

Signs of Mental Health



Happy Holidays

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Alabama Department of Mental Health

Office of Deaf Services

P.O. Box 301410, Montgomery, Alabama 36130



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On The Cover:

The ODS family pauses for a moment at its annual two-day meeting to wish our readers Happy Holidays and a Mentally Healthy New Year.



ODS to Offer Mental Health First Aid Training in ASL

Amanda Somdal and Steve Hamerdinger completed training as Mental Health First Aid instructors November 5 – 9 in Nashville, TN. They join a growing group of certified instructors in the country offering this life-saving course.

According to the National Council for Behavioral Health, Mental Health First Aid is an evidence-based, in-person training program with proven ability to teach individuals how to recognize and respond to the warning signs of mental illness and substance use disorders and link people with appropriate treatment and support. Mental Health First Aid increases the understanding that mental illnesses are real, common and treatable.



Steve Hamerdinger and Amanda Somdal with their "ALGEE," MHFA mascot.

Originating in Australia in 2001, Mental Health First Aid has expanded to more than 23 countries worldwide. Since the program was first introduced in the United States in 2008, more than 11, 000 instructors have been certified to teach the program and hundreds of thousands of Americans have now been trained as Mental Health First Aiders. The National Council's goal is to make Mental Health First Aid as common as CPR.

Hamerdinger and Somdal will be working with agencies in Alabama to set up training sessions in ASL in 2019. The goal is to partner with sister organizations and offer the training on a regional basis. ✍



Editor's Notes

Another year comes to a close and ODS finds itself in unfamiliar territory. There are currently no vacant positions! This is the first time this has happened since the major restructuring in 2008. For the editor, it means there is no

"Help Wanted" page. That means another page of content. A nice problem.

This issue contains a guest article by our old friend, Neil Glickman. The original article first appeared in the National Association of State Mental Health Program Coordinators (NASMHPD) weekly *Update*. Dr. Glickman graciously allowed us to reprint a slightly edited version. There's other good stuff for your enjoyment too. Let us know what you think. ✍

Beth Moss Joins ODS as New Staff Interpreter



Beth Moss is a native Texan, who comes from a big, close-knit family, most of whom live in central Texas. She has a twin sister, a younger brother, and lots of extended family. Though no one else in her family signs, she learned about interpreting from a close friend of the family who became an interpreter after having a deaf son. Beth loved the challenges of learning a new language and culture and started the path to becoming a professional interpreter soon after.

After high school, Beth attended and graduated from McLennan Community College in Waco, TX with an Associates degree in Interpreter Training. Beth transferred to Maryville College in Maryville, TN where she graduated in 2005 with a Bachelor of Arts, double majoring in Interpreting and ASL/Deaf Studies. After graduation, she moved back home to Waco and interpreted at Texas State Technical College. She particularly enjoyed learning how to interpret the automotive classes. In 2007, Beth moved to Nashville, TN and worked as a staff interpreter for a local community center, Bridges for the Deaf and Hard of Hearing, where she had also done her internship.

Her time in Nashville was only made better by the incredible community of Deaf individuals and interpreters who mentored and supported her so that she could develop her skills as an interpreter. While she was in Nashville, Beth began interpreting for local theater companies and Broadway national tours. Her favorite two being *Les Misérables* and *The Book of Mormon*. Beth also began working with student interns at Bridges, which was one of her passion projects. She credits her past mentors with helping her gain any professional success and was thrilled with the opportunity to give back to future interpreters. She also worked with the youth program at Bridges, where she served as a camp counselor for the annual Rise and Sign weekend. Beth was also involved with the Tennessee Registry of Interpreters for the Deaf for many years, where she previously served as secretary and then vice president on the state board.

A few years ago, Beth began specializing in mental health interpreting. She attended MHIT in 2015, completed her practicum, and received her *Qualified Mental Health Interpreter* certificate from the Alabama Department of Mental Health. She began providing an introductory mental health training for the local interpreters in Nashville and began training mental health

facilities on how to work with deaf and hard of hearing patients through her work at Bridges.

Beth has recently taken the Mental Health Interpreter III position at Bryce Psychiatric Hospital in Tuscaloosa. She is thrilled to begin this new chapter in her life and to get to work with such a fantastic team of professionals.

Beth loves to spend time with her friends and family and relaxing at home with her cat, Luna. She has a love for books and enjoys reading in her spare time. She also loves decorating cakes, as skill she developed competing in the annual Halloween bake-off at Bridges. Though she never officially won, she was able to produce some awesome cakes and learned a fun, creative outlet. ✂

Operation Deaf Santa Brings Joy to Deaf Residents



Deaf consumers living in the various group homes around the state sometimes have miss out on the Joys of the Holiday season. Whether it is because they lack family support for one reason or another, or they are far from home, the season of joy and celebration can be a depressing time of year. But a dedicated group of people band together every year to make the days a bit merrier and brighter.

Since 2010, Friends of Deaf Services have annually purchased gifts for the group home residents. Enthusiastic participation from both staff and the larger community helps make this a successful project year after year. In an average year, 18–20 gifts are distributed. A call for contribution went out before Thanksgiving and the list was totally covered in 48 hours.

This year, 22 presents were carried off to the homes by ODS staff members. It's a fun tradition for us and a welcomed event for the consumers. ✂

Language Deprivation and Deaf Mental Health

Neil Glickman, Ph.D.
Assistant Professor of Psychiatry at
the University of Massachusetts
Medical School



In many respects, the process of mental health care between native users of sign and spoken languages is comparable. This is especially the case when working with deaf people who are native users of either spoken or sign languages. In these cases, a cultural perspective on Deaf people is often much more useful than a disability perspective in planning services. Mental health care of culturally Deaf people has many parallels with mental health care of other linguistic, social or cultural minorities (Glickman, 2013; Glickman & Gulati, 2003; Glickman & Harvey, 1996; Leigh, 2010). Cultural self-awareness, a respectful, affirmative attitude, a body of specialized knowledge about the target community, specialized language, communication and intervention skills are all essential, as they are when working with other minority populations (Glickman, 1996; Sue, Arredondo, & McDavis, 1992).

Many Deaf people object to the notion of deafness as a disability. They experience themselves as members of a community who have a language and culture or several cultures. The capital D in Deaf reflects this use of Deaf to represent a culture, not a kind of sensory deprivation. This positive view of sign language and all-other-things-Deaf is reflected in the title of an important recent book, *Deaf Gain* (Bauman & Murray, 2014) However, many deaf people (notice the lower-case d), especially those unaffiliated with the Deaf community who lose their hearing later in life, do experience their hearing loss as disabling; and for them deafness may well be associated with psychological conditions like depression and anxiety. Becoming deaf can certainly be experienced as traumatic. An example of this is Beethoven, for whom deafness was the worst calamity of his life. Like many late deafened people, he struggled to hide his hearing loss, at great psychological cost to him. Deafness also meant for him, as it does for many others, *not* membership in a special community, but isolation and loneliness.

While deafness may or may not be experienced as disabling for particular D/deaf people, there is a condition to which deaf people are vulnerable, language deprivation, which is unquestionably disabling. Deaf people are the only people in

the world who, with normal intellectual potential, may grow up without native language skills. This is not just because they are unable, even with new medical interventions like cochlear implantation, to hear sufficiently to acquire spoken language as hearing children do, but also because they may not be exposed sufficiently to natural sign languages (American, British or French Sign Languages, for example) to acquire native signing skills. For children with severe or profound deafness, acquiring spoken language skills requires great effort and is often not possible; whereas acquiring native sign language skills can be natural and effortless, providing the right environment is present. Without native abilities in either spoken or sign languages, deaf people develop dysfluent or impaired language abilities, and dysfluent language skills can be associated with cognitive impairments, social-emotional and behavioral problems. The dysfluencies range from mild and barely noticeable to profound and complex. They are often clinically significant in mental health contexts.

At the extreme end of the language deprivation continuum are a-lingual deaf people; that is, people with no or minimal formal language skills. Hearing people have usually never met any such people and may find it hard to believe that human beings with normal intelligence can be, essentially, languageless. Inside the Deaf Community, however, the problem of language deprivation is well-known. People know others who have limited language skills. Programs and specialists that serve D/deaf people usually know some a-lingual or semi-lingual deaf people.

In the United States, we are most likely to find a-lingual deaf people among immigrants from third world countries where they received minimal education, but you can also find them in rural, isolated American communities, or in other places where they have been hidden from the larger world. When they are discovered, such unfortunate people are often referred to mental health agencies who are always unprepared for them. There are a number of famous cases of a-lingual deaf people, such as that of Donald Lang, who in 1979 became the subject of a movie with LaVar Burton, of *Star Trek: The Next Generation* fame. Susan Schaller wrote a book about a community of a-lingual deaf people (Schaller, 1991). Most states have some of these difficult to serve people identified in either their state departments of mental health or their correctional system.

In the last few years in the Deaf Community and the Deaf mental health provider community, increasing attention is

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being paid to the problem of language deprivation. This is because the vast majority of deaf children are now mainstreamed and lack the opportunities of previous generations to learn natural sign languages (Spencer & Marschark, 2010). It is also because the practice of cochlear implantation, which does help some deaf children develop spoken language skills, commonly comes with the strong recommendation to the parents that they prevent their deaf child from having sign language exposure (Szarkowski, 2019). The problem is that the results of cochlear implantation are highly variable, and dependent upon factors other than the medical procedure itself. Discouraging early childhood sign language exposure is a high risk strategy, and when it fails, you have children with neither a sign nor spoken language foundation (Gulati, 2019; Szarkowski, 2019). Thus, opportunities for deaf children to develop native sign language abilities are dwindling, and with that we are seeing more deaf people without native language skills in any language.

If you ponder the issue of language deprivation, you'll realize how easily it can become the cause of learning and other cognitive deficits. People with significant language deprivation are unlikely to be literate, even at an elementary level, and they are also likely to have impaired abstract reasoning abilities and difficulty learning.

Consider this thought experiment. Is it possible to think about a squirrel in a tree without language, without names for squirrels or trees? It is. One can think about the image of the animal we call a squirrel moving about in an image of something we call a tree. You can do this without language. The author of this article, who worked for 17 years in a specialty Deaf psychiatric unit, had numerous opportunities to work with near a-lingual deaf persons who were able, sometimes, to give detailed accounts of events or things they experienced using very little formal language. It was a bit like watching a masterful mime although mimes usually have the advantage of knowing spoken language and therefore having capacities for story-telling already established linguistically. People with severe language deprivation, by contrast, often struggle to tell a clear story which has a beginning, middle and end, a defined set of characters or actors, logical segues, different points of view, and an appreciation of what details are essential to include. Even when they are expert gesturers, their language and thinking is often imprecise and difficult to follow.

Is it possible to consider without language, by contrast, a question like, "Why do squirrels climb trees?" That question, and everything else you might want to know about

squirrels and trees, requires formal language. Of course, it doesn't require spoken language. These questions can be pondered equally well in sign languages. Indeed, sign languages offer linguistic strategies for describing aspects of the visual environment that are often vastly superior to spoken languages.

Language deprivation has impact beyond cognitive impairment. It impacts psychosocial development. For instance, the mental health skills we refer to as emotional self-regulation, or coping, which is the focus of so much contemporary cognitive behavioral therapy (CBT), can be done without language (think of sensory strategies like rocking or jumping for self-regulation), but understanding the concept of self-regulation, and advancing beyond sensory movement interventions, requires formal language. Certainly, language deprivation can dramatically limit one's set of strategies for self-regulation. Similarly, interpersonal skills such as communication, problem solving and conflict resolution, which are also common foci of evidenced-based CBT, require formal language, though not necessarily full native language (Glickman, 2009, 2017). Indeed, appreciation of theory of mind (the idea that other people think differently than you do) also seems to require formal language (Ketelaar, Rieffe, Wiefelerink, & Frijns, 2012). Failure to develop adequate language skills may be associated with failures to develop empathic attunement (empathy) with other people (Gulati, 2019).

When deaf people are significantly language deprived, they are also vulnerable to developing behavioral problems. This also shouldn't be hard to understand. If you can't express yourself in language, and you have few of the tools that language enables, you are likely to "act out," to express yourself behaviorally. This is why we tell children to "use your words." But what could we tell a child, or, for that matter, an adult, who doesn't have many words or signs or who has vocabulary but limited grammar for organizing vocabulary? Would we send them to therapy? Doesn't therapy, the "talking cure," also require language? Doesn't it also require the linguistic ability to tell one's story?

Of course, one can do therapy in sign language, and we need more providers who have this skill. But the highly variant language abilities of language deprived deaf people means that besides interpreters, we are going to need communication specialists who can guide treatment providers in understanding what communication resources are needed. These resources will likely include Deaf interpreters who have a variety of creative interpreting strategies, all of which take more time, to "unpack" formal ASL and English and approximate linguistic equivalence (Wattman, 2019). They also likely include clinicians who have specialized knowledge and skills to work competently in mental health settings with

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deaf people whose language foundation, and therefore whose conceptual world, is very deprived.

These questions are coming increasingly to preoccupy specialists in Deaf mental health. They are discussed in depth in a new book edited by myself and Wyatte Hall, *Language deprivation and Deaf mental health* (Glickman & Hall, 2019). They are also the subject of an upcoming NASMHPD webinar by Steve Hamerdinger, the Director of the Office of Deaf Services in the Alabama Department of Mental Health. Some of the crucial questions emerging from work with language deprived deaf people are:

How might language deprivation complicate assessment of deaf people served in mental health programs? (Glickman, 2007; Pollard, 1998b)


Is there such a disorder as what Deaf psychiatrist Sanjay Gulati calls “language deprivation syndrome,” and might it exist as a common form of clinical co-morbidity in some deaf persons treated in mental health settings? (Gulati, 2019; Hall, Levin, & Anderson, 2017).

What are the challenges for interpreters when they are working with persons who are not fluent language users? Are interpreters effective as reasonable accommodations when clients lack significant language skills? When do we add Deaf interpreters to the interpreting team? What do clinicians need to know about the interpreting challenges with dysfluent language users? (Glickman & Crump, 2017; Pollard, 1998a; Wattman, 2019)

What would a comprehensive and valid communication assessment look like for deaf persons who appear to have dysfluent sign and/or spoken language? Should specialized communication assessments be required, as is currently done in four states, for deaf persons served in mental health or developmental disability agencies? (Williams & Crump, 2019) What questions could such assessments answer? (Henner, Reis, & Hoffmeister, 2019; Williams & Crump, 2019).

Are there emerging pedagogical practices that can enhance the language and communication skills of people who are passed the critical period for childhood language acquisition? (Spitz & Kegl, 2019)

How does one adapt mental health interventions so that they are more likely to be effective with deaf persons with language deprivation? (Glickman, 2017) Can this be done without hiring staff with highly specialized skills?

How do state mental health agencies insure they are providing services attuned to the cultural, linguistic and disability issues of diverse D/deaf people? (Gournaris, Hamerdinger, & Willians, 2013) 

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ODS Director Does National Webinar for NASMHPD

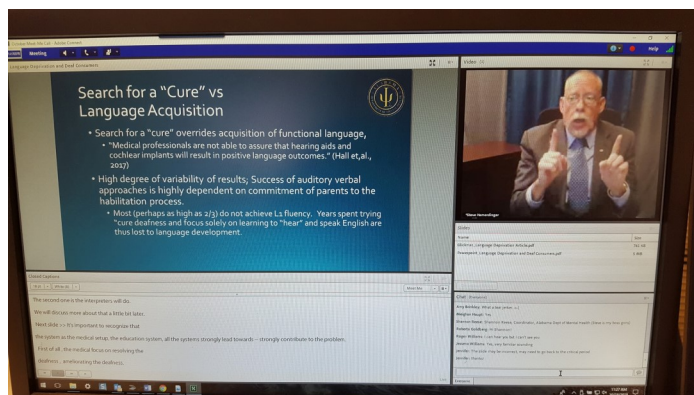
Steve Hamerdinger, Director of the Office of Deaf Services, led a national webinar under the auspices of the National Association of State Mental Health Program Directors on October 18, 2018. His topic was Language Deprivation and Deaf Consumers: An Under Recognized Barrier to Effective



Brian McKenny provides voice interpretation of Steve Hamerdinger's national webinar.

Mental Health Services. The webinar was part of the NASMHPDs' "Meet Me Call" series. The purpose of these calls is to raise the visibility of clinical issues important to state mental health authority leadership.

The webinar focused on a phenomenon unique to deaf people, which is growing up with poor language exposure resulting in extreme language dysfluency in the absence of a cognitive disability. This phenomenon is virtually unknown among people who are not deaf. This dysfluency, which is called language deprivation, has a profound and life-long impact on the deaf person's development, leading to involvement with a broad spectrum of legal and social services, and significantly complicates provision of those services.



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Webinar

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Hamerdinger discussed how this happens and offered suggestions and strategies to mitigate the consequences of language deprivation. He also talked about various system challenges and ideas for addressing them.

The webinar was presented in American Sign Language. Brian McKenny, ODS staff interpreter, provided the English interpretation. The webinar was also closed captioned. There were 71 active listening points connected to the call.



Meighan Haupt, NASMHPD Chief of Staff, said, "This issue is critical and preventable. The presentation brought home how language deprivation affects families, deaf consumers, and our behavioral health systems. This webinar had the most inquiries I have seen - and from different askers. I think that is indicative of the great interest of the people who attended and the desire for change/improvement." A recording of the webinar can be found at <https://nasmhpd.org/content/nasmhpd-october-meet-me-call-language-deprivation-and-deaf-consumers-under-recognized>. ↗

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 Certified Deaf Interpreters . *Denotes QMHI- Supervisors.

*Charlene Crump, Montgomery**
Denise Zander, Wisconsin
Nancy Hayes, Talladega
*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
Kathleen Lamb, North Carolina
Stacy Lawrence, Florida
Sandy Peplinski, Wisconsin
*Katherine Block, Wisconsin**
Steve Smart, Wisconsin
Stephanie Kerkvliet, Wisconsin
*Nicole Kulick, South Carolina**
Janet Whitlock, Georgia
*Sereta Campbell, Tuscaloosa**
Thai Morris, Georgia
Tim Mumm, Wisconsin
Patrick Galasso, Vermont
Kendra Keller, California
June Walatkiewicz, Michigan
Melanie Blechl, Wisconsin
Sara Miller, Wisconsin
Jenn Ulschak, Tennessee
Kathleen Lanker, California
Debra Barash, Wisconsin
Tera Cater Vorpahl, Wisconsin
Julayne Feilbach, New York
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, Oregon
Michael Klyn, California
Cali Luckett, Texas
Mariah Wojdacz, Georgia
David Payne, North Carolina
Amber Mullett, Wisconsin
Nancy Pfanner, Texas
Jennifer Janney, Delaware
*Stacie Adrian, Missouri**
Tomina Schwenke, Georgia
Bethany Batson, Tennessee
Karena Poupard, North Carolina
Tracy Kleppe, Wisconsin
Rebecca De Santis, New Mexico
Nicole Keeler, Wisconsin
Sarah Biello, Washington, D.C.
Scottie Allen, Wisconsin
Maria Kielma, Wisconsin
Erin Salmon, Georgia
Andrea Ginn, New Mexico
Carol Goeldner, Wisconsin
Susan Faltinson, Colorado
Crystal Bean, Arizona
Mistie Owens, Utah†
Claire Alexander, Minnesota
Amanda Gilderman, Minnesota
Jolleen Hudson, Washington State
Melissa Marsh, Minnesota
Bridget Sabatke, Minnesota
Adrienne Bodisch, Pennsylvania
Beth Moss, Tuscaloosa

Jasmine Lowe, Georgia
Pam Hill, Georgia
Lori Erwin, Georgia
Jenae Hanson, Minnesota
Katherine Anderson, Birmingham
Christina Healy, Oregon
Becky Lukkason, Minnesota
Leia Sparks, Wisconsin
Roxanna Sylvia, Massachusetts
LaShawnda Lowe, Prattville
Leia Sparks, Wisconsin
Jamie Garrison, Wisconsin (Emeritus)
Deb Walker, Georgia
*Tara Tobin-Rogers, New York**
Leah Rushing, Georgia
*Keshia Farrand, Huntsville**
Lori Milcic, Pennsylvania
Shawn Vriezen, Minnesota†
Kathleen Drerup, Texas
Melody Fico, Utah
Emily Engel, Minnesota
LaVern Lowe, Georgia
Paula MacDonald, Minnesota
Margaret Montgomery, Minnesota
Rachel Effinger, Virginia
Karen Holzer, Wisconsin
Rebecca Conrad-Adams, Ohio
Dixie Duncan, Minnesota
Brandi Hoie, Minnesota
Renae Bitner, North Dakota
Jennifer Kuyrkendall, Tuscaloosa
Jessica Minges, Kentucky
Lisa Heglund, Wisconsin
Colleen Thayer, Oregon†
Susan Elizabeth Rangel, Illinois†
Tina McDaniel, Oregon
Melissa Klindtworth, Washington

ODS Conducts Regional Training Event to Help Interpreters Better Understand Mental Health Work

By Keshia Farrand,
Region I Interpreter Coordinator

On November 2, ODS Region I hosted Ashley Reuss from Minnesota, who presented, "A New Way of Interpreting for 12-Step Programs." This was a foundational workshop focused on learning the Alcoholics Anonymous Big Book and the 12-Steps. Twenty-five people were in attendance at the training which was held at North Central Mental Health Center in Decatur, Alabama.



Reuss holds a Bachelor's degree in Social Work and a Masters degree in Deaf Studies and Sign Language Teaching from Gallaudet University. She works as a Domestic Violence Advocate with ThinkSelf, a Minnesota-based 501c3 nonprofit serving deaf, deafblind, deaf disabled and hard of hearing individuals from a wide range of backgrounds. It offers Adult Basic Education to deaf and hard of hearing Minnesotans who wish to expand their literacy skills, learn about workforce preparation, and establish long term career goals. Its other primary program



focuses on domestic violence and sexual assault advocacy, providing support and creating opportunities for healing and self-empowerment to survivors.


While the day focused on AA meetings and recovery, other 12-Step programs have borrowed from this program making the information applicable in other recovery settings. As the

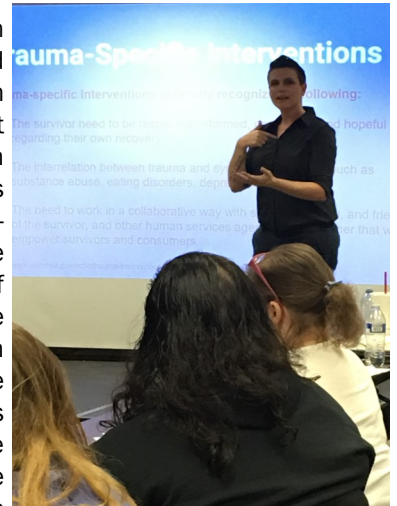
Big Book was written in 1939 and has remained untouched – aside from the personal stories that have been added through the years – the language is not always clearly understood – even by literate hearing adults. For deaf people, especially those with limited English proficiency, it can be impenetrable. This creates challenges for both the hearing and Deaf people participating in the groups and interpreters alike.

Reuss took the participants through the 12-Steps, expanding their knowledge of what each one means and the impact that certain phrases can have on the recovery process. During this discussion, Reuss stopped at key steps to give everyone the opportunity to experience the process firsthand. Understanding the program is key for an interpreter to be able to effectively interpret the message. Participants were able to learn more about the experiences of Deaf participants of 12-step programs and the challenges they face when attempting to access recovery – not only trying to understand the Big Book, but barriers to accessible meetings.

To ensure we can appropriately support the Deaf community, we need more interpreters that are both are willing to work in this challenging setting and have exposure to what 12-step programs look like. The result would be that when individuals seek recovery, they will be able to access the resources they need. We had a great turn out with no shortage of discussion and collaboration between attendees.

ODS staff members, Keshia Farrand and Kim Thornsberry organized the event, They were grateful to all who came out. ODS plans several such one-day events around the state in 2019. If you have any topics you would like to learn more about, please feel free to let us know.

ODS is partnering with other agencies to offer a deaf-focused track at the Alabama School for Alcohol and other Drug Studies, March 18 – 22, 2019 in Tuscaloosa. Among the scheduled speakers from ODS are Steve Hamerding, Charlene Crump, Kent Schafer and Brian McKenny. See <http://asadsonline.com/> for more information. 



The interests of the deaf child and his parents may best be served by accepting that he is a deaf person, with an elaborate cultural and linguistic heritage that can enrich his parent's life as it will his own.

Harlan Lane

As I See It

Paul Hamacher



This fall, I had the privilege of conducting a webinar for the National Association of State Mental Health Program Directors. The webinar came about because of a conversation between my two good friends, Dr. Neil Glickman, of Massachusetts and Meigan Haupt, the Chief of Staff at NASMHPD. This webinar is discussed elsewhere in this issue. Dr. Glickman, along with several colleagues, including Dr. Melissa Anderson and Dr. Wyatt Hall, have been on the forefront of promoting language deprivation as a major emerging issue in deaf mental health care.

Actually, to call it “emerging” is misleading. The problems created by the lack of functional language have been known to us since the field solidified in the later part of the 20th century. It just hasn’t always been recognized for what it was. I remember an ADARA conference I attended, back in late 80’s, where Dr. Barry Critchfield made the assertion that the top functioning 20% of the consumers served by the mental health system consume 80% of the resources, while the system ignored the more compelling needs of the 80% that did not have the wherewithal to successfully advocate for themselves. The consumers who got the most resources were frequently those who were the least debilitated by the combination of mental illness and language dysfluency.

Since that time, the larger mental health system has not recognized the problem or responded in helpful ways. Labels given to the phenomenon have been worse than useless – they tended to be detrimental. From “primitive personality disorder” and “low-functioning deaf” to “surdophrenia” and “high-visual,” these labels diverted attention from the root causes and, more importantly, the implications for treatment. Some of this mislabeling has simply been the result of well-intentioned, but misguided attempts to be politically correct or socially sensitive. “Traditionally Underserved Deaf” was the term of art at one time. Passed down by the same great minds in the cloistered halls of the Federal government that gave us “hearing impaired,” it was a distinctly useless euphemism. It could – and was – argued that most deaf people were underserved!

In some cases, the labels were attempts to classify a certain set of observable behavior and define them in clinical terms prevalent at the time. In others, the labels derived from condescending attitudes of a social service system that was

irritated when a particular group of people failed to fit into bureaucratically established pigeonholes.

There have always been deaf people who grew up in language-impooverished environments. Even in the United States, there are areas where people are too isolated to be captured by the social service/education net, or who, for various reasons, chose to avoid those systems. In some parts of the world, this language impoverishment is the norm. In the U.S., it used to be an exception. One of the reasons for this was that until the 1990’s, a vast majority of deaf children were educated in state schools for the deaf. It was not uncommon for a child to arrive at the school without a functional language, but most deaf kids were able to develop language over the time they were pupils at the deaf school. They were immersed in a language-rich environment, surrounded by excellent language models.

Things have changed. Today, a vast majority, something close to 90% of all deaf kids are educated in public schools – mainstreamed – with widely divergent quality of language models. It is not uncommon for a deaf child to go through public “education” and emerge, not only functionally illiterate, but functionally ailing. (See the case of F.M. & L.G. versus Barbour County.)

This is not to say that kids going to center schools for the deaf were without problems. You do not spend the first five to six years of your life without a functional language and not develop some kind of psychological scar tissue. The wonder is not that deaf people have mental health issues related to lack of language development, but that so few do. Resiliency of deaf kids is an amazing thing. But oh, how wretched is the lot of those who never were able to overcome that deprivation. Heavily publicized stories of people like Donald Lang and Junius Wilson read like psychological horror novels. They, and many like them, became lost in a system that was, and still is, unable to address the root problem, which is that deaf people, deprived of functional language are not able to be served in the current social welfare system. Their fates are often either incarceration or institutionalization.

There are two different and unique reasons for asserting that our mental health care system poorly serves people with language deprivation. The first is that the system, as a whole, poorly serves deaf people generally. Whether it is from a lack of awareness that addressing deaf people as a linguistic minority is more effective than addressing them as a disabled population or due to ideological rigidity, most places do not really modify services to fit people who are deaf. Notice that I used to word modify, not accommodate. There is a reason for this. All social service systems are required by law to “accommodate” people with disabilities. In theory, this means that people with disabilities are supposed to be able to enjoy the benefits of any program that receives any public

money. In reality, the law does not require that these accommodations actually result in anyone benefiting from the services. Much the same as special education law absolves the education system of liability if a given disabled student does not progress in a program made “accessible” by “reasonable accommodations,” the mental health system is usually not called to account when it fails to serve a particular person effectively.

When this person is deaf, the nearly universal response is to provide an “interpreter.” The qualifications of that interpreter is the subject of another article or ten. But what about when the person being “accommodated” is language deprived? What good is an interpreter then? Much like what happens with students in the educational world, deaf people with mental illness thus fails repeatedly to benefit from the programs offered and spirals ever downward into more restrictive and even less appropriate placements. This inability to adjust points to the second problem, which is lack dedicated programs serving deaf people with mental illness.

Few states address deaf mental health care at the state level. These state-level programs vary widely in design and scope. Most simply appoint a low-level functionary, sometimes within an advocacy office, sometimes within another program and charge them to “make sure services are accessible.” Some states don’t even do that.


A position designated as a full-time state director exists in very few states and the effectiveness of those directors varies. However, there are some commonalities which can provide lessons for improving the effectiveness of the mental health system as a whole. It starts and ends with language competence. Unless the state director is fluent in American Sign Language, the Deaf Community is unlikely to be engaged. Furthermore, it is unlikely that the director will understand the complexities of the population that they are serving. It is rather like appointing someone who does not speak Spanish to head up a program serving Hispanic people. To put it another way, a large part of the job the state director is to be the public face of the mental health system in the eyes of the Deaf Community. That this even has to be explained speaks volumes about the pervasiveness of the debilitating attitudes among many people in the mental health community. It is as if the mere mention of the word “deaf” causes their critical thinking skills to be held in abeyance.

Which means the state deaf mental health program director also must be an extremely effective communicator in English, assuming we are talking about English-speaking governmental entities. Effective communication skills are usually hard-won through experience in a bureaucracy that is slow to adapt to different or unique points of view. Learning how to say something in a way

that will be understood by “the other” is hard. Learning when not to say something is even harder.

The state director of deaf mental health care needs thick skin. “Stupid Hearing People” is a meme in deafness related fields for a reason. We are often confronted with people who hold opinions about how deaf services should be delivered that are uninformed, at best, and oppressive, at worst. Some people are well-intentioned and can be persuaded. Others are ideologues who will not budge from cherished bromides about “inclusion” or least restrictive environments (LRE), regardless of the plethora of evidence that their “LRE” is the most isolating, oppressive, and damaging place possible for the deaf consumer. Encounters with these “true believers” often results in ingestion of massive quantities of calcium carbonate in hope of preventing peptic ulcers.

Finally, the state director is most effective if he or she has been clinically trained and experienced in working with deaf people with mental illness and who have language dysfluency. This should be blindingly obvious, but dealing with those who have a mentality that thinks two weeks of sign language classes equips a hearing person to be able to interpret a psychiatric evaluation, will see no issue with having that same “interpreter”, or someone even less familiar with deaf people, heading up a deaf mental health program. This is a recipe for, at best, ineffective, and more probably, outright harmful muddling up the lives of deaf people who have been neglected, systemically abused, individually oppressed all their lives. An effective state director will be one who not only understands clinical practice, but also has had experience in working with deaf people with all sorts of dysfluent language, including language deprivation. The state director has to have a deep understating of causes of language dysfluency and how to assess the impact and amelioration of the barriers to treatment caused by that dysfluency.

Language deprivation among deaf people is one of the most complex and frustrating challenges facing American’s social service system. It is an iatropic problem that can be laid squarely at the feet of warring factions within the medical, educational and social service systems. The arguments and recriminations derived from a mentality deeply rooted in Victorian era ideas of eugenics continue as virulently today as they did in the late 19th century when A. G. Bell and Edward Gallaudet heatedly debated each other over which approach to deaf education was “right”. Today, the human wreckage is all too real to those of us who work in deaf mental health care. *As I See It*, there will be no resolution to schism in my lifetime. The best we can hope for, is to improve deaf mental health care in order to salvage something from the lives so callously tossed aside in the interest of ideological purity, on both sides. 




DeafLEAD Announces New Service for the Deaf Community

By Dr. Stephanie Logan, Ph.D., M.B.A. Executive Director, DeafLEAD (formerly The L.E.A.D Institute)

DeafLEAD, a Deaf-run non-profit agency located in Missouri, is now offering two new services for Deaf victims of crime. The first services is a 24/7/365 crisis videophone hotline for the Deaf community called the Deaf Crisis Line. Crisis Line advocates fluent in sign language are trained to provide immediate emotional support, recognizing that trauma can have an ongoing impact on an individual's life, regardless of when the event occurred. By providing the Crisis Line services in sign language directly through the videophone, Deaf individuals receive unprecedented access to immediate assistance and resources that are both culturally and linguistically accessible utilizing a trauma-informed approach. This Crisis Line focuses on meeting the needs of Deaf individuals who are victims of crime (past or present) including: domestic and sexual violence of adults or children, bullying (cyber, physical, or verbal), teen dating violence, burglary or robbery, child abuse or neglect, elder abuse, drunk driving or other vehicular victimization, human trafficking, any hate crime, identity theft or other financial crime, any form of mass violence, terrorism whether domestic or international, and a violation of a court order. Here is a link explaining the new Deaf Videophone Crisis Line: <https://youtu.be/i042-DJWt8>.



Another service developed by DeafLEAD is free sign language interpreting for Deaf individuals who have been victims of crime, as well as for hearing service providers working with Deaf victims. Through the use of a videophone, Facetime, or Skype, DeafLEAD interpreters can facilitate culturally and linguistically effective communication to ensure that Deaf victims are provided accessible services and support. Services may include interpreting crisis intervention, legal and mental health appointments, shelter intakes and support, case management, services provided by law enforcement, and any other victim-related services. The DeafLEAD crisis interpreters are CI/CT nationally

certified with extensive training and experience working with Deaf victims of crime. The goal of the program is not to absolve agencies from their responsibility of providing accessible accommodations. Instead, the goal is to improve communication accessibility for Deaf victims with victim service providers more closely to the time that it is needed. It is hoped that this access to communication will increase the likelihood of Deaf victims successfully living free from their abuser. DeafLEAD staff then work closely with service providers to find interpreters in their area as needed. More information about DeafLEAD and the services they offer is available at DeafLEAD's website: www.deaflead.com. 

Danielle Elliot Bull Completes Internship




I am grateful for the opportunity to intern with the Alabama Department of Mental Health, Office of Deaf Services. My internship with Office of Deaf Services began at the end of May and now has ended this month of

December. It was a wonderful experience and made me even more certain that I would love to pursue a career in mental health counseling.

I was able to spend many hours with each therapist all over the state of Alabama – listening and talking with them about their experiences and learning from their feedback. It was incredibly rewarding to be able to learn from each therapist in all five regions. I was able to enrich my skills and knowledge as a therapist. Each therapist helped me recognize different strengths, weaknesses and challenges. Most of all, each therapist believed in me and encouraged me to be the best I could be.

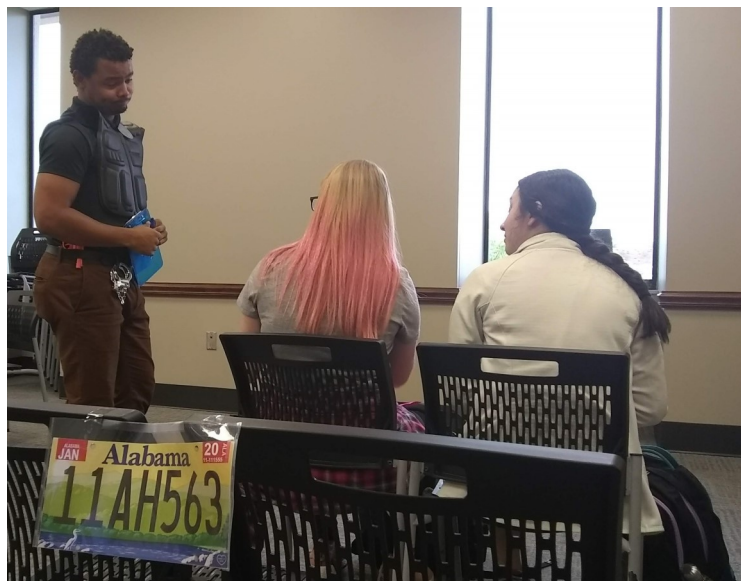
I also had the opportunity to work with different interpreters all over the state of Alabama as well. Interpreters from Office of Deaf Services empowered the deaf consumers and the deaf staff to be the best they could be. Each interpreter showed enthusiasm in all tasks to help every deaf consumer and deaf staff. It has been an incredible experience to be able to work with them.

The advice and feedback I have received from everyone has been tremendously helpful and rewarding over the past several months. I am grateful that Office of Deaf Services showed confidence in me by providing this internship. Lastly, it is with hope that after graduation, I might be able to find out at greater length about the direction I might take in pursuing a career with Office of Deaf Services. 

It's a Deaf, Deaf, Deaf, Deaf World!


ODS Helps Out at UA Training Event to Raise Deaf Awareness

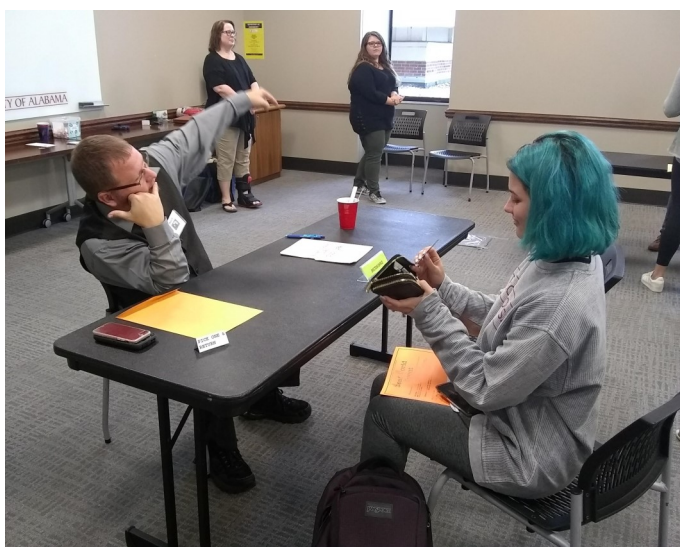
On October 16, several ODS staff members were involved in the University of Alabama, Critical Languages Center's first Deaf World Event held on campus in Tuscaloosa, Alabama. The event's purpose was to provide an opportunity for the University of Alabama students, faculty and staff to gain insight into the Deaf experience. There was a hands-on portion of the event, that allowed hearing participants to interact in daily scenarios, however, the only mode of communication allowed was American Sign Language. The goal was to increase awareness of the communication challenges Deaf people may encounter daily. The second portion of the event provided participants with an opportunity to debrief about their experience during the hands-on portion with an ODS mental health counselor, Miranda Nichols. The planning and execution of the DWE was by Jennifer Kuyrkendall, ODS Bryce-based mental health interpreter who is also a language trainer at UA's Critical Languages Center.



Justin Perez pulls over some reckless drivers.

Alabama Department of Rehabilitation Services, and Eric Liddie from the Alabama Institute for the Deaf and Blind Tuscaloosa Regional office. Participants were from various programs including accounting, advertising, anthropology, art, business, chemical engineering, civil engineering, communication disorders, communications, dance, early childhood, education, English, environmental engineering, hospitality, international relations, management, marketing, nursing, political science, psychology, public health, public relations and social work.

The event received overwhelmingly positive feedback from participants. As always, ODS looks forward to giving back to the community and being involved in future collaborations that impact our communities. 



Kent Schafer delivers medical results to a patient.

ASL-fluent volunteers manned stations that presented daily scenarios that included encounters at the bank, post office, airline counter, doctor's office and with law enforcement. At each station, participants picked a common task/scenario to be completed and when the task was sufficiently completed, participants moved onto another station, until their assigned activity route was completed.

Participants who were unfamiliar with the Deaf community were encouraged to attend. The event unexpectedly garnered under just 200 participants and included volunteers Susan Gordan and Beth Overland from the



An unexpectedly large crowd turned out for the event.



Important Recent Articles of Interest

Holcomb, T. K., & Smith, D. H. (2018). *Deaf Eyes on Interpreting*. Gallaudet University Press.

As the ASL-English interpreting field has become professionalized, there is a growing disconnect between interpreters and the Deaf consumers they serve. Whereas interpreting used to be a community-based practice, the field is growing into a research-based profession that begins in a classroom rather than in the Deaf community. Despite the many gains being made in the interpreting services profession, with an emphasis on the accuracy of the interpreted work, the perspectives of Deaf individuals are rarely documented in the literature. Opportunities for enhanced participation and full inclusion need to be considered in order for Deaf people to best represent themselves to the hearing, nonsigning public as competent and intelligent individuals.

Deaf Eyes on Interpreting brings Deaf people to the forefront of the discussions about what constitutes quality interpreting services. The contributors are all Deaf professionals who use interpreters on a regular basis, and their insights and recommendations are based on research as well as on personal experiences. These multiple perspectives reveal strategies to maximize access to interpreted work and hearing environments and to facilitate trust and understanding between interpreters and Deaf consumers. Interpreter educators, interpreting students, professional interpreters, and Deaf individuals will all benefit from the approaches offered in this collection.

Rogers, K. D., Ferguson-Coleman, E., & Young, A. (2018). *Challenges of Realising Patient-Centred Outcomes for Deaf Patients*. *The Patient-Patient-Centered Outcomes Research*, 11(1), 9-16.

Abstract: In general populations, it has been recognised that patients play a key role in the quality of their own healthcare. However, the idea of realising patient-centred outcomes for the signing Deaf community, who experience the world in a visual way, raises some challenging issues that are rarely acknowledged. Using published research and translational health projects involving Deaf people both in the UK and internationally, this article discusses the

challenges of realising patient-centred outcomes for Deaf people who are sign language users. The discussion includes an examination of: barriers to accessing healthcare for Deaf people; the impact of an insufficient acquisition of knowledge about health-related issues; Deaf people's limited fund of information; not recognising Deaf people's values and citizenship rights; and challenges in gathering Deaf people's reported outcomes. We contend that without including Deaf people in shaping the healthcare experience for them, whether at an interpersonal level of patient engagement or at a structural level, the concept of fulfilling patient-centred outcomes for Deaf people is not achievable.

Ackroyd, V., & Wright, B. (2018). *Working with British Sign Language (BSL) interpreters: lessons from child and adolescent mental health services in the UK*. *Journal of Communication in Healthcare*, 11(3), 195-204.

Abstract: Having good access to information is crucial when attending an appointment with a health professional; for 5% of the world's population, who have some degree of hearing loss, this is challenging. With the introduction of acts against discrimination in the U.K., there is a responsibility to provide equitable access to services; best practice states that professionals should work with a registered British Sign Language Interpreter. In child and adolescent mental health services, practitioners may work with the deaf child/young person and their families; this presents many challenges. Previous models of interpreting do not lend themselves to this setting; interpreters need to have high levels of language and two-way interpreting skills, imparting detailed information about language and communication demands they face. Method: The role of the interpreter in the team was audited at two time points using an activity recording sheet; this is integrated with available literature and our clinical expertise. Results: Based on iterative audits and expert panels to discuss good practice, we have formulated a helpful way of working with interpreters. To enable robust assessments and therapeutic interventions, clinicians and interpreters are required to co-work. We discuss our experiences of helpful practices when working with interpreters including the importance of pre-appointment meetings, co-working during sessions, and debriefing. Conclusion: We make recommendations for working with deaf children/young people, improving communication with them and their families, and their experi-

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Recent Articles

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ence of services, all of which could potentially improve outcomes.

Movallali, G., Musavi, Z., & Hakimi-Rad, E. (2018). *Feeling of Loneliness in Deaf Adolescents: the Effect of An Online Life Skills Program*. *European Journal of Social Sciences Education and Research*, 12(1), 130-137.

Abstract: The aim of the current study was to investigate the effect of life skills training on the reduction of feeling of loneliness among deaf and hard of hearing adolescents. This study had a pretest-posttest with control and experimental group design using convenience sampling. The Feelings of Loneliness Questionnaire developed by Dehshiri (1387) was filled in by 275 individuals who were joined in a special social network for the deaf. The age range of the sample group was from 17 to 37. Thirty of them who had the lowest scores in feelings of loneliness were randomly assigned to two fifteen-person groups. The experimental group received online life skills-based education, while the control group received no intervention. The training was performed in ten 120-minutes sessions. The data were analyzed by ANCOVA and repeated measures test. The results indicated that the online life skills-based training program reduced feelings of loneliness caused by a lack of interaction with friends and family in deaf adolescents. According to the results of this study, life skills are so important for deaf adolescents and paying attention to these skills is a social necessity through which the mental health of individuals with hearing impairment and deafness can be improved. In addition, regarding the effectiveness of online life skills-based education and considering the inaccessibility of conventional consultation for all of individuals with hearing impairment and deafness, online counseling and also online social, cognitive, and consultative rehabilitation can be used and is recommended in other domains.

Bartlett, S. (2017). *Disabled or Deaf? Investigating mental health clinicians' knowledge of and attitude towards Deafness as a culture*. *International Journal of Culture and Mental Health*, 1-10.

Abstract: Past research has shown people who predominately use British Sign Language to communicate have their own cultural identity. The current research used an online questionnaire and

opportunity sampling to assess clinician awareness of Deaf culture and their knowledge of D/deafness. The UK Department of Health previously published recommendations aimed at making mental health services more accessible for D/deaf individuals and so the current accessibility of services for D/deaf individuals is also considered. The study found mixed attitudes towards Deafness and limited knowledge of Deafness by clinicians working within a mental health context. There appears to be limited implementation of the recommendations given by the Department of Health. Suggestions are given for improving services for D/deaf clients. ✍

Notes and Notables

Events and Honors in the ODS Family

Kim Thornsberry and Amanda Somdal led “Lunch and Learn” sessions for Mountain Lakes Behavioral Health Center focusing on Domestic Violence in the Deaf Community. Two sessions, one on November 28 in Guntersville and one on November 29 in Scottsboro allowed nearly 40 members of the MLBHC staff to attend.



Miranda Nichols and Charlene Crump have both passed their National Counselor Examination and are certified by the National Board of Certified Counselors.

Addressing a group 75 juniors and seniors studying speech and language pathology at the University of Alabama, Kent Schafer gave a lecture on “Aural Rehabilitation – Form v. Function”, delving into the importance of visual language suggesting as currently practiced, the field probably should be called “Speech and English Pathology”! ✍

LANGUAGE DEPRIVATION AND DEAF MENTAL HEALTH



Edited by
Neil S. Glickman and Wyatt C. Hall



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Hb: 978-1-138-73538-5 | \$140.00

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Language Deprivation and Deaf Mental Health

Neil S. Glickman PhD, University of Massachusetts Medical School

Wyatte C. Hall PhD, University of Rochester Medical Center

Language Deprivation and Deaf Mental Health explores the impact of the language deprivation that some deaf individuals experience by not being provided fully accessible language exposure during childhood. Leading experts in Deaf mental health care discuss the implications of language deprivation for a person's development, communication, cognitive abilities, behavior, and mental health. Beginning with a groundbreaking discussion of language deprivation syndrome, the chapters address the challenges of psychotherapy, interpreting, communication and forensic assessment, language and communication development with language deprived persons, as well as whether cochlear implantation means deaf children should not receive rich sign language exposure. The book concludes with a discussion of the most effective advocacy strategies to prevent language deprivation. These issues, which draw on both cultural and disability perspectives, are central to the emerging clinical specialty of Deaf mental health.

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SOMH Editor's Note: This book has a chapter by ODS' Charlene Crump. We are proud as can be for her.

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PRESENTERS INCLUDE:

Bob Pollard, Robyn Dean, Roger Williams, Steve Hamerdinger, Charlene Crump, Amanda Somdal, Kent Schafer, et. al.

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Alabama Department of Mental Health-Office of Deaf Services
and ADARA PRESENTS



Language Deprivation:
How Does – or Should – it Change
What professionals in Deafness Do?

Thursday, April 11, 2019
9:30 am to 4:00 pm (5.5 clock hours)
***Lunch on your own**

\$40 Registration fee prior to March 1, 2019

\$50 if paid March 1 and after

\$20 registration for full time ITP or Counseling Students (Non-certified, non-working) prior to March 1, 2019

\$30 registration for full time ITP or Counseling Students (Non-certified, non-working) March 1st and after.

Registration fee waived for employees of ADMH, employees of CMHCs, and contracted SA provider agencies.



Presenter

Melissa L. Anderson, Ph.D., MSCI

Location

Alabama Department of Transportation
1409 Coliseum Boulevard, Montgomery, AL

A person impacted by language deprivation may struggle with concepts of time, story sequencing/developing a coherent narrative, a sense of self, cause-and-effect/the concept of why?, experiences of powerlessness/confusion, rigid modes of behavior, ability to learn from mistakes (use of generalizations), lacks awareness of others' need for context, lacks theory of mind (understanding others' perspectives), lack of understanding of limits to others' ability to figure out the message, abstract concepts, difficulty learning, emotional regulation, acting out of emotions/feelings, struggles in relationships, can lead to victimization or victimizing, competency to stand trial, reduced fund of information, etc.

This session is targeted at service providers who specialize in some aspect of deafness (therapists, rehabilitation counselors and specialists, direct care staff, substance abuse providers, teachers and education staff, and interpreters, etc.). The presenter will discuss various aspects of working with individuals who are deaf or hard of hearing impacted by language deprivation. This course will include a discussion of barriers that deaf/hard of hearing individuals face, unique characteristics of the population, best practice approaches, and cultural and linguistic differences that are part of the developmental process for deaf and hard of hearing individuals.

During this training, participants will gain a thorough understanding of the impact of language deprivation within the deaf community.

- Discuss the barriers that are present for the deaf population
- Develop population specific skills in recognizing thoughts, behaviors, cultural influences of language deprivation in the deaf population
- Discussing dilemmas that emerge from this field of work

After the training, participants will be able to:

- Identify challenges of work with individuals who are Deaf and have experienced language deprivation.
- Recognize culturally and linguistically appropriate approaches as they relate to deaf and hard of hearing communities;
- Identify strategies to engage deaf and hard of hearing consumers with language deprivation;
- Develop resource strategies for effective treatment and service options
- Discuss interpreting considerations related to communication approaches and alliances

Thursday, April 11, 2019 (Deaf/Signing Providers)

AUDIENCE: FOR DEAF AND/OR SIGNING PROVIDERS: Certified Mental Health Professionals, Nurses, Social Workers, Counselors, Rehabilitation Counselors, Case Managers, Psychologists, MH and SA Providers, Group Home Staff, Educators, Educational staff, Interpreters in Mental Health, Community Interpreters, Educational Interpreters, etc.

Melissa L. Anderson, Ph.D., MSCI, is Assistant Professor, psychologist, and clinical researcher in the University of Massachusetts Medical School Department of Psychiatry. She completed her graduate work at Gallaudet University, where she studied intimate partner violence and trauma in the Deaf community. At UMass, Melissa provides individual therapy to Deaf clients recovering from trauma and addiction and conducts research on best approaches for working with Deaf clients. She is the recipient of a Clinical Research Scholar Award (KL2) administered by the UMass Center for Clinical and Translational Science, with which she and a team of Deaf and Hearing clinicians and community members are developing and testing a digital American Sign Language therapy manual for treating trauma and addiction.



Eligible participants must be in attendance for the full program to receive credit for completing the course.

The Alabama Department of Mental Health

- is approved as a provider of continuing education in nursing by the Alabama Board of Nursing and approves this program for 6.6 contact hours. ABNPO150, Expiration Date: July 12, 2021.
- is an approved as a provider of continuing education in social work by the Alabama State Board of Social Work Examiners and approves this program for 5.5 contact hours. Provider #0125, Expiration Date: January 31, 2020.

The Alabama Department of Mental Health Office of Deaf Services

- is an approved RID CMP Sponsor. This activity has been awarded 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 # 0263.0419.02.
- Has been approved by NBCC as an Approved Continuing Education Provider, ACEP no. 6824. Programs that do not qualify for NBCC are clearly identified. The Alabama Department of Mental Health, Office of Deaf Services is solely responsible for all aspects of this program. Participants completing the program may earn up to a total of 5.5 CE Hours.

Pre-registration is strongly encouraged. Payment may be made by PayPal (CTRL+click on your selection below) or checks can be written to ADARA and mailed to address indicated below:

- [\\$40 Registration fee prior to March 1, 2019](#)
- [\\$50 if paid March 1 and after](#)
- [\\$20 registration for full time student prior to March 1, 2019](#)
- [\\$30 registration for full time student March 1st and after.](#)



FOR ADDITIONAL INFORMATION, REFUNDS, SPECIAL ACCOMMODATIONS OR TO SUBMIT YOUR REGISTRATION:

Office of Deaf Services
Alabama Department of Mental Health
PO Box 301410, Montgomery, AL 36130
FAX: 334-242-3025
application@mhitt.org



In the event the workshop is cancelled, you will be notified by email. No refunds will be provided for participant cancellation.

Please print clearly.

Name	Deaf	Hearing	H/H
Agency			
Address			
City	State		Zip
Phone VP	Accommodations:		
E-Mail			



Alabama Department of Mental Health-Office of Deaf Services
and ADARA PRESENTS



**The Impact of Language Deprivation has
on Our Work When Serving Deaf Individuals in
Social Service and Educational Settings**

**Friday, April 12, 2019
9:00 am to 3:00 pm (5.0 clock hours)
*Lunch on your own**

\$40 Registration fee prior to March 1, 2019

\$50 if paid March 1 and after

\$20 registration for full time ITP or Counseling Students (Non-certified, non-working) prior to March 1, 2019

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**Presenter
Melissa L. Anderson, Ph.D., MSCI**

**Location
Alabama Department of Transportation
1409 Coliseum Boulevard, Montgomery, AL**

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This session is targeted at service providers who do not specialize in deafness yet may work with individuals who are deaf. The presenter will discuss various aspects of deafness and the complications inherent in working with individuals who are deaf or hard of hearing impacted by language deprivation. This course will include a discussion of barriers that deaf/hard of hearing individuals face, unique characteristics of the population, best practice approaches, and cultural and linguistic differences that are part of the developmental process for deaf and hard of hearing individuals.

During this training, participants will have a thorough understanding of the impact of language deprivation within the deaf community.

- Discuss developmental and linguistic barriers that are present for the deaf population
- Develop population specific skills in recognizing thoughts, behaviors, cultural influences of language deprivation in the deaf population
- Discussing dilemmas that emerge from this field of work

After the training, participants will be able to:

- Identify challenges of work with individuals who are Deaf.
- Recognize culturally and linguistically appropriate influences as they relate to deaf and hard of hearing communities;
- Identify strategies to engage deaf and hard of hearing consumers with language deprivation;
- Develop resource strategies for effective treatment and service options

Friday, April 12, 2019 (Hearing/Non-fluent signing/Non-signing providers)

AUDIENCE: Certified Mental Health Professionals, Nurses, Social Workers, Counselors, Rehabilitation Counselors, Case Managers, Psychologists, MH and SA Providers, Group Home Staff, Educators, Educational staff, etc. etc.

Melissa L. Anderson, Ph.D., MSCI, is Assistant Professor, psychologist, and clinical researcher in the University of Massachusetts Medical School Department of Psychiatry. She completed her graduate work at Gallaudet University, where she studied intimate partner violence and trauma in the Deaf community. At UMass, Melissa provides individual therapy to Deaf clients recovering from trauma and addiction and conducts research on best approaches for working with Deaf clients. She is the recipient of a Clinical Research Scholar Award (KL2) administered by the UMass Center for Clinical and Translational Science, with which she and a team of Deaf and Hearing clinicians and community members are developing and testing a digital American Sign Language therapy manual for treating trauma and addiction.



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The Alabama Department of Mental Health Office of Deaf Services

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Name		Deaf	Hearing	H/H
Agency				
Address				
City		State		Zip
Phone	VP	Accommodations:		
E-Mail				



*Best Wishes from
All of us at Deaf Services*

Kimberly Thomas *Steve Hamendinger*
Keshia Farand *Shannon E Reese*
Chad Fry *Amanda Bond*
~~*Kathleen*~~
Elizabeth *Sereta Campbell* *Winnie*
Bryce *LeAnn* *Stevanie Jr.* *TKA*
Jaylan *Justin*
J *Jeff*

