Signs of Mental Health

13th MHIT Draws Largest Class Yet

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

National Recovery Month
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SEPTEMBER 2015

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In This Issue

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ADMH, Office of Deaf Services
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On The Cover:

Role plays at MHIT Institute are great fun! Seated, left to right: Sue Fischbach, Diane Riddick, Hijrah Hamid. Standing: Brian Thornsberry

Help Wanted
Join Our Team

Job Announcement: Regional Therapist
Office of Deaf Services
Alabama Department of Mental Health

Mental Health Specialist II (Regional Therapist) SALARY RANGE: 74 ($39,290.40 - $59,517.60)

Work Location: Deaf Services Region III Office, Mobile, Alabama

QUALIFICATIONS: Master's degree in a human services field, plus experience (24 months or more) working with deaf individuals in a human service setting.

Human services field includes the following disciplines: Social Work, Psychology, Criminal/Juvenile Justice, Special Education, Sociology, Speech Education, Rehabilitation, Counseling, Speech Pathology, Audiology, Nursing, Physical or Occupational Therapy, and any related academic disciplines associated with the study of Human Behavior, Human Skill Development, or Basic Human Care Needs.

NECESSARY SPECIAL REQUIREMENTS: Must have near native-level signing skills equal to Advanced Plus level or higher in American Sign Language (ASL) as measured by a recognized screening process such as the Sign Language Proficiency Interview (SLPI). Must have a valid driver's license to operate a vehicle in the State of Alabama.

This is a highly responsible professional position within the Office of Deaf Services involving direct clinical services supporting deaf consumers and community mental health programs that have deaf consumers in their caseloads.

The person in this position will be responsible for providing direct clinical services to deaf individuals, advocates with other mental health agencies in support of deaf individuals who need services, arranges or supervises the arrangement of interpreter services to support service provision for deaf individuals, and serves as a liaison between the Alabama Department of Mental Health and community service providers located in the Coordinator's service region. This position will work under the direct supervision of the Director of the Office of Deaf Services

REQUIRED KNOWLEDGE, SKILLS, AND ABILITIES: Knowledge of mental illness and the effects thereof upon individuals who are deaf or hard of hearing (D/HH). Knowledge of psychotropic medications, their use and side effects. Thorough knowledge of deaf culture. Knowledge of American Sign Language. Knowledge of community mental health and community substance abuse service providers. Ability to utilize computer, internet resources, and various software packages. Ability to communicate effectively both orally (i.e. spoken English or American Sign Language) and in writing. Ability to acquire understanding of visual-gestural communication approaches used by consumers who are dysfluent. Ability to establish and maintain contact with other agencies, the general public, and community providers.

Thornsberry Adds Expertise to Staff Promotes Self-Advocacy Among Deaf People

By Kim Thornsberry, ODS Regional 1 Therapist

In August of 2015, the National Consortium of Interpreter Education Centers (NCIEC) posted an available access to Deaf Self Advocacy Training toolkit on its website: http://www.interpretereducation.org/deaf-self-advocacy/. It has been a privilege to work with NCIEC on this exciting curriculum. I received training in 2010 to become one of the 30 original Deaf Self Advocacy Training (DSAT) consumer trainers and was promoted to one of 14 DSAT Master Trainers in 2011. I had the opportunity to review the original DSAT curriculum and made revisions along with 13 other DSAT Master Trainers in summer of 2011.

Kim Thornsberry leads a poster Session of Deaf Self Advocacy at the 2015 Interpreter Institute

I have conducted several consumer trainings and train the trainer workshops in Utah, Idaho, Washington, Arizona, California, and Maryland. I conducted the recent Train the Trainer workshop in Salisbury, Maryland last May.

After each training, based on the results of pre and post—knowledge tests, participants left feeling good, more knowledgeable, and empowered. Most of them reported seeing a difference in their advocating skills for effective communication and sharing the knowledge and tools with their Deaf, Hard of Hearing, and DeafBlind peers.

Now since I live in Alabama, I am in the process of working out the details and hope to conduct DSAT Train the Trainer workshop soon.

Since the curriculum was first unveiled in 2010, more than 2,000 Deaf, hard of hearing and DeafBlind consumers have attended a DSAT consumer training and more than 250

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13th MHIT Institute Breaks Records—Again

"This was the most rewarding week of my career," exclaimed, Loni Scalercio of El Cajon, California. Scalercio was one of a record-shattering 93 people from 23 different states who attended the 2015 Interpreter Institute of the Alabama Mental Health Interpreter Training project, which ran August 3 – 7 in Montgomery.

Commissioner James Perdue Opens the 13th Institute

The 40-hour Institute is a partnership between the Alabama Department of Mental Health, ADARA (American Deafness and Rehabilitation Association) and Troy University. This was the 13th annual running of the internationally acclaimed training. (See MHIT at a Glance starting on page 8.)

The Alabama Department of Mental Health's newest Commissioner, James Perdue opened the week by welcoming the participants and telling them that he was very proud of the work done by MHIT. "It has earned an international reputation that they are proud of and should be. We are honored that you are here."

That reputation of the training is a draw for many participants. "Many people who had the opportunity to go to MHIT and learn [would] relentlessly tell me: "CHAMP! Wonderful experience, and LOTS of information," said Benjamin Swindle, of Driftwood, Texas. Swindle was one of eight deaf participants in this year's event.

Above: Benjamin Swindle , of Texas, (left) listens as Claire Alexander, from Minnesota, makes a point.

Below: A nearly passed-capacity crowd attends to a presenter

The depth and breadth of the information presented was cited by participants as a reason for attending. "The information was intensive and it was readily apparent that they have perfected the service delivery by selecting [presenters] that were the best in their field to share this information," Kent Schafer, a psychologist who happens to be deaf told us.

This year's faculty included familiar faces from around the country such as Robyn Dean, Bob Pollard and Roger Williams, as well as long-time Alabama faculty members Charlene

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Crump, Steve Hamerdinger, Brian McKenny, Carter English and Kathy House. Another long-time veteran, Shannon Reese, coordinated volunteers and handle much of the "behind the scenes activity that makes the training impressive to first time attendees."

With the increase in interest from interpreters who are deaf there was a need for expanding offerings tailored to their unique needs. Deaf interpreters are those who have exceptional language skills and are trained to work with language deprived deaf consumers. Master Mentor Carole Lazorisak was brought in for the second year to teach a class for this group. She also taught an alumni session leading a discussion on CDI/HI relationships in mental health settings.

This year the Institute also was able to further tap into the knowledge and expertise of Robyn Dean. Dr. Dean has been on the faculty for 11 years, but this was the first time she stayed on through the week. She taught an additional class in the alumni track.

Robin Dean explores ethics and supervision in an alumni-only class offered for the first time this year. Her class was one of several that made up a unique track specifically for those people who have been to the Institute in the past.

Angela Kaufman, a nationally renowned expert on emergency preparedness in the deaf community

The veteran faculty members were joined by some new faces this year. Angela Kaufman, is the ADA Compliance Coordinator for the City of Los Angeles. Kaufman was brought in to teach a pair of classes in the new alumni track related to her specialty area, disaster preparedness. "It was an honor and pleasure to have been invited to present at this year's MHIT. [It] is such an incredible opportunity for interpreters," Kaufman said. "It should be required for all interpreters early in their careers."

The Institute draws people back again and again. This year, 10 of the 91 participants were alumni. While there have been special classes for alumni each year, this year, for the first time, the Institute ran a special track for those who have attended before. A total of seven alumni—only classes were offered.

In addition, two clinician panels were offered. One, comprised of hearing clinicians who are experienced in working with interpreters, and the other a panel of deaf clinicians. Both addressed clinical interpreting from their

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13th Annual Interpreter Institute Breaks Records

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unique points of view.

Melissa Marsh, of Uno Lakes, Minnesota, was one of an official delegation from the state Deaf and Hard of Hearing Services Division. "I work in a large health system that provides service to a large community. The education I gained during this week will go a long way to impact not only my own ability to provide services; it also provides me with information to improve our entire system process." Dr. John Gournaris, the Mental Health Program Director for DHHS talks of his desire to see Minnesota interpreters embrace the practice profession approach taught at the Institute. "We had some grant money available to send a group down to Alabama and also hopefully fund some to go through the practicum. I am excited to see the concept expand up here." Minnesota was one of four states to send delegations.

Michelle Niehaus, the Statewide Coordinator for Deaf Services at the Kentucky Department for Behavioral Health, Developmental, & Intellectual Disabilities is another supporter. "Since 2010, the Department has sponsored up to four scholarships for interpreters working in Community Mental Health Centers and state facilities to attend Alabama's renowned Mental Health Interpreter Training. Graduates then return and assist [me] with training and mentoring interpreters in-state."

Minnesota and Kentucky join Alabama, Georgia and Wisconsin in officially or semi-officially basing interpreter requirements and payment on competencies taught at MHIT.

As with previous years, interpreters working in spoken languages found the training helpful. Anna Maria Ramirez Sawyer, who is a Spanish/English interpreter told us, "Although most of it was about ASL, the mechanics, responsibilities, and ethics for spoken language interpreting is the same. Thank you for the framework that will help me look more closely at what I do in interpreting."

Maria Pardo, of Staten Island, New York, is a tri-lingual interpreter, fluent in ASL, Spanish and English. For her, learning how to assess communication skills was one of the highlights of the training. "My clients come from different countries, most with no early formal education, and I have to adjust my skills to theirs. The tools the program gave me are instrumental for me to improve and do a better job with them."

The 40-hour Institute, which is mandated by Alabama state law, is one leg of a three-pronged process for being recognized as a *Qualified Mental Health Interpreter.* The others are completing a supervised practicum and passing a comprehensive examination. In most years, roughly 10% of the participants go on to earn the certification.

Since its inception in 2003, 935 different people have attended the Institute. Of those, 87 earned certification as Qualified Mental Health Interpreter.

For pictures from the Institute, see https://www.flickr.com/photos/134712216@N02/sets/72157656784167059 .

"I have gained a new respect for how the lives of individual living with mental health issues are impacted daily. I was given valuable tools as to how to work with these individuals and for that I say "THANK YOU!' You, Charlene, Shannon, all of the presenters and interpreters did a phenomenal job! THANK YOU, THANK YOU, THANK YOU!!," said LaTanya Jones, from Philadelphia, Pennsylvania.

'Since I have been back home, interpreters have inquired as to how the training went and I bragged about how much I learned, about my networking experiences and encouraged them to attend the next training."

Student Representatives Get Exposure to Mental Health

Editor's Note: Each year, four students, nominated by their interpreter preparation programs, are selected to attend the Institute as volunteers. This year, we had students from Texas, Ohio and Alabama. Here are their stories…

Samantha Geverts, Ohio

I am a recent graduate of the University of Cincinnati's Interpreter Training Program. I chose to apply to attend the Mental Health Interpreter Training as a student representative because I have a strong interest in mental health not only as an interpreter, but as a professional as well. I am grateful that my ITP provided me an opportunity to be able to observe in a mental health setting, which only increased my interest. After hearing about the MHIT from former attendees, I knew that it was a place I needed to be to grow as a professional interpreter.

The amount of learning that this training provides is incredible. The hearing voices simulation is something that really impacted me, as I'm sure it did with all of participants. It gave me insight to what some mental health patients experience and also how they are treated. As someone who understands Deaf culture and the Deaf community, I was surprised at how this simulation gave me an even greater understanding of how the Deaf community has been treated in the past. Even though it was a simulation, we as "patients" were not treated very well and it gave a lot of insight to how the mental health system operates. In addition to the hearing voices simulation, I learned a wealth of information including, but not limited to self-defense, terminology, interpreting methods and examples of language dysfluency. In my ITP, we had a mental health module, but it only scratched the surface of the knowledge that is out there and available. This training provided a more in depth learning opportunity that I enjoyed greatly.

While I may not utilize all of the information I learned in the immediate future, it will always be in the back of my mind and available in the event that I do come across a mental health assignment. Now that I am no longer in an ITP, this training is something that I plan on coming back to as a participant. The beauty of health fields is that they are always changing and new information is always being presented. That being said, I don't believe this is a training that you can come to one time and say that you learned all there is to know. There will always be new information and findings that we as interpreters and clinicians need to know if we want to work in this setting.

One last aspect of this training that I am very appreciative of, are the presenters themselves. Being able to listen to presenters like Robyn Dean, Robert Pollard, Steve Hamerdinger, and Roger Williams was very special. The opportunity to learn from them and interact with them in an intimate atmosphere is something that I very much appreciated. This training was very eye opening and one that I enjoyed very much. MHIT really encourages and provides the opportunity to me meet and network with the other interpreters and professionals that come to this training, which I find to be unique. I am very grateful to have been one of the four student representatives chosen to work this training. I hope to be back in the near future and take full advantage of everything this training had to offer.

Britt Guilbeau, Texas

I first learned about MHIT through my ITP program. In class while studying different settings in which interpreters can work and the demands involved, I became interested in field of mental health interpreting. I wanted to attend the training to both serve as a volunteer and help out in any way possible, and to take advantage of the opportunity to learn firsthand from professionals in the field. I feel very grateful for the experience and left with a wealth of knowledge. I enjoyed not only learning about situations

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Department of Mental Health
Office of Deaf Services

Alabama Mental Health Interpreter Training At a Glance 2015

The Office of Deaf Services is responsible for developing and implementing programs that meet the linguistic and cultural needs of DMHs consumers who are Deaf or Hard of Hearing. Services are designed to be affirmative and supporting to consumers who traditionally have not been able to benefit from services offered by the department.

Vital Statistics

- MHIT is in its thirteenth year and constitutes a week long training consisting of 43.25 hours of actual classroom time.
- 130 individuals (93 Registered Participants and 37 presenters, staff and volunteers) participated in the training this year and a total of 935 individuals have been trained since its inception. Several individuals have taken the training more than once, these numbers are not duplicated in the total number of participants. We continue to carry a waiting list each year of individuals who were not able to attend because the class was full.
- Participants: 10 Deaf (18 total including staff and volunteers), 1 HH, 82 Hearing. 9 returning alumni with four of them as certified Qs.
- Participants hailed from 26 States and included one Spanish/English interpreter.
- Record breaking numbers attended this year's training as well as attendance highs at the social activities including the Rosa Parks Tour and ASL Dinner Social.
- 46 different workshops with 4.325 possible ceus were offered (43.25 clock hours of training) during MHIT.
- 4 student workers from Texas, Ohio and Alabama.
- Addition of seven alumni courses

Course List

- *Introduction to Mental Health Systems/MHIT*
- *MH Providers and Treatment Approaches*
- *Interpreting in Substance Abuse Settings*
- *Working with Dysfluency in MH*
- *Universal Precautions*
- *Interpreting as a Practice Profession*
- *Demand Control Schema and Ethical Decision Making for Work in MH Interpreting*
- *Concepts of Normalcy/Normal Differentness*
- *Psychiatric Evaluations, DSM and Clinical Though Worlds*
- *Reflective Practice/Supervision in MH*
- *Psychopharmacology*
- *Auditory Hallucinations*
- *Perspective of the Therapists for CDIs/DIs and VGCS (Deaf participants only)*
- *Secondary Trauma Stress/Vicarious Trauma and Self Care*
- *Sources of Communication Impairment and Fund of Knowledge Deficits*
- *Techniques for Dealing with Dysfluency*
- *Role Playing and DCS Analysis*
- *Mental Health and Legal Settings*
- *Confidentiality Laws and Considerations*
- *Communication Assessments in MH*
- *Practicum Experiences/Instructions*

- Core Instructors included Robert Pollard, Robyn Dean, Steve Hamerdinger, Roger Williams, Carole Lazorisak, Charlene Crump, Brian McKenny, Shannon Reese, and Carter English.

Poster Sessions

- *DBT and Deaf Consumers*
- *Defense Mechanisms*
- *Tour of Rosa Parks Museum (General Studies)*
- *Autism and Deafness*
- *Interpreting Play Therapy*
- *Diversify Your Life*
- *Personal Protection Strategies (Grabs)*
- *Personal Protection Strategies (Chokes/Hair)*
- *MH Interpreter Portfolio*

- Poster session instructors also included; Scott Staubach, Lynne Lumsden, Shannon Reese, Charlene Crump, Kim Thornsberry, Brian McKenny, Wendy Darling, , Lee Stoutamire, Carole Lazorisak and Vyron Kinson.

Alumni Sessions

- *Hearing clinicians perspectives*
- *Supervision interventions and case analysis*
- *Abuse and violence in the deaf community*
- *Active shooter scenario*
- *Partnerships in MH – a CDI's perspective*
- *Ethical discourse and moral reasoning patterns*
- *Deaf professionals in MH, etc.*

- Instructors for the Alumni Sessions included:, Carole Lazorisak, Kate Block, Daphne Kendrick, Chris Driskell, Dr. John Toppins, Katherine Anderson, Angela Kaufman, Robyn Dean, Kent Schafer, Kim Thornsberry and Kevin Henderson.

OTJ

On the John (OTJ) posters were placed twice a day in the restrooms and included short summaries of research articles related to MH and Deafness.

- Post training learning activities include bi-monthly online discussions of research articles in mental health and deafness, listservs, and 40-hour practicum and a comprehensive written examination designed to certify the individual as qualified to work in mental health settings.

- MHIT 2015 had an extensive waiting list with over 35 individuals who submitted an application to be on the waiting list and a multitude of others who wanted to submit an application but were unable to due to the lengthy waiting list.

Student Representatives Get Exposure to Mental Health

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specific to interpreting but also general mental health information.

I learned a lot about different mental health diagnoses and the process a Deaf individual might go through to receive treatment. It was an eye opening experience. I saw so many interpreters and other professionals passionate about their work in mental health and it was very inspiring. Getting to hear different personal experiences and challenges working in the field gave me a good starting off point and helped me to realize that I do want to pursue a career in mental health interpreting.

Jacquelin Presswood, Texas

Being a student representative at MHIT was an unparalleled experience for me. I am currently in my last year in Austin Community Colleges' Interpreter Training Program in Austin, Texas. Previously in my classes we have looked at a variety of the possible demands and controls which may present themselves to the interpreter working within the mental health setting. During the week at MHIT, we looked at and delved into the depths of the industry and my eyes have been forever opened; as well as exacerbating my desire to further my studies with in this fascinating field.

I applied to volunteer at the MHIT conference because it is a goal of mine to one day work as an art therapist with Deaf children. I don't have much experience in mental health settings and this conference is the best way to acquire information, advice, and access to the most recent and relevant research available, from the most respected and acclaimed individuals in the industry. I can barely scratch the surface of the many things that I took away from my week at MHIT.

Because language usage and communication are such inherent aspects of diagnosing and treating mental disorders, it is of the upmost importance that interpreters working within this specific field possess the following: have in place firm, well established, L1 & L2 skills, understanding the differences culturally between hearing and deaf communities. Interpreters must be able to quickly decipher if communication norms for the culture not being followed is related to a language dysfluency vs. a disfluency, and furthermore be able to efficiently, and effectively relay this important linguistic information to clinicians. Diagnostic criteria for various psychological conditions is not always standardized across hearing and deaf patients. One must be able to recognize these variances, and again, be able to relay this to the clinician to aide in facilitating a diagnosis. All of this must be accomplished without overstepping the boundaries of the clinician and their staff as well; therefore interpreters must be capable of handling these situations with the utmost respect and appropriateness.

The schizophrenia simulation activity is absolutely unprecedented. There is no way that I could ever fully understand the struggles of this condition, or what it must be like to live with it every single day. Through this activity, I experienced a small glimpse of what the day to day struggles look like for those with this condition. Because of this experience I walked away with a great sense of empathy and a small, but much better, understanding of the challenges this mental disorder presents to those affected.

I am greatly appreciative to have had the opportunity to attend MHIT, as a student representative. I intend to carry the knowledge I obtained at MHIT with me through my remaining semesters in the ITP, sharing what I have learned here with my peers, and into my future interpreting career.

Elizabeth Shiver, Alabama

For the past few years I have had the joy of working with an individual that has been diagnosed with Asperger's Syndrome; the imagination this young person has is wonderful. Social and communication skills, however, are lacking greatly. The consumer grew up during the time when students were being taught using Signing Exact English (SEE), which meant I had to dust off my old SEE dictionary and refresh my memory. Also, since there was little sign language used at home, this individual's sign bank was limited to the basics and after graduating and returning home, there were no more opportunity for growth. Needless to say, the two of us have had to become inventive at times when communicating.

Also, working with a person that has Asperger's and seeing firsthand the struggles that an individual can be faced with in terms of communication caused me, as an interpreter, to want to find ways to support the consumer in the best possible way… ways to encourage the consumer to become more social and involved with the Deaf community, as well as, to foster a semblance of independence. In the midst of this, however, I find myself daily looking for ways to make myself understood and to understand. There have been times when the consumer has become frustrated if I did not readily comprehend a statement or question and by the time the conversation was over, we both would be at our wits end.

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Student Representatives Get Exposure to Mental Health

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It is because of those types of situations that I wanted to be a part of MHIT. I was confident if I was able to attend the training, I would gain knowledge and skills that would be beneficial for both me and the consumer.

During the week at MHIT, I not only learned more about discourse and how to make it effective when communicating with a person that may have a low word/sign base. I also observed strategies of how to communicate with clarity. Having the opportunity to observe so many skilled interpreters was a wonderful bonus to the week. I gleaned information from each and every one of them, making many notes on sign choices, the context in which a sign was used and how the signing space was utilized.

Charlene Crump discussed features of dysfluency development during her lecture on "Considering Dysfluency in Mental Health". Her comments about the need to consider how conversational elements such as topic-comment, clear referents and time indicators, may be missing within a conversation were very valuable for me. Many times the consumer that I work with will leave out information when telling a story, sometimes starting in the middle of a thought or sentence and not giving the often important, when or where, information. That lecture gave me insight on how to handle those types of situations and I now know to ask simple follow up questions after a statement that is not complete. Questions such as, "WOW, HAPPEN, WHICH DAY? MONDAY, TUESDAY, WEDNESDAY, etc. or I will use a calendar to encourage the consumer to think about the 'time' portion of a statement thereby reinforcing the importance of adding that information to the statement.

My official title is Community Living Support personnel. My job description states that I am to "assist the person with the achievement, preservation, or improvement in skills." My desire is to fulfil that role to the very best of my ability, to see this consumer, and any other that I may work with in the future, grow in communication skills, grow to the point where there is no longer such frustration where communication is concerned and be able to live life to the fullest.

As I See It

The gods had condemned Sisyphus to ceaselessly rolling a rock to the top of a mountain, whence the stone would fall back of its own weight. They had thought with some reason that there is no more dreadful punishment than futile and hopeless labor. Albert Camus

There are times when working in mental health and deafness rewards the soul. A consumer rebounds from a hellish episode of psychosis, begins the lifelong journey of recovery, speeds wings and soars, carrying others along with them. We are then content to be admirers of the effort, watching with joy.

Often though, the task seems Sisyphean; one step forward, two steps back. Some people tell me to be happy that the rock does, in fact, move. The fact that it rolls back just means I have ~~continual employment~~ to come back and try again tomorrow.

Recently, I have been involved with discussions with various groups around Alabama related to communication access in hospitals. The process has been... educational.

Interestingly, what comes up over and over is cost containment. That's not just related to bottom line interpreter payment, of course, but also in administrative costs involved in operationalizing access plans. (Let's pretend for a minute, that all hospitals have a well-thought out policy on communication access. Go on, humor me for 5 minutes.) A business manager will be under pressure to reduce those overhead costs, one of which is to reduce the number of contracts that must be monitored. There are two ways to do that.

One, is to hire one or two (or more) full-time staff interpreter(s) instead of contracting with several. But staff interpreters also introduce costs that can be avoided by using solely contracted people.

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AS I See It

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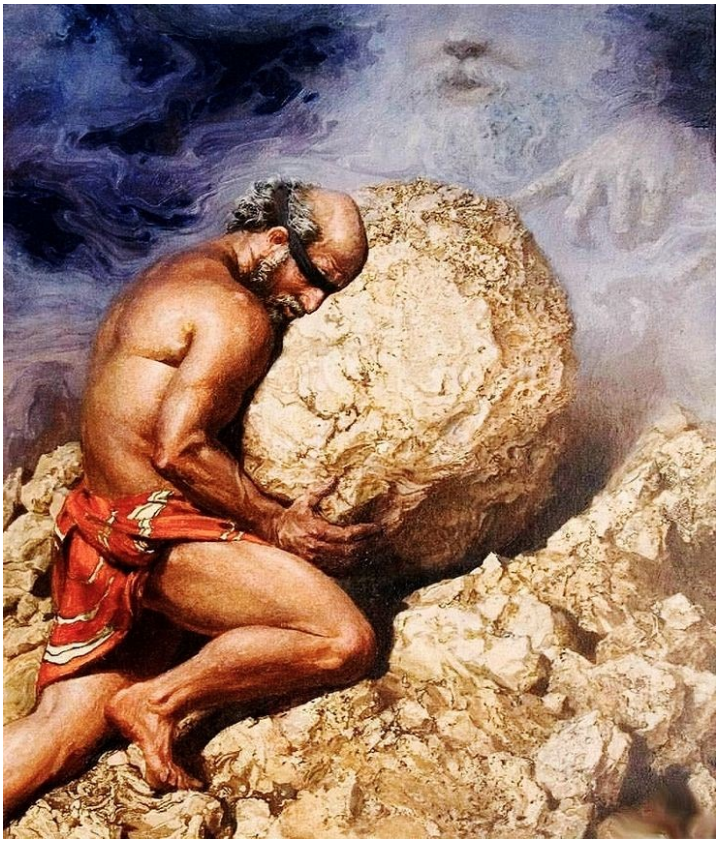
The other way is to contract with a single vendor who will then be responsible for filling assignments. This can work in areas where there are large concentrations of interpreters. Unfortunately for Alabama deaf people, no such concentration exists in our state. But… Birmingham, you protest. Birmingham actually has a low concentration of licensed interpreter proportional to its population of deaf people. Quick: how many licensed interpreters are in Birmingham that are not working full-time for some agency or other?

This is the niche that Video Remote Interpreting providers are exploiting. The pitch is simple. "We are available 24/7/365 and all you have to do is contract with us and we will provide everything you need." It's an appealing pitch. Heck, ODS has a contact with one provider to cover our shortfalls!



One major problem arises when the contracts are developed by someone who doesn't understand interpreting and all the various best practices, regulations, protocols, and so on, related to the profession. The pitch from the VRI companies' promises that they will make sure the hospital is "covered" and that is all the business office cares about. Whether the specific technology works or not is not on the minds of the contract writer.

Come on, let's face it. The promise of having a "qualified" interpreter available on a moment's notice right on an iPad that has Wi-Fi access anywhere in the building sounds like Nirvana. Reality frequently does not match the vision.

Anyone who depends on video interpreting (VI), either for Relaying phone calls (VRS) or ad hoc interpreting (VRI) knows that quality of interpreting is highly variable. (*SOMH* ran a couple of articles on VRI in 2014. Part 1 is here. Part 2 is here.) Anyone who has had to make a critical phone call late at night knows that getting a skilled interpreter is, at best, a crap shoot. "But I ordered pepperoni on my pizza and this is anchovy!" "Sorry, the lady said you wanted anchovy and if you won't pay what you owe us we will blacklist you."

Imagine the same issue at the emergency room at "2 in the morning on Saturday night."*

Such FUMTUs happen often enough that the deaf community has developed a knee-jerk reaction when VRI is proposed or ~~imposed~~ offered. (NAD CEO, Howard Rosenblum, has a nice primer on some of the issues at: https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0CB4QtwIwAGoVChMIgtuRk6_JxwIVzDk-Ch2tRwNb&url=http%3A%2F%2Fwww.youtube.com%2Fwatch%3Fv%3DUy-9Iz-8xjw&ei=jhDfVYLcJszz-AGtj43YBQ&usg=AFQjCNE-rLIhi8sNvzHyESbS1NA9_yI7tw.

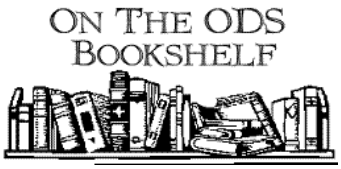
In our work, even more than in general medical settings, we encounter deaf people who are dysfluent. This can be because of psychosis or because of language deprivation. Often, it is both. That's why Alabama has explicit requirements for interpreter competency in mental health settings.

Now mix in the green, not mental health (or medical or legal) trained, beginning interpreter late at night with a psychotic, language deprived deaf person in a medical ER. It is not a pretty picture. And, more often than not, it will result in a grossly inappropriate clinical decision by the physician.

Who is at fault when that psychotic deaf person is released back to the police and is either let loose on the street or taken to jail.

So here we are, right back to where we were 15 years ago when deaf people in acute psychiatric crisis had a very poor chance of getting anything resembling appropriate services. Like Sisyphus, the Deaf community fought an uphill battle to change that. Just when it seemed the battle was over and the victory won, the rock starts rolling downhill again. ***As I See It,*** it's up the deaf community to stop the rock and begin, in Sisyphean fashion, to push it back up the hill.

**With apologies to Shel Silverstein*



Important Recent Articles of Interest

Wilson, J., Guthmann, D., Embree, J., & Fraker, S. (2015). Comparing Outcomes from an Online Substance Abuse Treatment Program and Residential Treatment Programs for Consumers who are Deaf: A Pilot Study. JADARA, 49(3), 172-184. Retrieved from http://repository.wcsu.edu/jadara/vol49/iss3/3

> Numerous barriers exist when attempting to provide culturally-appropriate substance use disorder (SUD) treatment to persons who are deaf or hard of hearing (deaf). These include a lack of accessible community-based treatment providers, a low geographic census of deaf persons who are referred to treatment at any given time, difficulties in maintaining anonymity for deaf individuals in treatment, minimal alternatives for accessible self-help support groups, and a general lack of information about SUD and deafness by SUD treatment and deaf service providers (Feldman & Gum, 2007; Guthmann & Blozis, 2001; Moore et al., 2009; Moore & McAweeney, 2006; Pereira & Fortes, 2010; Scheier, 2009; Wilson & Wells, 2009). Since 2008, the Deaf Off Drugs and Alcohol (DODA) program has provided culturally appropriate cessation and recovery support services via a telemedicine program to deaf individuals who are clinically diagnosed with a SUD. DODA is a collaborative effort among the Substance Abuse Resources and Disability Issues (SARDI) Program in the Boonshoft School of Medicine at Wright State University, the Consumer Advocacy Model Program in Dayton (Montgomery County, Ohio), the Deaf Community Resource Center Communication Service for the Deaf (CSD) of Ohio, and the Ohio Department of Alcohol and Drug Addiction Services (ODADAS).
>
> In 2011, SARDI received a field-initiated research grant from the National Institute on Disability and Rehabilitation Research (NIDRR) to evaluate whether or not an online SUD treatment program was an effective way to serve the deaf population with substance use disorders (SUD). The NIDRR project was based on the premise that a technology-assisted e-therapy SUD treatment program was an effective way to serve the deaf population, which is largely technologically savvy, widely dispersed geographically, and underserved (and often unserved) due to communication and other cultural barriers. The ultimate goal was to establish a culturally appropriate, evidence-based e-therapy practice that would serve as the gold standard for SUD treatment for deaf people.

Armstrong, K., David, A., & Goldberg, K. (2014). Parent–Child Interaction Therapy With Deaf Parents and Their Hearing Child A Case Study. Clinical Case Studies, 13(2), 115-127.

> There are few proven effective treatments such as Parent–Child Interaction Therapy (PCIT) for use with deaf parents and their children, even though it is likely that the prevalence rate for disruptive behavior problems including attention deficit/hyperactivity disorder (ADHD) and oppositional defiant disorder (ODD) are similar to those reported for all U.S. children. Medication and behavioral therapy involving parents comprise the cornerstone for ADHD/ODD management, with PCIT endorsed as one of the most effective interventions available for children aged 2 to 7 years. This case study presents the implementation of PCIT with deaf parents and their 7-year-old hearing son with ADHD/ODD, with the help of a certified interpreter and readily available video technology. Findings from this case report documented PCIT as a promising treatment option for use with individuals who are deaf.

Bhuvaneswar, C., Colon, J., Matthews, J., Burke, B., & Stern, T. A. (2015). Psychiatric Care of Deaf Patients in the General Hospital: An Overview. Psychosomatics, 56(1), 1-11.

> While the number of Deaf and hard-of-hearing patients worldwide is estimated at six hundred million, few specialized psychiatric services or training resources exist to support the provision of mental health care to this population. This presents a particularly acute problem in the general hospital, where the consultant psychiatrist is likely to be confronted with the challenges of providing comprehensive psychiatric evaluation, diagnosis and treatment to patients with whom he or she may have limited experience or confidence. Method: We review critical considerations in the work-up, differential diagnosis, and management of commonly-presenting psychiatric disorders among Deaf patients in the general hospital setting.

Emond, A., Ridd, M., Sutherland, H., Allsop, L., Alexander, A., & Kyle, J. (2015). Access to primary care affects the health of Deaf people. British Journal of General Practice, 65(631), 95-96.

(Continued on page 16)

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

World's Wealthiest Universities Discriminate Against Deaf People

The National Association of the Deaf (NAD) and four deaf and hard of hearing individuals filed two federal class action lawsuits today against Harvard University and the Massachusetts Institute of Technology (MIT), charging that the schools discriminate against deaf and hard of hearing people by failing to caption the vast and varied array of online content they make available to the general public, including massive open online courses (MOOCs).

The cases, filed in U.S. District Court in Massachusetts, assert that these universities violate the Americans with Disabilities Act and the Rehabilitation Act by denying deaf and hard of hearing people access to thousands of videos and audio tracks that each university makes publicly available, for free, on broad-ranging topics of general interest. These include, for example, campus talks by luminaries such as President Barack Obama and Microsoft founder Bill Gates; educational videos made by MIT students for use by K-12 students; "self-help" talks; entire semesters'-worth of courses; and regular podcasts such as the "HBR IdeaCast" by the Harvard Business Review. The universities boast that their content is available free to anyone with an Internet connection. Millions of people have visited the websites.

http://creeclaw.org/online-content-lawsuit-harvard-mit/

Really Bush League

When San Diego Padres outfielder Jeff Francoeur joined the minor-league El Paso Chihuahuas baseball team last month, he got hazed. But instead of pressuring him to drink too much or subjecting him to public humiliation, Francoeur's teammates and coaches pretended that Chihuahuas pitcher Jorge Reyes was deaf.

The team's "prank" fails on its fundamental premise – which is that anything about deafness is funny.

The media reaction to Francoeur's hazing has been predictably ignorant. Both Deadspin and the Washington Post called the team's antics "hilarious" CBS Sports used the word "amazing". They've all succumbed to the narrative of "co-workers hilariously prank the new guy", and ignored the more accurate version: "coworkers spend a month treating the new guy like absolute shit while also making fun of disabled people".

(http://www.theguardian.com/commentisfree/2014/apr/16/fake-deaf-pitcher-jeff-francoeur-prank-not-funny)

It's Enough to Make One Go "Postal"

A deaf woman said a post office in Port Orange discriminated against her when staff members refused to communicate via writing.

The woman wants to remain anonymous, but she texted Local 6 about what happened when she asked the clerk for help with mailing some packages.

"She became agitated when I informed her I am deaf and need her to write down the answer to my question," said the woman.

The woman claimed she explained three times to the employee that she is deaf and can't hear but said, "I pointed to the paper she had pulled out. She mocked me by pointing at the paper I had but speaking at me again. I asked for a supervisor. She became angry and pointed that I had to go away from her section of the counter."

(http://www.clickorlando.com/news/deaf-woman-says-port-orange-post-office-discriminated-against-her/31700446)

Ever Notice...

All these great news stories about things that happen to deaf people are almost never captioned when they are put on the web. (One assumes that they have at least robo-captioning when they are broadcast on live TV). On the web? Nothing. Not even when the stations have already paid good money to have the things captioned in the first place.

Deaf Self Advocacy Training

(Continued from page 3)

Deaf, hard of hearing, and DeafBlind individuals have been trained as DSAT consumer Trainers.

In this curriculum we cover the following seven modules:

- Advocating for yourself and others
- Self-esteem and self determination
- Working with interpreters
- Ethics of working with interpreters
- Interpreting services using video technology
- Preparing for self-advocacy
- Utilizing resources for action

According to NCIEC, the overall DSAT curriculum is a rich and complex curricula of English text, PowerPoints, videos (signing and closed captioned), electric Braille, interactive learning/sharing, and many more. In addition, the curriculum consists of three independent curricula; Deaf Self Advocacy Training (DSAT), Deaf Blind Self Advocacy Training (DBSAT), and Train the Trainer (for experienced consumer trainers).

Knowing our rights as Deaf or Hard of Hearing Americans as well as responsibilities to make effective reasonable accommodation requests is crucial to our success in many settings including mental health, medical, education, legal, and employment settings. This information is important to everyone with hearing loss to know how to make effective requests, to advocate for yourself and successfully obtain the services you need.

There are two types of training available:

- Consumer training for Deaf, Hard of Hearing, and Deaf-blind consumers: this training is conducted by a Deaf DSAT-trained instructor and is designed to teach D/HH/DB consumers how to effectively advocate for themselves. The consumer training is often offered in a 6-8 hour time block.

- Train the trainer workshops: this training is conducted by an NCIEC master trainer and is designed for Deaf, Hard of Hearing, and Deafblind individuals wanting to become DSAT consumer trainers. This training is conducted in a 16 hour time block.

If you have questions in regards to Deaf Self Advocacy training, please contact DSAT at deafselfadvocacy@gmail.com or the NCIEC center in your geographical area. For more information about the Deaf Self-Advocacy initiative and the curriculum including downloading the resources contained in the toolkit DVD, please go to http://www.interpretereducation.org/deaf-self-advocacy/deaf-self-advocacy-training-toolkit/

Current Qualified Mental Health Interpreters

Becoming a *Qualified Mental Health Interpreter* in Alabama requires a rigorous course of study, practice, and examination that takes most people nearly a year to complete. It involves 40 hours of classroom time, 40 hours of supervised practica and a comprehensive examination covering all aspects of mental health interpreting. *(Alabama licensed interpreter are in Italics)* ***Denotes QMHI- Supervisors***

Charlene Crump, Montgomery*
Denise Zander, Wisconsin
Nancy Hayes, Remlap
Brian McKenny, Montgomery*
Dee Johnston, Talladega
Lisa Gould, Mobile
Gail Schenfisch, Wyoming
Dawn Vanzo, Huntsville
Wendy Darling, Montgomery
Pat Smartt, Sterrett
Lee Stoutamire, Mobile
Frances Smallwood, Huntsville
Cindy Camp, Piedmont
Lynn Nakamoto, Hawaii
Roz Kia, Hawaii
Kathleen Lamb, North Carolina
Dawn Ruthe, Wisconsin
Joy Thompson, Ohio
Judith Gilliam, Talladega
Stacy Lawrence, Florida
Sandy Peplinski, Wisconsin
Katherine Block, Wisconsin*
Steve Smart, Wisconsin
Stephanie Kerkvliet, Wisconsin
Nicole Kulick, South Carolina
Rocky DeBuano, Arizona
Janet Whitlock, Georgia
Sereta Campbell, Tuscaloosa*
Thai Morris, Georgia
Lynne Lumsden, Washington*
Tim Mumm, Wisconsin
Patrick Galasso, Vermont
Kendra Keller, California*
June Walatkiewicz, Michigan
Melanie Blechl, Wisconsin
Sara Miller, Wisconsin
Jenn Ulschak, Tennessee
Kathleen Lanker, California
Debra Barash, Wisconsin
Tera Vorphal, 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
Lori Milcic, Pennsylvania
Amber Mullett, Wisconsin
Nancy Pfanner, Texas
Jennifer Janney, Delware
Stacie Bickel, 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.
Maria Kielma, Wisconsin
Erin Salmon, Georgia
Andrea Ginn, New Mexico
Carol Goeldner, Wisconsin

On the ODS Bookshelf

(Continued from page 13)

Deaf awareness training is necessary for all healthcare staff so that they become aware not only of the barriers faced by Deaf people in accessing their services, but also that these barriers are putting them at risk of ill-health and potentially reduced life expectancy.

Emond, A., Ridd, M., Sutherland, H., Allsop, L., Alexander, A., & Kyle, J. (2015). The current health of the signing Deaf community in the UK compared with the general population: a cross-sectional study. BMJ open, 5(1), e006668.

Deaf people's health is poorer than that of the general population, with probable underdiagnosis and undertreatment of chronic conditions putting them at risk of preventable ill health.

Hsieh, E., & Nicodemus, B. (2015). Conceptualizing emotion in healthcare interpreting: A normative approach to interpreters' emotion work. Patient education and counseling.

By juxtaposing literature in signed language interpreting with that of spoken language interpreting, we provide a narrative review to explore the complexity of emotion management in interpreter-mediated medical encounters.

Anderson, M. L., Glickman, N. S., Mistler, L. A., & Gonzalez, M. (2015). Working Therapeutically With Deaf People Recovering From Trauma and Addiction. Psychiatric rehabilitation journal.

Deaf people report higher rates of mental health problems than the general population. Although initial empirical work with the deaf population suggests high rates of posttraumatic stress disorder (PTSD) and substance use disorder (SUD), little is known about the rates of comorbid PTSD/SUD or how to effectively address this comorbidity in treatment.

Substantial work is needed to raise awareness of comorbid PTSD/SUD and provide treatment tools to agencies and providers who work with deaf clients, infusing trauma-informed care into deaf SUD services and SUD treatment into deaf mental health care. Fortunately, several endeavors are on the horizon to disseminate assessment and treatment tools to work with deaf people recovering from trauma and addiction.

Goldstein, M. F. (2015, November). A Linguistically and Culturally Specific Web-based Deaf Depression Screener: Validity and Reliability. In 143rd APHA Annual Meeting and Exposition (October 31-November 4, 2015). APHA.

Screening, treatment and referral for depression has become standard in primary care. Many deaf persons cannot be screened using written instruments due to cultural and linguistic differences in their expression of depressive symptoms and low reading levels. While published reports suggest that deaf individuals experience depression more frequently than do hearing persons, deaf individuals may be less likely to be diagnosed and treated due to lack of a valid and reliable screening measure in American Sign Language (ASL).

Thus far 272 Deaf persons have recruited. Current results on validity were obtained by comparing the DDS to remote assessment by a signing mental health clinician. Both DDS and mental health clinician used DSM criteria to determine the presence or absence of probable depression. Sensitivity is estimated at 85%; specificity at 70%. Symptoms were summed and a Pearson correlation coefficient of .85 between the scores from the first and second test administrations indicates good test-retest reliability.

The DDS shows acceptable levels of validity and reliability. It will allow for patient privacy and cultural specificity while meeting the need for screening for depression, the most common mental health disorder seen in primary care

Heiman, E., Haynes, S., & McKee, M. (2015). Sexual Health Behaviors of Deaf American Sign Language (ASL) Users. Disability and Health Journal.

Deaf respondents self-reported higher numbers of sexual partners over the past year compared to the general population. Condom use was higher among Deaf participants. HIV was similar between groups, though HIV testing was significantly lower among lower-income, less well-educated, and female Deaf respondents. Deaf individuals have a sexual health risk profile that is distinct from that of the general population.

Things People Ask Us

Real Issues—Real Answers

Frequently our office is asked for information related to mental health and deafness and/or interpreting. Below are a few of the examples we have been asked recently. The responses are not meant to be exhaustive listings of all possible resources, but provide information for the individual or agency requesting guidance. (Some information has been changed to protect the confidentiality of the consumers).

How does fund of information deficits factor into mental health treatment?

I know this was discussed somewhat at MHIT, but I was hoping you could help me understand it a bit more. How does FOI deficits impact our work as interpreters in mental health and how can we work with therapists who don't know anything about it? Can you give me some resources that discuss this?

This is a complex issue, but here are a few to get you started.

- http://gupress.gallaudet.edu/excerpts/PDC2svntn4.html
- https://www.urmc.rochester.edu/NCDHR/documents/InTech-Social_determinants_of_health_in_deaf_communities.pdf
- Pollard R. Q & Barnett, S. (2009). Health-related vocabulary knowledge among deaf adults. Rehabilitation Psychology, 54, 182-185.
- Pollard, R. Q., Dean, R., K., O'Hearn, A.M., & Haynes, S.L. (2009). Adapting Health Education Materials for Deaf Audiences. Rehabilitation Psychology, 54, 232-238.
- Pollard, R. Q., et.al., Integrating Primary Care and Behavioral Health with Four Special Populations. American Psychologist, 2014, Vol. 69, No. 4, 377-387.

Do you know of any recent research on deaf clients who are victims of bullying?

I was curious if you knew of any recent research on bulling and mental health/deafness – I know it's happening a lot to deaf adolescents but surely some adults as well? I do know that a lot of my clients are victims of bullying but was curious to see if any data was formed from that? or if there is any information in general about deaf/bullying?

(Response by Kent Schafer)

Bullying is part of the socio-emotional curriculum. "Quality of life" is another possible area. I have seen "social adjustment" used before. Unfortunately, International research has us beat in this field of deafness. Let me find you some articles and get you started. For future references - Fellinger is the go-to author for this area of research.

- http://www.researchgate.net/profile/Robert_Pollard_Jr/publication/221712323_Mental_health_of_deaf_people/links/00b7d52a86f7b1b685000000.pdf
- Predicting Behavior Problems in Deaf and Hearing Children: The Influence of Language, Attention, and Parent-Child Communication. Barker, et. al. Dev Psycholpathol. 2009; 21(2) 373-392.

There are a couple articles in Marc the Shark's book with "deaf learner" or "school related" that will tie in. Book: Educating Deaf Learners: Creating a Global Evidence Base

- http://www.amazon.com/Educating-Deaf-Learners-Creating-Perspectives/dp/0190215194/ref=sr_1_1?ie=UTF8&qid=1431370921&sr=8-1&keywords=Educating+Deaf+Learners%3A+Creating+a+Global+Evidence+Base
- Fellinger, J., Holzinger, D., Sattel, H., & Laucht, M. (2008). Mental health and quality of life in deaf pupils. European child & adolescent psychiatry, 17(7), 414-423.

(Continued on page 18)

Things We Get Asked

(Continued from page 17)

- Quality of life v. Mental health. Conduct, emotional, and/or peer relational concerns. http://link.springer.com/article/10.1007/s00787-008-0683-y#page-1

- Fellinger, J., Holzinger, D., Sattel, H., Laucht, M., & Goldberg, D. (2009). Correlates of mental health disorders among children with hearing impairments.Developmental Medicine & Child Neurology, 51 (8), 635-641.

- The difference in understanding another vs. being understood themselves is helpful in bullying context.http://onlinelibrary.wiley.com/doi/10.1111/j.1469-8749.2008.03218.x/epdf

- Musselman, C., Mootilal, A., & MacKay, S. (1996). The social adjustment of deaf adolescents in segregated, partially integrated, and mainstreamed settings. Journal of Deaf Studies and Deaf Education, 1(1), 52-63.

- Various theories into adjustment for big D and potential measureshttp://jdsde.oxfordjournals.org/content/1/1/52.full.pdf

- Sheppard, K., & Badger, T. (2010). The lived experience of depression among culturally Deaf adults.Journal of psychiatric and mental health nursing, 17(9), 783-789.

- Had a couple interviews chronicling their experiences. http://onlinelibrary.wiley.com/enhanced/doi/10.1111/j.1365-2850.2010.01606.x/

- VBan Agt, H., Verhoeven, L., van den Brink, G., & de Koning, H. (2011). The impact on socio-emotional development and quality of life of language impairment in 8-year-old children. Developmental Medicine & Child Neurology,53(1), 81-88.

- Short research into language disorders by the Dutch Deaf. http://onlinelibrary.wiley.com/doi/10.1111/j.1469-8749.2010.03794.x/epdf

Do you have any info on Deaf people and handcuffs?

Do any of you have information on policies for handcuffing persons with mental illness, developmental disabilities and/or deafness?

This is a very emotional issue for deaf activists. It raises the blood pressure of law enforcement officers when it is brought up as well.

The first thing to remember is that handcuffing someone in a law enforcement situation is not the same thing as the use of restraints in a treatment seeing. That latter has been dealt with in depth in a white paper, titled *Reducing the Use of Seclusion and Restraint Part III: Lessons from the Deaf and Hard of Hearing Communities* published by the National Association of Mental Health Program Directors in 2002.

Interactions between LEO and deaf individuals will vary, but the different world views and cultural perspectives sometimes lead to tense situations.

In January 2008, a deaf girl called 9-1-1 in Frederick County Maryland to report an alleged domestic violence dispute between her and her father.

Knowing that the family was deaf, the police had an interpreter arrive at the scene about 45 minutes later, though the interpreter was unable to successfully communicate with the father.

Though the police determined 30 minutes later that no domestic violence had occurred, the father filed a lawsuit against the police department. He argued that the incident caused “emotional issues” and that the department violated the Americans with Disabilities Act by failing to reasonably accommodate him by refusing to handcuff him in front of his body so he could continue to communicate with the police during their questioning, as well as by failing to use a “qualified sign language interpreter.”

The Fourth Circuit Court ultimately ruled against the deaf man stating that, “the police were following standard procedures for responding to domestic violence calls and that the department attempted to accommodate him by bringing an interpreter.”

Nor is this the only such decision. Although there are some cases arguing to the contrary, most courts are deciding that officer safety has priority over any right to communicate.

This is not to say that it would be nice if LEO would consider communication issues in the process of detaining a deaf person. Unfortunately, the nature of police work in 2015 militates against a “kinder, gentler approach.” Deaf people can do much to reduce the tension. Oscar-winning deaf actress, Marlee Matlin, who is married to a police officer, gives advice at https://www.youtube.com/watch?v=pAvewviVwjY on how to do just that.

Each September, the Substance Abuse and Mental Health Services Administration (SAMHSA) ***(http://www.samhsa.gov)*** sponsors ***National Recovery Month (Recovery Month)***, an observance that increases awareness and understanding of mental and/or substance use disorders while encouraging those in need to seek treatment for these conditions. This year's theme, ***"Join the Voices for Recovery: Visible, Vocal, Valuable!"*** highlights opportunities for recovery education, support, and celebration. The theme encourages communities to: ***be visible*** by knowing the prevalence of mental and/or substance use disorders; ***be vocal*** by noticing warning signs and symptoms; and ***be valuable*** by raising awareness of the resources available to help.

In 2015, ***Recovery Month*** will:

- Spread the message that behavioral health is essential to overall health, prevention works, treatment is effective, and people recover from mental and/or substance use disorders;
- Educate Americans about how to identify signs and symptoms of mental and/or substance use disorders;
- Empower high school students, college students, family supports, and peers in recovery to start conversations about behavioral health conditions; and
- Celebrate people in long-term recovery and recognize those who are dedicated to providing prevention, treatment, and recovery support services.

Resources are available through the ***Recovery Month*** website: http://www.recoverymonth.gov.

Please contact SAMHSA ***(http://www.samhsa.gov)*** at 240-276-2750 for more details.

Resources for this year's ***Recovery Month*** observance will include:

- A toolkit for event organizers and attendees, featuring media templates; current data on behavioral health conditions; resources for prevention, treatment, and recovery support services; and tips to assist in event planning and community outreach, at http://www.recoverymonth.gov;
- SAMHSA-produced television and radio public service announcements and the *Road to Recovery* television and radio series, at ***http://www.recoverymonth.gov***;
- A ***Recovery Month*** website and accompanying social networking websites, including:
  - Facebook (http://www.facebook.com/RecoveryMonth),
  - Twitter (http://www.twitter.com/RecoveryMonth),
  - YouTube (http://www.youtube.com/user/RecoveryMonth);
- Opportunities for individuals to make a Pledge for Recovery, located on the ***Recovery Month*** Facebook page, and to share personal examples of recovery on the ***Recovery Month*** website at ***http://www.recoverymonth.gov*** under the Personal Stories of Recovery section;
- A national ***Recovery Month*** kickoff on September 10 in Washington, D.C., and more than 1,000 national, local, and community events held throughout the country and online, celebrating people in recovery from mental and/or substance use disorders, as well as their support systems and prevention, treatment, and recovery providers; and
- A poster and web banners.

SAMHSA
Substance Abuse and Mental Health Services Administration
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

SMA-15-4915Eng

SAVE THE DATE!

ADARA BREAKOUT 2016
COLORADO

A NATIONAL CONFERENCE PROMOTING WELL-BEING IN THE DEAF COMMUNITY

MARCH 16TH - 19TH, 2016

Conference Registration Opens Fall 2015

Please join leaders from across the nation in a spectacular and relaxed setting in Colorado Springs, CO. Come to collaborate and be inspired by the work of others who are contributing to the well-being of the deaf, deafened, deaf-blind and hard of hearing communities. ADARA is excited to announce the ADARA Breakout 2016 Colorado Conference. The purpose of the Breakout Conference is to provide professional development and networking opportunities for behavioral health professionals, administrators and related professionals serving deaf, deafened, deaf-blind and hard of hearing persons.

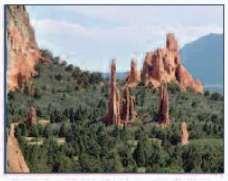
Stunning Location

Cheyenne Mountain Resort is a premier Colorado location set against picturesque mountain views and surrounded by Colorado Springs' naturally breathtaking scenery. Amenities include an impressive range of year-round recreational activities including swimming, golf, tennis, horseback riding, indoor half-court basketball and a full-service workout center complete with state-of-the-art fitness equipment. Cheyenne Mountain Resort's relaxed and restorative environment promotes self-care and well-being.

Hotel Registration is open at Cheyenne Mountain Resort.

Colorado School for the Deaf and Blind

Olympic Training Facility



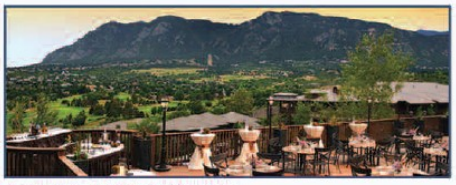
Garden of the Gods

"Purple Mountains Majesty"

The conference will take place in beautiful Colorado Springs, CO, the city at the base of Pikes Peak. Colorado Springs is home to the U.S. Olympic Training Center, Garden of the Gods, U.S. Air Force Academy and since 1874, the Colorado School for the Deaf and the Blind.

Beautiful mountain views

Luxurious hotel rooms



Great views of the Rocky Mountains

A Focus on Well-Being

Delivery of healthcare and behavioral healthcare services in the U.S. is changing rapidly. There is a growing emphasis on treating the whole person through integrated care and integrated systems. Rather than a focus on "managing" disease, we now have the opportunity to optimize well-being. Topics for ADARA Breakout2016 Colorado include:

- Wholistic Approaches and Integrated Care
- Evidenced-Based and Best Practices
- Trauma-Informed Care
- Community Education and Social Awareness
- Deaf Plus
- Culture and Identity
- Interpreting in Behavioral Healthcare, Domestic Violence, and Primary Care Settings

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