nurses are being applied for will be offered. Additional updates to follow.

The Alabama Department of Mental Health is an approved RID CMP Sponsor. This activity has been awarded 0.425 and 0.55 CEUS in the area of Professional Studies by The Registry of Interpreters for the Deaf at the "some" Content Knowledge Level for CMP and ACET participants. Activity #s 0263.0213.01 and 02.



**FOR ADDITIONAL INFORMATION OR SPECIAL ACCOMMODATIONS OR TO SUBMIT YOUR REGISTRATION, CONTACT:
 Registration Fees: Thursday \$50 / Friday \$20
 Checks should be written to ADARA and mailed to:**

Charlene Crump
 Office of Deaf Services
 Alabama Department of Mental Health
 PO Box 301410, Montgomery, AL 36130
 FAX: 334-242-3025
charlene.crump@mh.alabama.gov

In the event the workshop is cancelled, you will be notified by email. Please print clearly.

Which Date		<input type="checkbox"/> Thursday February 21	<input type="checkbox"/> Friday February 22
Name		<input type="checkbox"/> Deaf <input type="checkbox"/> Hearing <input type="checkbox"/> H/H	
Agency			
Address			
City		State	Zip
<input type="checkbox"/> Phone	<input type="checkbox"/> TTY	<input type="checkbox"/> VP ()	Fax ()
E-Mail		Accommodations:	

Sponsored by DMH, ADARA and Gallaudet University Regional Center - Southeast

AS I See It

(Continued from page 8)

- What if the "Deaf Community" cared as much about services for deaf people with mental illness as they do for getting CDLs for deaf truck drivers?
- What if restraint, either physical or chemical (aka "PRN"), applied to a consumer, because of behaviors that arose from the inability of a provider or staff member to speak directly and competently with a consumer who is deaf or limited English proficient and thus unable to provide the same level of comfort and de-escalation that any staff member would reasonably be expected to provide any English-speaking consumer, were considered to be abuse of consumers on par with striking them?

Are these unreasonable on a human level? If not, then why are there so many barriers, so much resistance to developing and strengthening services to deaf people and people with limited English proficiency? Why are those issues persistently after-thoughts in system planning? Why are they last to be considered for funding priority and first to be cut?

Over the past several months the news has been full of economic gloom with little hope for improvement in the foreseeable future. The Alabama Department of Mental Health has now had four straight years of budget cuts and fifth one looms. The larger national economy gives little hope that we will avoid a sixth, even a seventh. This is a strangulation of services of biblical plague proportions.

Those of a more optimistic nature will point out that it could be worse. Certainly it is true that Alabama has done more to protect mental health services for deaf consumers than most other states have. The pessimistic will ask, "Who will be on the last lifeboat to leave the Titanic?"

January will mark the 10th anniversary of the Office of Deaf Services. *As I See It*, that's not a bad milestone. There are only a handful of programs that have been around longer. We still have about half the original staff we had at the end of the first year. That pretty good too. Yes, it could be worse... Here's to hoping we will be around for our 20th anniversary!

✂



ODS Director Steve Hamerdinger was invited to give a keynote address October 18th at the 2012 Southeast Regional Institute on Deafness in Chattanooga, TN. Hamerdinger spoke on what he saw as emerging trends in mental health care for deaf people. This article was adapted from parts of that speech.

Signs of Mental Health

Statewide Needs Assessment

(Continued from page 7)

biggest barrier/gap in the service continuum in Alabama. Included in this umbrella are "providers who speak my language."

Fascinatingly, this was the same lack of "providers who speak my language" was also emphasized by the Asian respondents, who reported a significant drop off in using services after losing clinicians who speak their language. They indicated a preference to travel some distance to get services from a clinician who speaks their language and indicated dissatisfaction with interpreted services.

The final report will be published in a few months and the Signs of Mental Health will report on further findings and recommendations in the forthcoming issues. ✂

Pollard, R. Q. 1992. Cross-cultural ethics in the conduct of deafness research. *Rehabilitation Psychology* 37:87-101

Notes and Notables

Altogether is was 60 miles in three days toward one goal. (Plus 8 blisters/bruised toes.) **Shannon Reese** participated in the Susan G. Komen 3-day Walk for the Cure was on October 19-21st. The walk raised \$4.2 million dollars which will go to various research organizations working to finding a cure for breast cancer and for free mammograms to those who cannot afford or do not have insurance. Shannon's mother passed away from breast cancer two years ago and that made her determined to get involved with these kinds of events. "It was a wonderful experience. My feet are still recovering though!" Shannon said.



Over the summer (winter in Peru) **Wendy Darling** went on a mission trip to Peru to serve as an interpreter. The Refuge of Hope is a non-profit organization serving people with disabilities. They provide education, therapy, and job skills. Annually, they have a camp in July for people of all ages and various disabilities. This year, among the campers, there were a record 11 Deaf participants. *Lenguas de Señas de Perú* differs from ASL. However, due to the strong influence of American missionaries, the people she met at the camp signed a lot like ASL. Regardless, they understood each other (of course, they also used gesturing, miming, and anything else they could think of). All of the participants and the interpreters had lots of fun and Wendy can't wait to go back!



Minneapolis, MN

May 29-June 1, 2013

Workshop Tracks:

- Mental Health/Chemical Dependency
- Rehabilitation
- Transition/Independent Living
- Professional Development

**Early Full Conference
Registration
Fee: \$325**

*Professionals Networking For Excellence in Service Delivery with
Individuals Who are Deaf or Hard of Hearing*

www.adara.org



Hilton Minneapolis/Bloomington*

3800 American Boulevard East

Bloomington, MN 55425

*\$99 per night for Double, King, or Junior Suite



Happy Holidays!

From all of us
at the
Office of
Deaf Services



Steve Hamudique

Sereta Campbell

Heidi Darling

Shannon Reese

LeKean Stouhaire, Jr.

Chad Fry

Lance Rahn

Bryce

Donna

DeVay

Joyce Canana