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Steve Hamerdinger, Editor

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**ADMH/MR**

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# Signs of Mental Health

## WALTRIP TO HEADLINE 2006 CONSUMER CONFERENCE

Vikee Waltrip, a nationally known deaf comedienne, will be one of the highlights of the 2006 Consumer Conference at Schooco Springs, May 2. She will be speaking about her experiences as a consumer, who happens to be deaf, through trying to find her way through a maze of linguistically inappropriate services.

Waltrip, who became deaf at age 7, has starred in television and theatre productions including the John Larroquette Show. Calling herself an "all-round handy-womyn," Waltrip is also a playwright, director and actress. She has worked as a make-up artist, costume designer and has been involved in production work on multiple levels. She has worked with a number of Schools for the Deaf across the country as Artist-in-Residence.

In spite of her success as an artist, it has not been an easy road for Waltrip, whose struggles with bipolar disorder have shaped much of her life and philosophy. Living with mental illness and dealing with a series of major

setbacks in life have taught her much about how "the system" often comes up short in helping consumers, especially those who are deaf. Her experiences have given her a rich source of material for her comedy and a burning passion for improving mental health services for deaf people.



The Consumer Conference, now in its 14th year, drew almost 900 consumers from all over the state last year. It is one of the most successful consumer-run, consumer-oriented conferences in the nation. The Office

of Deaf Services proudly partners with the Office of Consumer Relations to provide communication access at the conference for those who are deaf or hard of hearing.

Plans are being made for Ms. Waltrip to also have a performance for the Deaf Community while she is here. More details will follow. For more information about Ms. Waltrip see her website at [www.v-dreamer.com](http://www.v-dreamer.com).

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## CRITCHFIELD TRAINS CLINICIANS IN CULTURAL IMPLICATIONS OF ASSESSMENT

The Office of Deaf Services, as part of the Mental Health Interpreter Training program sponsored a workshop on psychiatric assessment of deaf people. The instructor was Dr. A. Barry Critchfield, the director of the Office of Deaf Services at the Missouri Department of Mental Health and a nationally recognized expert on mental health and deafness.



*Above: Dr. Critchfield discusses the MSE with interpreters Below: The session for clinicians we well attended*

There were two sessions, one for interpreters and one for clinicians. The session focused on interpreters was held on January 21<sup>st</sup> and discussed specifics related to interpreting mental health and assessments. This session was attended by 25 interpreters from around the



state. The clinicians' session was on January 24<sup>th</sup> with 72 participants.

Dr. Critchfield discussed some of the psycho-social barriers clinicians who are not trained in deafness will discover confounding their test results. In particular he cautioned that when giving a Mental Status Exam the tester must be aware that consumers who are deaf may very well have "Fund of Knowledge" deficits that might be misinterpreted. He also discussed differences in "world view" that alter how deaf people perceive things.

During the interpreter session, role plays were utilized to emphasize how easy it is for an interpreter to skew the results as well as how important it is for the interpreter to understand what the examiner is attempting to do. Boundaries and alliances were highlighted and emphasized.

Participants at both sessions were able to interact with the presenter and ask probing questions that delved deeply into cultural differences. One participant remarked that the way deaf people have been treated would be considered "racist" if they were ethnically different.

This workshop was one of a series of workshops conducted under the auspices of the Mental Health

Interpreter Training project, funded by the Department of Mental Health and Mental Retardation and the Alabama Mental Illness Planning Council.



### **Region 1: Northern Alabama TBA, Coordinator**

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### **Region 2: Central Alabama Shannon Reese, Coordinator**

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## **VISUAL-GESTURAL COMMUNICATION LEADS TO BETTER LIFESTYLE**

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A small but significant subset of consumers we serve are those who have severe language dysfluency. For these consumers, language development has been poor both in English and sign language. They are sometimes identified as people with “minimal language skills” or “low functioning.” In any case, these consumers have a number of challenges that make it hard for traditional mental health services to be effective.

Language dysfluency may occur anywhere on a continuum between mild to severe. It can take several forms from coherent and consistent, but incorrect sign production – sometimes called “home signs” - to total incoherence and inability to iconically represent objects. While many people who are dysfluent have cognitive impairment, the relationship is not necessarily causative, unless one considers the lack of language exposure causing developmental retardation. On the other hand, some congenital etiologies of deafness include neurological deficits which

inhibit language development. Additionally, prenatal trauma, either in the form of maternal chemical dependency or physical injury may cause poor neurological development, also hindering language acquisition.

Many, if not most, non-organic cases of language delay in deaf children are sociological in origin. By this we mean that many young deaf children are not exposed to



functional language in their infancy and early toddler years. Delayed diagnosis of hearing loss, parental grieving process, uncertainty over how best to approach language and communication with babies, and lack of resources available to the parents all play a role in language development delay. The longer the delay, the more likely the child is to have deficient exposure to functional language.

At its most extreme, this deficiency can be nearly zero

exposure to language until the child enters school at age 5. Though extremely rare, this does happen, even with Early Intervention programs in place. In most cases, these children have other risk factors such as poverty, rural environment, or parental unavailability (either because both must work to make ends meet or because of family dysfunction).

This lack of exposure leads to maladaptive ways of manipulating their environment. In cases where the parents are emotionally unavailable acting out behavior may be an attempt to gain attention. Sometimes “explosive behavior” is merely an entirely human reaction to

communication barriers. When a person is unable to express wants and needs, the resulting frustration needs a vent. Lacking a verbal outlet, the emotional pressure is often vented in a physical way.

Demonstration projects have shown that increasing language and expressive communication leads to a decrease in maladaptive behavior. In a classic case study, a young DeafBlind man,

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*V-G Communication specialists use picture books, toys, and other visual cues to help dysfluent consumers develop communication skills.*

diagnosed with “intermittent explosive personality disorder” was being housed in developmental disability center. His near total lack of expressive or receptive communication presented many challenges to the staff. In an attempt to reduce the number of physical holds required (which often were several times a day), an intensive course of visual-gestural communication instruction utilizing a deaf person, one-on-one, was implemented. Over the course of six months, restraint holds were reduced in a classic “hockey stick” curve – slowly at first but more rapidly toward the end of the project.

Encouraged by this success, further exploration into the concept of visual-gestural communication was undertaken using deaf people with developmental disabilities and lesser degrees of language dysfluency. At the same time, work was being undertaken in Massachusetts at the Westborough State Hospital along similar lines involving deaf people with severe mental

illness. The results in both places, not surprisingly, indicated that increasing language had a direct correlation to decreasing maladaptive behavior.

The Office of Deaf Services is very interested in transplanting some of these concepts to Alabama. Piloting of this concept is now occurring in two of our state facilities with consumers who are waiting for a bed in the yet to be opened deaf inpatient unit. In one instance, staff are working with a consumer who, until V-G communication training intervention, was believed to be incapable of spontaneously producing language. He was labeled echolalic and MR. While still in early stages of intervention, he is now initiating communication and asking basic questions.



*V-G communication emphasizes practical ways of communicating information as opposed to traditional grammar-based sign language instruction.*

Training in visual-gestural communication has been conducted. Also, as part of the Mental Health Interpreter Training program, workshops for deaf people who wish to become interpreters have been conducted. Intermediary or relay interpreting is when a deaf person who is skilled in the use of visual-gestural communication works as a team with another interpreter to

facilitate communication with a consumer who is dysfluent. While visual-gestural communication development and intermediary interpreting are not the same, they are complementary skills and are taught in tandem.

One of the critical pieces to the inpatient unit staffing plan as proposed was a Communication Specialist. This position, modeled on a position of similar name at Westborough, will be responsible for both assessing and developing communication with severely dysfluent consumers and also serving as an intermediary interpreter for those consumers.

Dysfluent deaf consumers have traditionally had little or no input to their treatment plans. One of the core tenets of the consumer rights movement is that all consumers should have a voice in their treatment. Visual-gestural communication skills development, coupled with effective intermediary interpreting will give them a chance to have a voice. It will also increase their quality of life, which is, after all, the whole point of treatment. 



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## PREPARING DEAF ALABAMIANS FOR DISASTER

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Disaster is no stranger to Alabama. Unfortunately, emergency preparedness for the deaf community is not advancing as rapidly here as in some other places in the country. Nevertheless, there is action on this front, spearheaded by the Council of Organizations Serving Deaf Alabamians. The Office of Deaf Services is involved with this initiative. The effort, chaired by Evon Black and Ricky Holman, has several goals:

- o Form a Regional Committee to develop a regional emergency preparedness system
- o Implement several websites in Alabama to release the weather/emergency information to residents across the state.
- o Develop a standard PowerPoint presentation to train Emergency Management Agency officials, 911 and other necessary personnel groups – (Preparing them to work with Deaf/HH residents)
- o Have a basic training of Community Emergency Response Team (CERT) in some regional area.

There are a number of good resources for the deaf community on the internet. The Community Emergency Preparedness Information Network (CEPIN) Project is developing a comprehensive “all-hazards” site with a lot of useful information ([www.cepintdi.org](http://www.cepintdi.org)).

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## As I See It

By Steve Hamerdinger



Thinking on recent events brought to mind the famous Mary Mapes Dodge tale of the little Dutch boy who tried to stop the dike from leaking – or more properly the old Walt Disney cartoon where Mickey, cast in the traditional Hans Brinker role, finds that for every leak plugged another one springs open.

Three years into the development of Deaf Services finds several leaks in the dike. Personnel rules seriously hamper hiring staff needed to open the Bailey Deaf Unit as a culturally appropriate entity and a very small, but powerful group of people in positions of authority disparage the whole concept of specialized programming for people who are deaf. Nor is the Bailey Unit the only place where power and politics are trumping common sense and consumer needs.

Large sums of money are being expended to send kids out of state for psychiatric treatment, but no money can be found to develop appropriate services for deaf children who have emotional or behavioral disorders. Even though common sense and fiscal prudence would dictate that an intensive, linguistically appropriate program for deaf kids like this would be better all the way around, the concept founders on the shoals of an audist mindset.

By the time you read this, the legislative session will be well underway. Already we see ominous signs that the dike is leaking on that front as well. There are rumbles that funding for mental health services will be seriously short of what is needed for continuation of programming. Shortfalls like this often fall on the groups least able to lobby for their programs. The *Wyatt* lawsuit (and of course the *Bailey* lawsuit) are now in the “distant” past in political memory. No longer do the denizens of Goat Hill have to worry about fire and brimstone raining down from the court room of Marion Thompson.

On another front, the Dual Party Relay Fund is in danger of becoming a source of pork for well-connected groups who have nothing to do with deafness or hearing loss. This fund, established by a small surcharge on landline phones provides the funding needed to run the Alabama Relay system. The Relay allows for people who are deaf or hard of hearing full access to telecommunications – or so is the intent of the original legislation. Legislation now being considered in both houses will open the fund to other groups with disabilities who do not rely on the relay for communication.

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Even though it says it is still in development, important information is posted. The vital report, "Emergency Preparedness and Emergency Communication Access: Lessons Learned Since 9/11 and Recommendations" is available at

[www.cepintdi.org/dhhcanemergencyreport.pdf](http://www.cepintdi.org/dhhcanemergencyreport.pdf). In addition to this report, CEPIN has "Fact Sheets," which are downloadable and are very useful.

[www.cepintdi.org/national.htm](http://www.cepintdi.org/national.htm)

Another very good resource is the Emergency Email & Wireless Network, which broadcasts emergency alerts by e mail and text messaging. Its states that its mission is to "[p]rovide notification to citizens of local, regional, national and international emergencies utilizing the Internet and electronic mail (email) in a secure and expedient manner" Since many deaf people have text pagers, this is a service which can save lives. Most of the staff members of ODS and affiliated programs monitor this network. More information can be found at

[www.emergencyemailnetwork.com](http://www.emergencyemailnetwork.com).

During hurricane season, ODS monitors alerts from the National Hurricane Center (<http://www.nhc.noaa.gov>) and broadcasts specific information about hurricanes threatening Alabama on our listserve ALDMH. Deaf or hard of hearing people who wish to receive those notices can join the list at <http://health.groups.yahoo.com/group/ALDMH/>



## FOCUS ON THE TEAM

### Mona Nealy



My name is Mona Nealy, and I work as a Communication Specialist for the future Bailey Inpatient Unit AT Greil Psychiatric Hospital. I began my job on January 9, 2006.

As Communication Specialist, I am responsible for making sure that all deaf and hard of hearing patients have effective communication access. I do communication assessments of all deaf and hard of hearing patients, which provide the map from which we can design effective communication strategies. Communication assessments are done through patient interview, direct observation, chart review, and discussions with the Unit Staff. The assessment helps us figure out how to expand the patient's communication choices and reduce communication barriers. I provide sign language lessons for the consumers if they can and want to learn the sign language. I also provide one-on-one training in visual-gestural communication for consumers who are dysfluent. I used to work with some consumers with similar language dysfluency in my work at Janice Capilouto Center for the Deaf.

Another important part of my job is to function as a "relay interpreter." This is something I have done for "highly visual" deaf consumers before. At Bailey, I will continue to do relay interpreting and work towards earning certification as a Deaf Interpreter. I will also teach the general staff at the hospital sign language and provide consultation on Deaf and Hard of Hearing communication needs.

I started my education at a school for the deaf at the age of 4, and grew up attending deaf community events with my mother. I went to Model Secondary School for the Deaf for high school, and then went to Gallaudet University. While growing up, my family and I were involved in a church with Deaf and hearing members worshipping together. Many of those hearing church members were also involved in Deaf community activities.

My mother, Rev. Barbara Montague, who is a minister to deaf people, is the founder and director of Journey to Recovery, Inc., a recovery and sobriety resource agency for the deaf and hard of hearing community. I am currently involved in the new organization for Alabama Black Deaf Advocates as Vice President. It is just beginning.

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## As I See It

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Advocates for such legislation argue that there is a surplus in the fund and, in tight times, money should not “go to waste.” Perhaps so, *ceteris paribus* (all things being equal). But they are not. Historically there have been very few sources of funding for programs specifically for people who are deaf or hard of hearing, and those programs have traditionally been funded at fairly low levels. The Dual Party Relay fund is the notable exception. When Congress mandated that the states establish this fund, it did so mindful that over the course of history the Deaf community has largely been left behind the gravy train of entitlements routinely offered to other disability groups.

Why is it that some people think it is all right to take the one program that is specifically for people with hearing loss and turn it into yet another source of money for people who are able to communicate perfectly well by hearing and speech and who use this advantage to pillage programs designed for those who do not? What is it about deafness that causes people to run roughshod over those who have a hearing loss? Are we not as equally entitled to programs and services as those who are blind?

The same societal disrespect for the communication needs of those who are deaf and hard of hearing that lead to this unconscionable raid on the dual party relay fund are at the root of many of the problems that are being experienced in completing the development of the Bailey Deaf Unit or the

establishment of appropriate programming for deaf kids. “I don’t need to treat deaf people any different than I do other people,” was one objection given to the mission of Bailey.

The fact is, though, our needs are different and to “treat us equally” is, in fact to deny us service. Whether this is done overtly, by decimating a fund that could allow for universal access to telecommunications for people who are deaf or hard of hearing, or covertly, by refusing to cooperate with a well-designed, and time proven plan for mental health services for people who are deaf, the result is the same. **As I See It**, Deaf people are, once again, the ones who suffer. ✎

### FOCUS ON THE TEAM: MONA NEALY

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I enjoy spending time with my fiancé and our daughter, Maya, who is the joy of my life. I love shopping, traveling to visit with my family in PA and going to church. ✎

## “SEND ME A DEAF INTERPRETER!”

Many people mistakenly use the term “deaf interpreter” to mean a hearing interpreter who works between English and American Sign Language. This person should properly be called an interpreter. Sign language interpreters do not “interpret for the deaf” but rather interpret between speakers of English (usually hearing people) and people who use ASL.

But there is such a thing as a Deaf Interpreter! This is a deaf person who has been trained to work with other deaf people who have several language dysfluency and who rely heavily on visual-gestural communication (see page 3.) These individuals are used in high-risk situations where failure to communicate information can result in severe harm to the deaf consumer. Court hearings, forensic evaluations, and other assessments which may result in changes to a person’s basic civil freedoms are all situations that call for using a Certified Deaf Interpreter (CDI). ✎

## UPCOMING TRAINING

**April 10 - 13**

***Signed Communication Proficiency Interview Rater Training*** (By invitation only)

**April 17: Place TBA**

***Overcoming the Communication Barrier: Working With Consumers Who Have Hearing Loss***

This workshop will be an enjoyable, practical and hands-on workshop helping providers work better with consumers who are hard of hearing. Emphasis will be on understanding the impact of hearing loss and how to “work around” breakdowns in communication.

**September 11 – 16: Montgomery  
*Mental Health Interpreter Institute***

This is DMH’s nationally renowned annual 40-hour mental health interpreter training. Admission is open on a competitive basis to licensed or license-eligible interpreters only. Applications will be available soon. Contact Charlene Crump for more information.

# POSITIONS WITH THE OFFICE OF DEAF SERVICES

## OFFICE OF DEAF SERVICES

### **COORDINATOR, Region IV (Mobile)**

SALARY RANGE: 78 (\$42,458 - \$64,623)

QUALIFICATIONS: Master's degree in a clinical human service field such as Psychology, Sociology, Social Work, Counseling, or Rehab Counseling, plus experience (24 months). *Other job related education and /or experience maybe substituted for all or part of these basic requirements upon approval of the Job Evaluation Committee.*

### **INTERPRETER, Region III (Montgomery)**

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

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

For more information or for application, please contact: Steve Hamerdinger Director  
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Alabama Department of Mental Health and Mental Retardation  
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(334) 353-4701 (TTY)  
(334)353-4703 (Voice)

## THE BAILEY DEAF UNIT

The Bailey Unit, is hiring qualified clinical specialists who are fluent in American Sign Language to open this 10-bed specialized unit for deaf and hard of hearing people who have mental illness. The following positions are now open and applications are being accepted:

### **PSYCHOLOGICAL ASSOCIATE I**

SALARY RANGE: 69 (\$27,079 - \$41,035)

QUALIFICATIONS: Graduation from an accredited four-year college or university with a Master's degree in Psychology, Counseling or Social Work. Preference given to individuals with clinical area of concentration and practicum experience in working with deaf and hard of hearing individuals.

### **DEAF UNIT MENTAL HEALTH WORKER**

SALARY RANGE: 46 (\$16,502 - \$23,322)

QUALIFICATIONS: One year of college/post-secondary technical training and one year of experience in providing direct care or teacher aide services to deaf and hard of hearing individuals, preferably in mental health psychiatric hospital, group home, or nursing home. Other job-related education and/or experience may be substituted for all or part of these basic requirements upon approval of the Job Evaluation Committee.

All positions will be based at Greil Memorial Psychiatric Hospital, 2140 Upper Wetumpka Road, Montgomery, AL. 36107

For more information or for application, please contact:

Dr. Frances Ralston, Program Director  
Bailey Deaf Unit  
Office of Deaf Services  
Alabama Department of Mental Health and Mental Retardation  
100 North Union Street  
Montgomery, AL 36130

[Frances.ralston@greil.mh.alabama.gov](mailto:Frances.ralston@greil.mh.alabama.gov)

(334) 353-4701 (TTY)  
(334) 262-0363 ext 322 (Voice)

## GROUP HOMES

Group homes in Birmingham and Mobile are always accepting applications for direct care staff.

## BREAKOUT IX

National Mental Health & Deafness  
Conference



"Cultivating Recovery"

June 15-17, 2006

Hilton Hotel at Easton  
Columbus, Ohio



## DID YOU KNOW?

Deaf persons may manifest communication deficits or atypicalities for reasons other than mental illness. Sources of difficulty associated with studying language processing in deaf persons include:

1. The number of deaf who experience considerable language deprivation during childhood, a period crucially important for normal language development.
2. Certain prenatal or perinatal insults to the brain that cause deafness may, in some cases, also damage other parts of the brain. Such damage to the brain may create language deficits or disorders that resemble those seen in persons with schizophrenia when schizophrenia is not at all involved.

Being able to identify these confounding factors requires knowing what is "normal" development in deaf people. For this reason assessors are advised to use caution and seek expert consultation before assuming language dysfluency is the result of mental illness.