

Signs of Mental Health

Greeves Impresses at Annual Clinical Training

Helping Deaf People Recover All In A Day's Play...

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



Editor's Notes



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This issue is particularly content rich. We have two great guest articles and lots of news, What's not to like? Dr. John Gournaris, the Mental Health Program Director at Minnesota Department of Human Services, Deaf and Hard of Hearing Services Division, provided training for Office of Deaf Services staff on December 20. The training focused on ways a mobile field-based staff can apply best practices related to documentation and reporting.

While the topic was not glitzy, the training was exciting in other respects. The field of mental health with deaf people is very small and the limited number of experts are scattered all over the country. Using teleconferencing, Gournaris provided the training from Minnesota, which resulted in substantial savings over what it would have cost us to bring him on site. And unlike webinars, which do not allow for easy interaction with deaf participants, this approach allows the trainer and the participants to interact in real-time. None of this is new, of course. Technology gets better and cheaper making it more feasible to use in broader applications.



Another benefit is the validation that occurs when seeing that professionals in other places have the same experiences and frustrations that the ODS staff have. The concepts and techniques discussed were valuable precisely because field-based staff working with deaf people with mental illness see the same challenges as their Alabama colleagues.

ODS staff teamed up with a large cast of friends and supporters to make Christmas special for our consumers. You can read about it starting on page three.

If it's February, it must be time for the MHIT Clinical Training. Alexis Greeves provided two outstanding sessions. Beginning with page four you can check out the story and pictures.

This issue is unique because we have guest articles from two past presenters at the Clinical Training. The 2012 presenter, Angela Kaufman, has the first part of a two - part article on video interpreting. You won't want miss it, so check out page six.

The 2013 presenter, Michael Harvey, has graciously allowed us to run an excerpt of an article that he will have published later this spring. We are grateful that he allowed us to do this. Quite unintentionally, this issue has turned into a clinical briefing in its own right. Details on page eight.

The new feature, "Stack of Stupid Stuff" has generated some buzz. We mentioned Apache ASL Trails fight with HUD in the last issue. Read the follow up, beginning on page nine. ✍

Signs of Mental Health
 ADMH, Office of Deaf Services
 James Reddoch, Commissioner
 Steve Hamerding, Director
 P.O. Box 310410
 Montgomery, AL 36130
steve.hamerding@mh.alabama.gov

On The Cover:

Alexis Greeves leads the two-day Clinical Training, part of the MHIT project. This is the 7th annual event, which is made possible, in part, by the tremendous response to the Interpreter Institute.

Making Christmas a Little More “Merry and Bright”

Christmas can be a lonely and depressing time of year if you are mentally ill. This is even more true when you are also deaf and separated from friends and loved ones.

Deaf people living in community programs around the state had a bit brighter Christmas this year thanks to a joint project of Office of Deaf Services and the Alabama Association of the Deaf's (AAD) Friends of Deaf Services fund (FODS).

The project involved surveying all deaf group homes and determining what the residents needed and then buying presents for them to have at Christmas. It was a project well received.

The project was coordinated by Dr. Frances Ralston, staff psychologist at ODS. Enlisting the help of most of the staff, as well as other members of the Deaf Community, she was able to ensure that all deaf residents of Bryce, as well as the four deaf group homes around the state, were able to have at least one present to open.

A resident of Civitan Group home wrote to tell us, "Thank you for Christmas gifts. I like them and wear them. Also the lotion smells good. I love it. I think it best Christmas ever I had."



Residents of the Civitan House group home express their appreciation for their Christmas gifts. Right to Left: Kelly Cheyne, Tootsie Peterson, Kirk Glover.

It required some coordination to be sure the gifts were delivered in four different cities around the state on the same day! Fortunately, ODS staff members were more than willing to go the extra mile – in some cases, literally – to be sure the residents had their share of Christmas spirit.

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DEAF SERVICES DIRECTORY

Central Office

Steve Hamerdinger, Director, Deaf Services

VP: (334) 239.3558

Text: (334) 652-3783

Charlene Crump, State Coordinator

Communication Access

Office: (334) 353-7415

Cell: (334)324-1972

Shannon Reese, Services Coordinator

VP: (334) 239-3780

Frances Ralston, Ph.D. Psychologist

VP: (334) 239-3613

Text: (334) 414-1831

Joyce Carvana, Administrative Assistant

Alabama Department of Mental Health

RSA Union Building – 4th Floor

P.O. Box 301410 (Mailing Address)

100 North Union Street (Physical Address)

Montgomery Alabama 36130

Main Number: (334) 353-4703

FAX: (334) 242-3025

Region 1

Lance Weldgen, Therapist

Dawn Vanzo, Interpreter

Mental Health Center of Madison County

4040 South Memorial Pkwy

Huntsville, AL 35802

Office: (256) 705-6347

Cell: (256) 684-5589

VP: (256) 217-4308

Region 2

Therapist, Vacant

Sereta Campbell, Interpreter

Bryce Psychiatric Hospital

200 University Boulevard

Tuscaloosa, AL 35401

(205) 759-0698 (Voice)

(205) 759-0890 (FAX)

Region 3

Therapist, Vacant

Lee Stoutamire, Interpreter

AltaPointe Health Systems

501 Bishop Lane N.

Mobile, AL 36608

Office: (251) 461-3447

Cell: (251) 472-6532

VP: (251) 281-2258

Region 4

Scott Staubach, LPC, Therapist

VP: (334) 239-3596

Text: (334) 324-4066

Wendy Darling, Interpreter

Montgomery Area Mental Health Authority

2140 Upper Wetumka Road

Montgomery, AL 36107

(334) 279-7830 (Voice)

Region 5

No Clinician Assigned

Brian McKenny, Interpreter

P.O. Box 301410

Montgomery Alabama 36130

Office: (334) 353-7280

Cell: (334) 462-8289

Bryce Based

Katherine Anderson, Interpreter

Vyron Kinson, Communication Specialist

2014 Clinical Training Focuses on Non - Verbal Approaches; Greeves Impresses Audience



Above: Part of the audience attending the February 7th session. As in the past, this event was split over two days, with Thursday being for ASL-fluent groups.

Below right: Rashada Lee prepares to knock a balloon “out of the park” in the “Balloon Battle” activity.

Greeves went out of her way to make her sessions interactive and engaging. Sam Feibelman, President of the Council of Organizations Serving Deaf Alabamians, said that Greeves is an "excellent presenter and I enjoyed it very much."

For her part, Greeves enjoyed it as well. "What a great time presenting to these audiences! I appreciated the willingness of the participants to take risks and try some of these activities which is important if we want our clients to take risks and try them as well." Greeves told *Signs of Mental Health*. "The audiences were engaged and asked great questions (and answered some too). I'll hold Alabama warmly in my memories thanks to my time there."

Nearly 150 people attended sessions over two days as Alexis Greeves, a nationally lauded expert on play therapy with deaf consumers shared her experiences and techniques with mental health providers and other interested attendees February 6th and 7th.

Greeves, a Licensed Professional Counselor and a Registered Play Therapist and Supervisor with a specialized training in work with children, adolescents and their families, specializes in working with deaf children and has a national reputation and following. Participants quickly understood why.



(Continued next page)



Following the pattern set over the previous several years, Thursday's session was designed for ASL-fluent audiences. The presentation was in American Sign Language and only limited voice interpreting was provided. That session drew 81 participants from around the state as well as some from as far as California. "The recently-completed training facilitated by ADARA and Alabama ODS was so useful and relevant for me and my colleagues," said Kevin Henderson from Hope House in Atlanta. "We strongly feel most deaf and hard of hearing adults in our program benefit from non-verbal approaches to recovery from alcohol and drugs but we are not well equipped with such tools to address that."



Other participants were equally effusive. "This was the best, most therapeutic workshop ever!" said one participant. Another clinician, who is ASL-fluent, remarked that the training, " [made] me want to [get] specialized training in play therapy so I can serve deaf people better."



Above: Carole Sexton-Samelo (right) and Scott Staubach post "worries" on the "Worry Wall."
Above right: Alexis Greeves works with Daphne Kendrick in yet another hands on activity

Friday's session was geared to people who work with deaf consumers but who are not ASL-fluent. That session was attended by 67 participants in spite of winter weather that paralyzed much of the south. Rashada Lee, a Team Leader at Fellowship House in Birmingham was effusive. "I was so excited to learn so much from this training! I left this training with the tools I need to be more effective as a clinician and more aware of the obstacles deaf individuals face."

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Providing Access Or Shirking Responsibility? Using VRS for Clinical Services

By Angela Kaufman, ADA Compliance Officer, City of Los Angeles

"I am excited that our counseling agency is offering counseling for Deaf clients. Using the video relay service (VRS) for therapy sessions is how we provide sign language! It is cost effective, as the therapist does not have to pay for an interpreter. VRS is free for both the Deaf client and the therapist. As far as I am aware it does not create any legal violations."

In a listserv discussion focusing on providing support to deaf consumers with trauma, this comment was made by the director of a service that was "interested" in serving "all" people. There are numerous problems with the sentiment expressed above, not the least being a thinly-veiled attempt to evade responsibility for interpreter costs. It is a concern for me, as an advocate, that 23 years after the ADA was passed the hearing world continues to attempt to find ways to not provide effective communication to the deaf and hard of hearing community. But that's not the biggest problem with that comment. There are several others that are even more troubling.

The first is the confusion in the minds of many "well-intentioned" hearing people is the confusion between a video relay service (VRS) and video remote interpreting (VRI). VRS is supposed to supplant the older text relay services and provide "functional equivalence" for deaf people using telephony. VRI, on the other hand, can be best conceptualized as "teleconferencing" an interpreter to a location that would otherwise not have access to one.

Emerging technology, increasingly used by the Deaf Community to effectively communicate, led the Department of Justice to amend the rules and guidance pursuant the Americans with Disabilities Act, which itself was amended in 2008. Among the technologies specifically referenced was Video Remote Interpreting as a service that can be offered by Title II and Title III entities as a provision of an auxiliary aid

and services, a category that includes "providing qualified interpreters on-site or through video remote interpreting (VRI) services as well as including voice, text and video based telecommunications products and systems, videophones, captioned telephones, and other equipment." (ADAAA §36.303(b)(1))

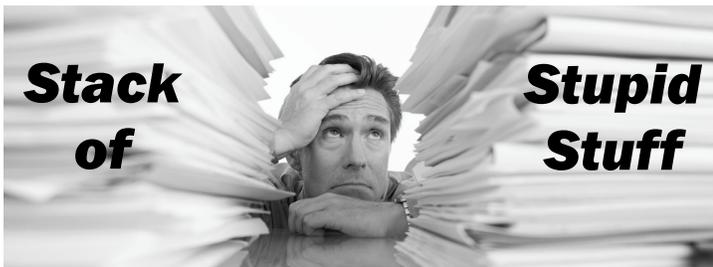
The commentator was not talking about VRI, however, but rather about VRS. In this age of fiscal constraints, unfunded mandates, and activist pressure, entities are trying to find any way to "get by". VRS appears to offer a tempting way to give the appearance of providing access but without any of the costs or responsibility. To be able to just pick up the phone and magically have an "interpreter" on the line is a siren song that can lead to disaster.

It is unfortunate, but the VRS environment, taken as a whole, has a variable record of "quality control" and minimal competency expectations. Video Interpreters (VI) are not required by federal law to hold any national certification prior to their employment. Some VRS companies will hire pre-certified interpreters in order to have warm bodies in the seats so that they are meeting the FCC requirements, however, many may not be "qualified" to be working as a Video Interpreter. Neither the caller nor call receiver generally has the knowledge or the ability to actually assess the VIs skills appropriately, unless both parties know each other very well

The lack of "qualified" interpreters is one of the major deficits of the system. The "well being" of VIs and the lack of systemic support, expressed by VIs to this author is another. A VI is human and personal vulnerabilities will play into the dynamics of the triadic session. If there is a communication breakdown attributable to "interpreter error", it will be impossible to determine if the VI is sick, distraught by personal issues, or simply having a bad day. Are there technical issues which are disrupting the call? Is the VI stressed by their company's policies, politics or performance metrics? Is the shift just starting and the VI has not settled in or is it near the end and the VI getting anxious to leave?



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Sometimes hearing people can do really stupid stuff! If any of you dear readers have something to contribute, send the item or link to the Editor at SOMH@mh.it.org.

No Apartment for You

A national watchdog group is filing complaints against three Charleston-area apartment complexes for alleged discrimination against prospective deaf and hard-of-hearing tenants. Rental agents at the apartment complexes are accused of denying equal access to information about rentals, discouraging potential tenants from applying to rent, and repeatedly hanging up on callers, among other things.

The National Fair Housing Alliance announced Thursday that it was filing eight complaints with the U.S. Department of Housing and Urban Development against the owners of apartment complexes in Little Rock, AR, Sacramento, CA, Atlanta and Savannah, GA, Long Beach, MS, Charleston, North Charleston, and Lexington, SC, and Austin, TX. The complaints allege violations of the fair-housing section of the Civil Rights Act, and NFHA President Shanna Smith says she intends to work with apartment owners to resolve the issues.

<http://www.charlestoncitypaper.com/charleston/deaf-housing-discrimination-alleged-at-three-charleston-apartment-complexes/Content?oid=4842452>

This Will Turn Out Well...

"We have two deaf students at our school with translators [sic]. My problem, is, that the one of the translators is the Mom of the student she is translating for. She is not well respected by the students because she gets involved in "stuff" that doesn't concern her. She has been making decisions that the teacher should be making, including kicking other students out of class. She is not a neutral party and seems to be only interested in her son's success. She is not certified in any way and I would prefer to have someone more neutral doing her job. My family has gone out of our way to invite her son to our home on a weekly basis in order to give the two of them space from one another but in my eyes she has turned into the class bully.

<http://www.streetleverage.com/2012/02/sign-language-interpreters-in-mainstream-classrooms-heartbroken-and-gagged/>

Sign Language Frightens Cops

Jonathan Meister was retrieving some stuff he was storing at an ex-roommate's home, when he looked up to find several members of the Hawthorne Police Department approaching.

The South Bay man claims officers didn't give him a chance to explain what he was doing before placing him in handcuffs, beating him and using a stun gun to shock him into submission.

The problem began when police reportedly misunderstood Meister's attempts to speak in sign language as threatening gestures.

Moreover, officers didn't realize that when they handcuffed Meister, who is "profoundly deaf" and non-verbal, they took away his ability to communicate.

The incident began on the evening of Feb. 13, 2013, when Meister arranged to get some things his ex-roommate was holding for him on his back porch. Someone saw Meister hauling items, thought it looked suspicious, and called police.

Officers met Meister on the sidewalk, where he "tried to tell them that he was deaf, using gestures to explain that he was there to pick up his stuff, but it didn't seem like they understood," Meister's attorney Anna Rivera said.

The situation deteriorated from there.

He was arrested and taken to the Hawthorne police station, where he communicated in writing.

Police initially charged Meister with assaulting officers but those charges were eventually dropped.

Hawthorne police provided a copy of the police report showing they recognized Meister was deaf early on and that he tried to resist.

Hawthorne police also say they officers already receive training on handling situations where communication proves difficult.

<http://losangeles.cbslocal.com/2014/02/17/police-beat-stun-deaf-man-after-confusing-sign-language-with-threatening-gestures/> 

Trauma Informed Care with Deaf Persons (with By Proxy Assistance from Supreme Court Justice Sotomayor)

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

Excerpted from an article to appear in the *Journal of the American Deafness and Rehabilitation Association*. Used with permission.

Several months after beginning psychotherapy, Sue, a 40-year old Deaf woman, told me about a recent event at work:

"My co-workers and I are in a room together and they're saying something to me that I can't understand. Then they're talking to each other, some laughing, some looking serious. Now my boss is coming in and he's saying something to the group and they look anxious and are talking over each other. I'm able to pick up a few words – or at least I think I do – but most of the conversation is gibberish."



Dr. Michael A. Harvey

Initially, her story was unremarkable and felt quite familiar, having heard many variations on this theme from Deaf individuals. She nonchalantly and matter of factly acknowledged that the inadequate accommodations at her work were the norm and that she had resigned herself to the circumstance. Then suddenly, seemingly out of nowhere, she sat up

right in her chair, her signing became more animated and encompassed a larger space with less clear hand shapes, and her face became flushed. She repeated "I can't leave, I can't leave" over and over again. She started to cry.

How to understand what Sue had shown me? Using terminology from *trauma informed care*, I wondered whether she was reacting to early trauma with characteristic alternating states of posttraumatic hyperarousal (panic) and hypoarousal (nonchalance).

Trauma informed care involves professional relationships and interventions that take into account an individual's trauma history as part of efforts to promote healing and growth. There is an important qualitative difference to how many Deaf people affectively experience trauma. This has to do with the acute and cumulative effects of linguistic isolation which impedes access to information and often cause language deprivation (Glickman, 2009). As an

example, Schild & Dalenberg (2012) defined *Information Deprivation Trauma* as when a Deaf person has limited or no information or knowledge about the impending event and, as a result, the trauma is experienced as more sudden, unpredictable, and uncontrollable.

As Sue gained some mastery of safety and stabilization tools, the next phase of our work was for her to recollect and articulate the relevant trauma narratives and process unacknowledged and unintegrated feelings, thoughts, and beliefs (Courtois & Ford, 2013). I asked for any earlier life events that her work meeting may have triggered. She needed no prodding; after only a few seconds, she recounted her mainstream academic environment:

"Before and after classes or during recess, everyone would talk about stuff: gossip, who they're hanging out with, friends, movies, etc., but I could understand only enough to know I was missing a lot. So I would just sit down in my front 'preferential seat' and do nothing. Looking back, I realize that I couldn't get much of the auditory information even from the teacher, even though I had an interpreter (who couldn't sign well), but I didn't know that then."

A timely coincidence: During the time period of my meetings with Sue, I happened to be reading a memoir by Sonia Sotomayor, Associate Justice of the U.S. Supreme Court. In *My Beloved World*, she recounted that her family of origin was marred by her father's alcoholism, a mother who was emotionally distant, marital conflicts, and being diagnosed with Type 1 Diabetes at age seven. I thought of Sue for two reasons. First, she had an avid interest in current events and closely followed Sotomayor's Supreme Court confirmation hearings in 2009. The second reason I thought of Sue was Sotomayor's vivid description of her constant "surveillance activities" with her family: "... Much was said at home, and loudly, but much also went unsaid, and in that atmosphere I was a watchful child constantly scanning the adults for cues and listening in on their conversations. *My sense of security depended on what information I could glean*, any clue dropped inadvertently when they didn't realize a child was paying attention." (Sotomayor, 2013, p. 14) (italics author's emphasis).

I wondered about Sue's *sense of security* in her family of origin. Like many deaf-member families, she was the only deaf member, her primary and preferred mode of communication was sign language, and her family did not sign (Harvey, 2003). I gave her Sotomayor's passage and asked what resonated for her. In contrast to Sotomayor whose *sense of security depended on what information she*

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The Battle for Accessible Housing

By: SOMH Staff, reporting based on information from National Association of the Deaf and other sources.

The U.S. Department of Housing and Urban Development (HUD) on January 24, 2014 ostensibly dropped its legal challenge against Apache ASL Trails (AAT) with respect to it being housing developed to meet the needs of deaf and hard of hearing individuals seeking community living with others are American Sign Language users.

This move was intended to end two and a half year battle where the Deaf Community fought to preserve the right to live in a linguistically-compatible community. Despite claims to the contrary, the fight has not ended, however since HUD continues to insist that AAT may not accept Section 8 funds, according to [Mary Vargas](#), of Stein & Vargas, who is representing AAT.



As reported in the "Stack of Stupid Stuff" in the last issue of **Signs of Mental Health**, the U.S. Department of Housing and Urban Development (HUD) approved for construction this 75-unit apartment in 2008. It had been initiated at the request of the deaf and hard of hearing community in Arizona. With this approval, the project was built by [Cardinal Capital Management](#) and then occupied primarily by deaf and hard of hearing individuals, including some with other disabilities. Some tenants are not deaf or hard of hearing and sign language interpreters were provided to ensure that those tenants could communicate with their neighbors at community events in the facility.

Nevertheless, in June of 2011, HUD a Letter of Findings against AAT because it had too many deaf and hard of hearing people living there! Members of the Deaf Community and their supporters were outraged that HUD would penalize a

facility for this reason after failing to ensure sufficient numbers of accessible housing in any part of the country. HUD's Letter of Findings was, in effect, a legal mandate from the Federal government that deaf and hard of hearing people could not live together in a community.



The community mobilized and fought back. For two and a half years, Deaf community members, as well as various allies, communicated and met with various officials at HUD to discuss the Letter of Findings and the overall problem of accessible housing for deaf and hard of hearing people. Representatives from the National Association of the Deaf (NAD) as well as Cardinal Capital Management (CCM) met repeatedly with HUD officials. The Arizona Department of Housing (ADOH), led by Director Michael Traylor, also advocated for Apache ASL Trails to retain its character of being a home for those who use ASL to communicate.

Despite all these efforts, in February 2013, HUD directed the city of Tempe to terminate the Section 8 vouchers that had been promised for some tenants of AAT.

In April 2013, NAD submitted a strongly worded letter to HUD that was accompanied by sign-ons from 75 organizations representing different groups of deaf and hard of hearing people across the country. In a move to put real faces on the problem, advocates persuaded HUD officials to appear at the Deaf Seniors of America national conference in hopes that the need for accessible housing for deaf and hard of hearing people would become more real.

Additional political pressure came from Congresswoman Kyrsten Sinema, Congressman Matt Salmon, and other members of the Arizona delegation to pressure HUD into resolving this situation with Apache ASL Trails.

After this lengthy stand-off, on January 24, 2014 HUD withdrew its Letter of Findings and closed the investigation on Apache ASL Trails. In a letter to Traylor, HUD indicated that Federal law **does** permit AAT to give priority in rental to those individuals who need the accessibility features of the units.

That should have been the end of it. However, Mary Vargas, the attorney representing AAT, told **Signs of Mental Health** that, "Since HUD withdrew its letter of finding acknowledging that AAT was in compliance with the law, it has now said AAT is permanently barred from section 8 funds meaning that those without means - often those who most need this hous-

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As I See It
Steve Hamendy



Important Articles You Must Read

R.Q.Pollard Jr., E. Sutter, C. Cerulli. (2013). *Intimate partner violence reported by two samples of deaf adults via a computerized American Sign Language Survey*. Journal of Interpersonal Violence, v. 20(10), pp.1-18.

Results from samples of deaf adults (national and Rochester sample) indicated that greater proportion of deaf individuals experienced physical abuse when compared survey of hearing individuals. Also, twice as many deaf persons experienced forced sex versus the hearing sample. After Deaf people experienced intimate personal violence (IPV) they used emergency departments much more than the deaf samples. These results suggest that deaf men and women who experienced IPV have significant physical and/or psychiatric consequences. Consequently, they will need treatment for trauma from their IPV experiences.

Bhargava, R. (2013). The use of reality therapy with a depressed deaf adult. *Clinical Case Studies*, 12(5), 388-396.

In the light of minimal research on the use of reality therapy on deaf adults, this provides a case study and theoretical basis of treating a depressed young male adult who is deaf with reality therapy. This client presents with complaints of depression and identity issues. The clinician used American Sign Language fluently. According to Glasser, the focus of reality therapy is on identifying and altering self-defeating and negative behaviors that affect the identity and self-esteem of the client. In this case, it was important that the clinician have cultural competence in working with deaf individuals. The client showed happiness by the end of therapy at 12 weeks as he became more independent of his hearing parents. Upon follow-up sessions He remained productive and free of depressed symptoms. A recommendation was made that the clinician be competent in cultural issues of deaf individuals as well as be proficient in ASL. If the clinician utilizes interpreting services, the clinician still must have an understanding of the client's background. "Clinicians should also be aware of the diversity of the deaf population, the makeup of the psychological, developmental, and mental health aspects of deafness, as well as the psychological therapeutic treatments that are most applicable to deaf children and adults," P. 395.

Let not thy left hand know what thy right hand doeth.

Matthew 6:3 King James Bible "Authorized Version",

Sometimes, yea cynical as I am, I am yet gobsmacked at the collective stupidity/duplicity/perfidy of the species *Bureaucratis Americanus*.

The story on page nine in this issue about the trials and tribulations of Apache ASL Trails apartments serves as case in point in a larger conundrum that has been vexing me for some time; the ability of bureaucrats in one part of a government agency to promulgate policies that contradict bureaucrats in another part of the same agency. Public housing must be accessible to deaf people, but it can't be too accessible that it becomes a "deaf ghetto". It's a perversion of the Field of Dreams. "Build it and they will come", but it better not be too many of them or we will cite you for occupancy violations.

This curious ability to write contradictory rules is on full display at the Federal Department of Health and Human Services.

On one hand, the Office of Minority Health (OMH) in the Federal Department of Health and Human Services (DHHS) has issued new ["guidelines" for providing services to people with limited English proficiency](#). Some good stuff, actually. Stuff that deaf advocates have been pushing for years. Two and a half cheers due.

As soon as that goes "across the hall" to Center for Medicaid Services, (CMS) which is also under DHHS, all that good stuff is tossed out the window. Anyone masochistic enough to read my rants each issue knows what I think of bureaucrats' ability to sink into unwise groupthink. CMS's efforts to push all mental health services under the general rubric of "healthcare" sorely test my willingness to ascribe to Hanlon's Razor. (Nation Deaf Academy is a case in point.) But don't get me started on that.

As the country is rapidly running out of "other people's money", we have a situation where funding rates are so low that mental health centers and other "behavioral health" entities are scrambling to reduce their costs in order to keep stockholders/State Medicaid happy. (See ["Thousands in Washington](#)

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Training Focus on Non - "Talk" Approaches

(Continued from page 5)



Illeen Moore stretches out for the "Where Does It Hurt" activity, designed to help people express vague somatic complaints and to develop resilience.

Several people attending Thursday's session, including Lee, were not ASL-fluent, so they also received a cultural immersion experience as well. "It was important for me to

experience the feeling of not being able to completely understand language as I was one of few who was hearing and non-signing," Lee told us. "I had to be intentional about paying attention to the speaker and those who were providing voice interpreting."

One of the goals of the training was to get across how people who are deaf may interpret things differently than people who are hearing. Projective techniques like play therapy and sand tray therapy are powerful and very effective with both groups. The critical component of that effectiveness is the ability of the therapist to recognize cultural contexts.

Another goal, of course, was to impart functional skills to the participants. To Daphne Kendrick, a Registered Play Therapist Supervisor, that goal was accomplished. "As a play therapist, I found this program very informative and addressed a therapeutic treatment modality which is underutilized in working with the Deaf (sic). Often you go to a conference and the speaker spends the entire presentation on theory and too little on techniques. I was able to walk away from this conference with several techniques which I can apply."

The sessions, part of the Office of Deaf Services' MHIT training series, was the seventh annual Clinical Training. Previous speakers have included Michael Harvey, Amanda O'Hearn and Sharon Hayes, Angela Kaufman and Amanda Somdal, Barry Critchfield, Joseph Murray and others.

At press time, plans are already being made for the 2015 clinical training Workshop coordinators told **SOMH** that they would love to hear from readers as with what topics would appeal them. Address comments to info@mhit.org. ✂

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*) *Denotes QMHI- Supervisors

Charlene Crump, Montgomery*
Denise Zander, Wisconsin
Nancy Hayes, Remlap
Brian McKenny, Montgomery*
Dee Johnston, Talladega
Lisa Gould, Mobile
Gail Schenfisch, Wyoming
Dawn Vanzo, Huntsville
Wendy Darling, Montgomery
Pat Smartt, Sterrett
Lee Stoutamire, Mobile
Frances Smallwood, Huntsville
Cindy Camp, Piedmont
Lynn Nakamoto, Hawaii
Roz Kia, Hawaii
Jamie Garrison, 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
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Tera Vorphal, Wisconsin
Julayne Feilbach, New Mexico
Sue Gudenkauf, Wisconsin
Tamera Fuerst, Wisconsin
Rhiannon Sykes-Chavez, New Mexico
Roger Williams, South Carolina*
Denise Kirby, Pennsylvania
Darlene Baird, Hawaii
Stacy Magill, Missouri
Camilla Barrett, Missouri
Angela Scruggs, Tennessee
Andrea Nelson, Washington

Providing Access Or Shirking Responsibility?

(Continued from page 6)

Depending on the Video Interpreter and which VRS company is being utilized, the VI could be switched out a minimum of three times in an hour session, with 3 different interpreters. It is bad enough that the therapists/agencies have difficulty in securing the same interpreter for "on-going" assignments, Using VRS, there could be up to three different VI's on a 50/60 minute session.

Nor is there any expectation that the relief VI will be from the same geographical area as the original VI. The dispersion of VRS (and to some extent VRI) providers will mean that the VI may not be familiar with regional variant "dialect" of ASL used by the consumer. The therapist will be reacting to the interpreter's understanding of what the deaf consumer said, not necessarily what the deaf consumer actually said. In addition, if there are name signs utilized or specific information, often the deaf individual will need to clarify with each new interpreter, which can cause the therapist to doubt the competence of the interpreter. Some individuals may have subconscious bias against the spoken accent of the VI. Other clinicians may attribute the interpreter struggling with interpretation to the deaf individual and their "unwillingness" to connect, or that they are being evasive.

Many states have passed licensure or laws requiring minimum certification requirements for anyone providing sign language interpreting services. In some states, there are requirements that interpreters have obtained a certain certification, or hold a license in their state. Several states have passed additional requirements for education or training for interpreters in law enforcement, medical, legal, mental health and educational situations,. This may pose a significant issue for therapists attempting to use VRS instead of hiring a "qualified" interpreter as required by their specific state laws or licensure regulations.

Complicating matters even further, Codes of Professional Conduct and best practices that Certified Interpreters follow, often conflicts with FCC regulations controlling VRS and VRS Company policies and procedures established to comply with those regulations putting VIs in constant ethical and moral conflict. The burn out rate is high and VIs report a host of somatic complaints, trauma and abuse. This has been known for well over a decade and work conditions have yet to really improve.

These concerns are important. But clinicians should also be concerned with liability issues that are raised because of the medium. The VRS VI is not permitted by FCC rules (and usually company policy) to pass on information about consumer affect. The clinician would not have eye-to-eye

contact during therapy sessions. They would be unable to assess any reactions to what is being discussed such as if the client appears confused, or becomes angry. Instead, the clinician must respond to the VI's discombobulated voice rendering her best understanding of the signs of the deaf consumer. Equally important, the clinician's words of comfort, guidance, inquiry or concern are no longer hers once spoken. Those words are received by the interpreter and rendered into signs according to the VI's best conceptualization of the clinician's meaning and sign that the interpreter "knows". For many sign language interpreters, it is not their first language and for those who do not have friends or family that are deaf or sign, and only interact with the community as a "job", their sign vocabulary is usually not as extensive and limited to their exposure.

Another, but by no means the final issue is how the mental health agency's policies regulate non-face to face therapy. Is tele-mental health allowed? What are the parameters and requirements? What releases and consents are required? Does the deaf consumer understand the risks?

Is this a common practice for primary therapy? Nearly every mental health practice has a protocol for handling emergency and crisis calls where at least some clinical work is done by telephone. Few agencies will allow the primary mode of therapy to be by telephone, at least not without a video component to allow the clinician to see the consumer.

The question a therapist must consider then is whether or not providing "phone therapy" is a routine and normal part of working with hearing consumers or if they are using "phone therapy" as a justification to use VRS and avoid the expense of hiring a sign language interpreter. If the agency/therapist provides therapy through a telephone for other clients, then use of the VRS system may be deemed "equal access" and thus, "legal". But not everything that is legal is ethical or appropriate. Even under this scenario, the clinician is liable for the outcome and there could be an argument that the deaf client is not being treated equally. The clinician and/or agency may have a deaf consumer file a complaint against them for treating them differently than hearing consumers, if the only way to receive services is through the Video Relay Service and they want in-person therapy.

Some of these issues can be addressed, in part, by using video remote interpreters (VRI) instead. Part II of the series will address strengths and shortcomings of VRI and present suggestions for when it is appropriate to use VRI and what things should be kept in mind. ✍

(Ed. Note: Thanks to Birnbaum Interpreting Services for story illustration.)

NPR Seeks Volunteers to Test Emergency Alerting System With Deaf Residents of Gulf States

National Public Radio (NPR) is looking for volunteers to help demonstrate the delivery of emergency alerts to people who are deaf or hard-of-hearing in the Gulf Coast states through local public radio stations. This is the first effort to deliver real-time accessibility-targeted emergency messages, such as weather alerts, via radio broadcast texts.

The demonstration is being conducted by NPR Labs, the technology research and development group of NPR, under a contract from the U.S. Department of Homeland Security (DHS) and the Federal Emergency Management Agency's (FEMA) National Continuity Programs Directorate.

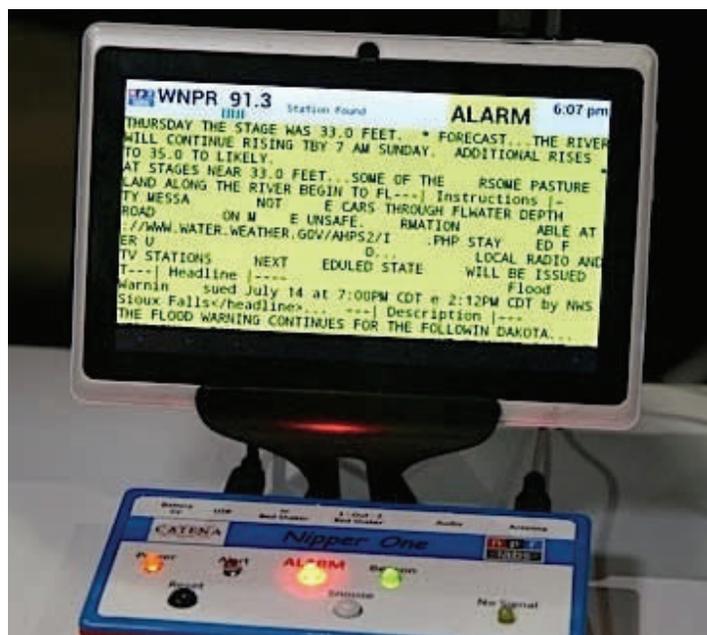


Ed.: Downtown Mobile during Hurricane Katrina. Information was difficult to get during the disaster. As difficult as this was to deal with, tornados are even more frightening, as central Alabama learned in April, 2011.

Volunteers will be given a special FM radio plus an Android tablet to receive the alerts and will be asked to complete an occasional survey to let NPR know how the demonstration is going. Over the course of the next few months, NPR will be asking volunteers to keep track of the alerts that they receive, and send back other information. The closed-captioned radio is a standalone box intended to supply emergency information whenever the power is out and WiFi isn't working.

In order to take part in the demonstration, volunteers will need to be close enough to one of 26 public radio stations in Alabama, Florida, Louisiana, Mississippi and Texas. To find out if you live within in the coverage area of one of the stations, enter your street address at <http://secure.nprlabs.org/alerting>. Anyone with hearing difficulty is encouraged volunteer by completing an application at <http://nprlabs.org/dhs>.

For more information on the emergency alerts demonstration, please contact NPR Labs at alerting@npr.org.



This early proof of concept prototype earned NPR recognition by the Consumer Electronics Association (CEA) as an International CES Innovations 2014 Design and Engineering Awards Honoree.

Emergency Alerting Demonstration FAQs

Who is eligible to volunteer?

Anyone with hearing difficulty can volunteer for the demonstration. However, not everyone who volunteers will be able to participate because NPR requires a representative sample of volunteers that matches the overall national distribution of age, gender and other factors.

NPR will contact prospective volunteers who complete an application at <http://nprlabs.org/dhs>.

As a volunteer, what will I be required to do for NPR?

Over the course of the next few months, NPR will be asking you to keep track of the test alerts that you receive, and pass along other information.

Are there any other requirements?

In order to participate and receive test alerts, you will need to live close enough to a public radio station involved in the demonstration. You can enter your street address at <http://secure.nprlabs.org/alerting> to find out if you are within the coverage area of one of the stations.

(Continued on page 14)

NPR Seeks Volunteers

(Continued from page 13)

Are there any benefits to volunteering?

In addition to helping to test the effectiveness of the emergency alerting system, you will be able to keep the FM receiver and Android tablet after the project is over.

Who can I contact if I have additional questions about the emergency alerting demonstration?

Please contact NPR at alerting@npr.org 

Making Christmas a Little More “Merry and Bright”

(Continued from page 3)

Another resident told us, " They did a fine job and good. Thank you for my Christmas present. Hope you had a Merry Christmas."

The project would not be possible without the help of the Alabama Association of the Deaf, who administer the Friends of Deaf Services fund. FODS is supported by charitable contributions from people who care about deaf people with mental illness. Funds also come from fund-raising events. AAD ensures that 100% of all donated funds go directly to the benefit of Deaf consumers with mental illness. When asked for a response to this story, Ben Hollingsworth, President of AAD, responded, "The Alabama Association of the Deaf, along with the Friends of Deaf Services fund, remains committed to a goal of providing opportunities for Deaf Alabamians with mental illness to benefit where they might not otherwise be able, not just for the holidays, but year round. We are pleased to partner with the Office of Deaf Services in this endeavor."



On the ODS Book Shelf

(Continued from page 10)

Diaz, David R; Landsberger, Sarah A; Povlinski, Jessica; Sheward, Jerry; Sculley, Charleen. Psychiatric disorder prevalence among deaf and hard-of-hearing outpatients. *Comprehensive Psychiatry*.54.7 (Oct 2013): 991.

Diaz, Landsberger, Povlinski, Sheward, and Sculley conducted a longitudinal, retrospective study on the prevalence rates of psychiatric disorders in deaf adults. The purpose of the study was to examine the diagnostic and clinical characteristics of deaf psychiatric outpatients in comparison to hearing psychiatric outpatients. The researchers utilized data from the electronic medical record of 586 adult outpatients from a Midwestern community mental health center from 2002 to 2010. "In this research study, the diagnoses of deaf outpatients (n = 241) from the Midwestern US receiving services from a specialized deaf mental health program were compared to hearing outpatients (n = 345) receiving services from general mental health programs." All of the services were conducted in ASL or the patient's preferred communication by bilingual staff members, with one exception who utilized an interpreter. The researchers compared demographic and diagnostic data, including the Axis I and II disorders. The results of this study found that deaf and hearing outpatients were diagnosed with depressive disorders, psychotic disorders, adjustment disorders, eating disorders, cognitive disorders, and personality disorders at the same rate. Deaf outpatients were diagnosed significantly more often with impulse control disorders, attention deficit hyperactivity disorders, pervasive developmental disorders, and intellectual disabilities. Adversely, hearing outpatients were more often diagnosed with anxiety disorders, bipolar disorders, and substance use disorders. 

Left: Dr. Frances Ralston with some of the gifts for deaf consumers. The bulk of the community-bound gifts were all delivered by ODS staff members on December 23. FODS was established originally as Friends of the Bailey Deaf Unit. Some of their past projects have been covered in these pages. When the Bailey Deaf Unit was closed, AAD broadened the focus to include deaf people in community programs.

Applications for Student Workers at the 2014 Institute are Now Available

Full-time students of recognized interpreter training/preparation programs are invited to apply for one of the four student worker positions available. Slots will be awarded based training, experience and future plans. Applications can be downloaded from the MHIT website. Faculty Recommendation is required. Those selected will have their registration waived. Transportation, lodging and meals will be the responsibility of those selected.

Please address any questions to applications@mh.it.org.

Trauma Informed Care with Deaf Persons

(Continued from page 8)

could glean, Sue had felt anything *but* secure. She kept nodding her head while reading the passage and then recalled a dark, rainy day when she was maybe four years old. Her parents were crying, several other people were over the house also crying, but Sue didn't know what was wrong. She found out the next day that it was "only" that her uncle suddenly died. She felt guilty for feeling relieved.

I continued to elicit trauma narratives. She produced memory fragments of many years of physical and sexual abuse by her uncle. His abuse started off innocently enough, as her uncle was a regular visitor to the house and had become a confidant for Sue, someone she could talk to, who would listen, and who even had taken several sign language classes. His abuse began when she was 14 years old and continued for three years. It was their secret, as he threatened harm to Sue and her parents if she dared tell anyone.

The posttraumatic sequelae of her physical and sexual abuse were inexorably connected to other information deprivation triggers in that often any one memory would trigger others. A common factor was her fantasy that if only she could discern auditory cues, maybe she would be more prepared and could cope better – whether the context be with her uncle, within her family, or in school.

Her memories kept on coming, often flooding her emotionally. An important caveat: If I had only elicited Sue's trauma narratives – e.g., repeatedly asking her to elaborate how she was victimized – it would have been re-traumatizing her. In addition to "Tell me more," another intervention is critical. Michael White (1997) referred to *double listening* – seeking double stories: the trauma story in which a person was victimized and the concomitant story of how that person responded to it; how that person held on to certain values through the trauma.

We discussed Sue's values of competency, empowerment, and integrity and how they had been threatened, but not obliterated, by her trauma experiences. Our identities are forged through our relationships with other people, real or fictionalized. I shared with Sue that reportedly Sotomayor was first inspired by the strong-willed Nancy Drew book character, and then after her diabetes diagnosis led doctors to suggest a different career from detective, she was inspired to go into a legal career and become a judge by watching the *Perry Mason* television series. At the age of 10, she knew she would go to college and become an attorney (Smith, 1998).

Our task was to generate positive characters in Sue's

life – real or fictionalized; past, present or future – that she could, in her words, "double click" in her mind get support (self-talk) to bolster her resilience (protection) against posttraumatic triggers. This intervention is what Michael White (1997) termed *re-membering practices*.

My first question to Sue: "If Sotomayor learned that you paint in your head in order to be less victimized by trauma and feel competent and empowered, what do you imagine she would think? What would resonate for her?"

Sue gave me a weird look, but then considered her response. "I think she would approve. Maybe she would even be impressed. She'd think back to what she learned from her mother – a single parent who tried as hard as she could, and, at the same time, had to kind of let go, do her own thing, take care of herself. Her mom probably cooked fun recipes in her head. I bet Sotomayor cooks fancy meals during boring courtroom testimonies."

I then asked Sue to speculate how her Sotomayor would respond to an important and difficult piece of our work: her guilt and shame regarding her uncle's abuse of her. Sue thought for a moment and reiterated what we had been working on for some time, but now via an imaginary dialogue with her mentor. "Sotomayor would help me understand what you and I have been talking about: the nature of abuse, the power differences between me and my uncle, that he was an adult and I was only a child and he kept threatening me if I didn't comply. And then she would ask me to imagine that he's in court on the stand and both she and I are cross examining him and how the jury only took practically no time to deliberate and rendered a verdict of "Guilty, guilty as charged!" Sue raised her hand in triumph. Sotomayor would have been proud. Her uncle and the traumatic agents in Sue's club of life were guilty as charged; Sue no longer had to hold the guilt and shame. Thus, our work of over 4 years came to an end. ✎

Serving People who are Deaf in Hospitals

This video presents tips and guidelines which are important when providing services to consumers who are Deaf. Two health consumers share their recent hospital experience.

<http://healthbridges.info/?p=427>

Healthbridges website offers information about social services, advocacy and behavioral health topics and resources available in Pennsylvania to persons who are Deaf, Deafblind and Hard of Hearing.

The Battle for Accessible Housing

(Continued from page 9)

ing - are barred from living there. [Cardinal Capital Management] will continue to fight for the right of all people who are deaf to have access to barrier free housing."

This apparently means that HUD's position is that they will withdraw the Letter of Finding, but because they were called out publically in an error, they will still punish AAT - and the rest of the Deaf Community - anyway by denying them Section 8 funds. In effect, this is the same result as if they had not withdrawn the letter.

Frequently language and communications barriers separate deaf and hard of hearing individuals who live in community housing from their neighbors. They are also usually separated from other deaf people. As a result, they can experience serious cases of loneliness. Many deaf and hard of hearing individuals who communicate in ASL desire to live among others who share their language.

As I See It

(Continued from page 10)

[could lose addiction recovery services](#)) The least politically and financially powerful groups are hit the hardest. Seriously mentally ill people or people with substance abuse problems will not have the same pull with policy makers that Big Pharma, the AMA or the Managed Healthcare Providers Association (MHPA). So money is taken from those who need it and given to those who are more politically connected.

Taking OMH rules to their logical and most efficient application would argue for specialized services in various languages, the very thing that Alabama had prior to 2009, at least in mental health services for deaf people. DHHS rules promulgated by CMS pursuant the passage of the so-called "Affordable Care Act," made niche services, say like addiction services or deaf-specific programming for example, financially infeasible.

At the same time, there is an ever greater push for "more interpreters." That fact that using interpreters instead of ASL fluent clinicians is paying for the same service twice, notwithstanding, the reimbursement rates are being driven down so low that the quality of those services approaches being worse than not having them at all.

Keep in mind that funding for interpreter training programs is drying up as well. New interpreters are not entering the field as fast as the old one are retiring or dying off. Yet over and over the excuse, "We tried to find an interpreter!" is proffered as a defense for discrimination.

And don't even get me started on the whole concept that

Signs of Mental Health

In response to this need, there have been numerous attempts by groups of deaf and hard of hearing individuals in various parts of this country to create "deaf-friendly" housing facilities where they can live together and enjoy ease of communication. AAT is one such effort, complete with visual alarms, video at the front entrance visible in every unit, enhanced Internet capacity for videophones, open sight line design in the hallways and rooms, reduced vibrations in the building design, and visual alerts on fans and disposals in every unit.

Another, in Mobile, AL, is Onderdonk Apartments, which has suffered the same fate as AAT. Under pressure from HUD, Onderdonk Apartments have been forced to accept non- ASL using Section 8 applicants, despite the original intent of the complex serving deaf people. This has created an environment where, not only are deaf people a minority in a place intended specifically for them, but the environment is no longer welcoming to them. ✂

paying for an interpreter is just a "cost of doing business" that providers have to eat. Yeah, I know that's what the law says. But providers quickly learn that there is little penalty for practicing "Irish Democracy," at least not relative to communication access.

There seems to be a determined push by the "Powers That Be" to reduce all services to deaf people to the lowest possible cost, regardless of the outcome. After all, deaf people with mental illness or addiction are among the least politically influential groups in the country. There are zero political consequences for policy makers throwing deaf people under the bus. (There are definite legal consequences when someone will fight. Alas, deaf people with severe mental illness or intellectual disabilities are hardly the most likely people to file a Title II or Title VI complaint.)

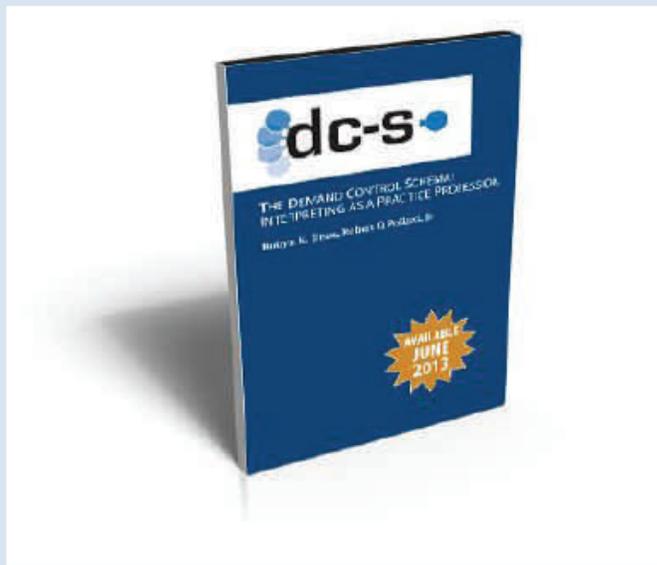
The article by Angela Kaufman in these pages this month demonstrates this thinking at the service provider level. These decisions are being made in obliviousness of decision being made elsewhere that negatively impact the quality of services provided.

As we increasingly see specialized services for deaf people being strangled off by funding decisions, we see proportionally increasing efforts to cut corners. **As I See It**, only constant vigilance, backed by decisive action will prevent a return to the dark days of the first half of the 20th century when deaf people were simply warehoused in institutions. Only this time, it will be prison instead of psychiatric hospitals. ✂

AVAILABLE NOW!

***The Demand Control Schema:
Interpreting as a Practice Profession***

by
Robyn K. Dean
and
Robert Q Pollard, Jr.



Dean and Pollard have been developing the demand control schema (DC-S) and their practice-profession approach to community interpreting since 1995. This textbook is the culmination of nearly two decades of work, as it evolved over the course of 22 articles and book chapters and nine DC-S research and training grants. Designed primarily for classroom use in interpreter education programs (IEPs), interpreting supervisors, mentors, and practitioners also will find this book highly rewarding. IEPs could readily use this text in introductory courses, ethics courses, and in practicum seminars. Each of its ten chapters guides the reader through increasingly sophisticated descriptions and applications of all the key elements of DC-S, including its theoretical constructs, the purpose and method of dialogic work analysis, the schema's teleological approach to interpreting ethics, and the importance of engaging in reflective practice, especially supervision of the type that is common in other practice professions. Each chapter concludes with a class activity, homework exercises, a check for understanding (quiz), discussion questions, and an advanced activity for practicing interpreters. The first page of each chapter presents a list of the chapter's key concepts, preparing the reader for an efficient and effective learning experience. Numerous full-color photos, tables, and figures help make DC-S come alive for the reader and assist in learning and retaining the concepts presented. Formal endorsements from an international panel of renown interpreter educators and scholars describe this text as "aesthetically pleasing," praising its "lively, accessible style," its "logic and organization," and referring to it as an "invaluable resource" with international appeal to "scholars and teachers." Spoken language interpreters also are proponents of DC-S and will find the material in this text applicable to their education and practice, as well.

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| Chapter 2: Controls of Interpreting | Chapter 7: Demand Constellations |
| Chapter 3: DC-S Rubric | Chapter 8: Consequences |
| Chapter 4: EIPI Categories | Chapter 9: Dialogic Work Analysis |
| Chapter 5: D-C Interactions | Chapter 10: The Reflective Practice of Supervision |

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2014 Mental Health Interpreter Institute

August 4 - 8, 2014

Montgomery, Alabama



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