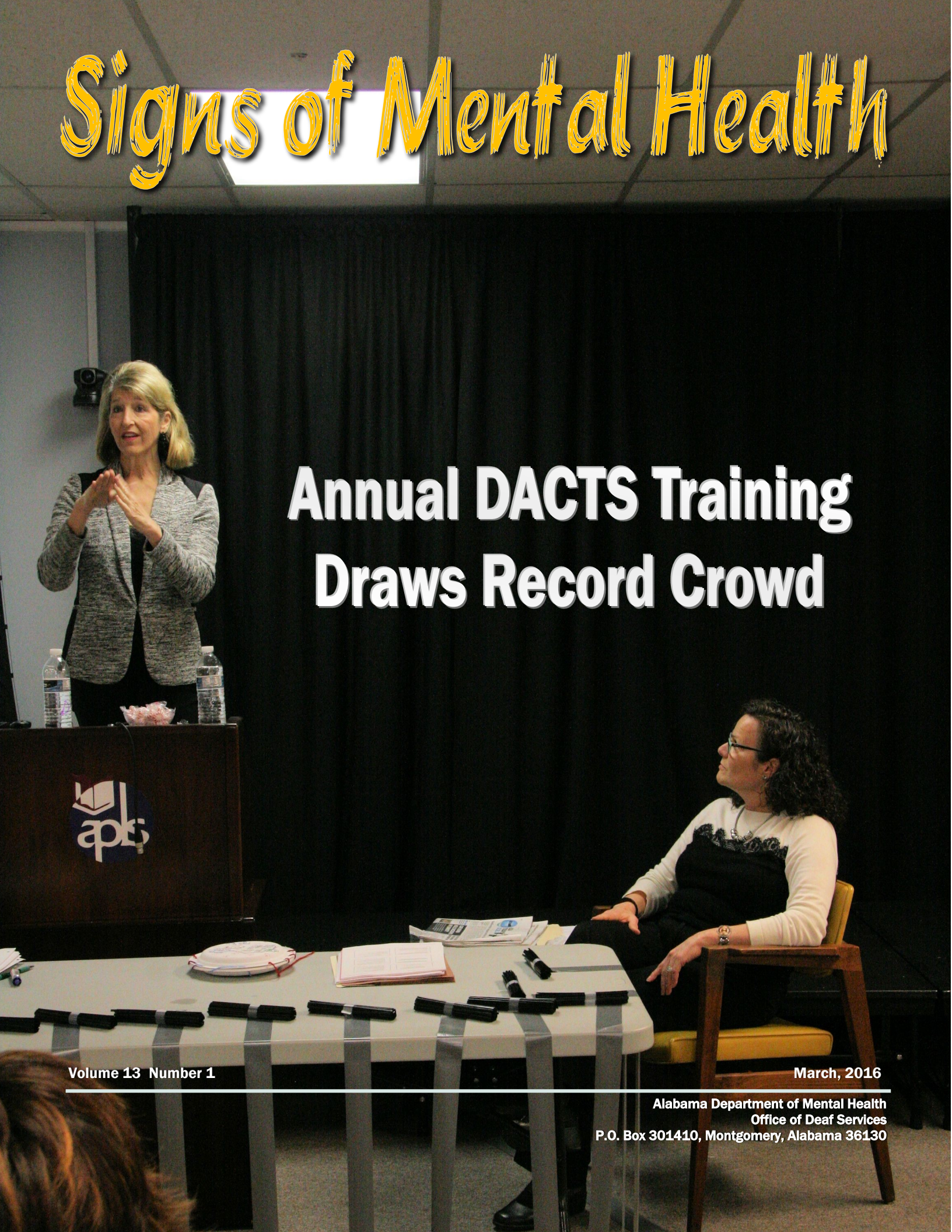
# Signs of Mental Health



## Annual DACTS Training Draws Record Crowd

Volume 13 Number 1

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

## In This Issue




*Signs of Mental Health*
*ADMH, Office of Deaf Services*
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## On The Cover:

*Dr. Debra Guthmann and Cindi Sternfeld lead this year's Deafness and Clinical Training Series, a program of the Mental Health Interpreter Training Project. Story on Page 4.*

# Help Wanted
# Join Our Team

### Job Announcement: Regional Interpreter (Two Positions)
### Office of Deaf Services
### Alabama Department of Mental Health

**MH Interpreter I (Two Positions Available)**
**SALARY RANGE:** 73 ($37,389.60 - $56,685.60)

**WORK LOCATION:** Deaf Services Region I , Huntsville, Region IV Central Alabama

**QUALIFICATIONS:** Bachelor's degree in Interpreting, Linguistics, Deaf Studies, Psychology, Sociology, or a related human service field, plus (24 months or more) of paid experience interpreting in a variety of different settings.

**OR**

High school diploma or GED equivalency, plus considerable (48 months or more) of paid experience interpreting in a variety of different settings.

**NECESSARY SPECIAL REQUIREMENTS:** Must be licensed or eligible for licensure by the Alabama Licensure Board of Interpreters and Transliterators. Must be certified or eligible to receive certification as a QMHI (Qualified Mental Health Interpreter) or its equivalent. **Certification must be obtained within 24 months of hire.** Must have a valid driver's license to operate a vehicle in the State of Alabama. Must be willing to work flexible hours.

**KIND OF WORK:**

This is professional level work in providing specialized services to individuals who are deaf and hard of hearing and who have mental illness, intellectual disability and/or substance abuse issues. Work involves interpreting between deaf or hard of hearing consumers, staff of the Alabama Department of Mental Health facilities or contract service providers. Other duties include providing communication training such as sign language classes to contracted service providers, and performing communication assessments of consumers who are deaf or hard of hearing.

**REQUIRED KNOWLEDGE, SKILLS, AND ABILITIES:** Knowledge of American Sign Language. Knowledge of the function of a professional interpreter and interpreting code of Ethics. Knowledge of deafness and deaf culture. Knowledge of telecommunication devices and their use. Ability to interpret between consumers using a variety of dialects and fluency levels. Ability to communicate effectively both orally and in writing. Ability to interpret in situations where partial control by interpreter is possible. Ability to utilize computer, internet resources, and various software packages. Ability to provide training in the American Sign Language and the use of adaptive technology. Ability to work flexible work schedule to include nights and/or weekends as needed.

**HOW TO APPLY:** Use an official application for Professional Employment (Exempt Classification) which may be obtained from this office, other Department of Mental Health Facility Personnel Offices, or visit our website at www.mh.alabama.gov. Only ***work experience detailed on the application will be considered.*** Additional sheets, if needed, should be in the same format as the application. Resumes will not be accepted in lieu of an official application. Applications should be returned to Human Resource Management, Department of Mental Health, P.O. Box 301410, Montgomery, Alabama 36130-1410 or RSA Union Building, 100 North Union Street, Montgomery, Alabama 36104. Copies of License/ Certifications should be forwarded with your application. An official copy of academic transcripts is required and must be forwarded by the school, college, or university to the personnel office at the above address.

**More positions listed on page 18.**

# NASMHPD Releases New Paper on Deaf Peer Support Services

***By Meighan Haupt, Chief of Staff***
*National Association of State Mental Health Program Directors*

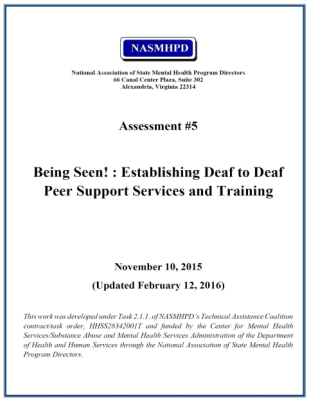
The National Association of State Mental Health Program Directors (NASMHPD) is pleased to announce the development of the assessment white paper entitled, "Being Seen! Establishing Deaf to Deaf Peer Support Services and Training: Successes and Lessons Learned from the Massachusetts Experience." This paper was developed through the NASMHPD Technical Assistance Contract funded through SAMHSA's Center for Mental Health Services, and can be found on NASMHPD's website (www.nasmhpd.org) under publications.

The paper was authored in collaboration with Deborah Delman, the Executive Director of the Transformation Center in Massachusetts; Marnie Fougere, Deaf Peer Support Specialist at the Transformation Center; the Deaf Community Voice Team in Massachusetts; allies of the Deaf Community Voice Team; and NASMHPD.

Although peer support services and training have been expanding and are being established in the hearing community, the Deaf and Hard of Hearing communities have not had the same access and opportunities. Establishing Deaf to Deaf peer support can provide a context of trust and acceptance to support the recovery process with minimal communication barriers.

Based on the Massachusetts experience, this paper provides specific lessons learned and recommendations on how to establish a Deaf and Hard of Hearing peer support community and how to provide the training within the Deaf and Hard of Hearing cultural and linguistic context. In addition, the paper provides specific recommendations on how Deaf and Hard of Hearing leaders and members of the larger community can serve as allies in support of the Deaf and Hard of Hearing Peers.

To prepare this paper, the Deaf Team Coordinator at the Transformation Center in Massachusetts reviewed interviews and recovery stories of all participants in the statewide Deaf peer support project and identified themes to explore further in a small number of interviews. The Deaf Team Coordinator worked with the Massachusetts Department of Mental Health and interviewed seven Deaf and Hard of Hearing Community leaders, two hearing peer coordinators, and held three focus group meetings to review and discuss themes and advice. The quotes in the paper come from the experiences shared during those interviews.


NASMHPD

National Association of State Mental Health Program Directors
66 Canal Center Plaza, Suite 302
Alexandria, Virginia 22314

Assessment #5

Being Seen! : Establishing Deaf to Deaf Peer Support Services and Training

November 10, 2015
(Updated February 12, 2016)

*This work was developed under Task 2.1.1. of NASMHPD's Technical Assistance Coalition contract/task order. HHSS283420011T and funded by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services through the National Association of State Mental Health Program Directors.*

We hope that this paper can be a starting point for other states to build and establish Deaf and Hard of Hearing Peer Support. Please feel free to distribute this paper widely.

If you have any questions about this paper or NASMHPD's initiatives related to Deaf and Hard of Hearing Mental Health Services, please contact Meighan Haupt, NASMHPD Chief of Staff, at meighan.haupt@nasmhpd.org or via phone at (703) 682-5181.

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# Annual Deafness and Clinical Training Draws Record Crowd

The annual Deafness and Clinical Training was held February 18 and 19 in Montgomery, This year, the workshop, Optimizing Outcomes: Substance Use Disorder and the Deaf Population, was led by Dr, Deb Guthman (left) and Cindi Sternfeld. (right).

Attendance on Thursday, February 18th shattered all previous records, with 123 registered participants, not counting presenters, interpreters and staff. Numerous agencies sent staff to the training, in addition to professionals who signed up on their own.

As in the past several years, the training event was held at the Alabama Public Library Services building in Montgomery. APLS has been a collaborator in this effort for 5 years. Past presenters have included Michael Harvey, Neil Glickman, Alexis Greeves, Angela Kaufman, Amanda Somdal, Sharon Haynes and Amanda O'Hearn.

Thursday was geared to participants who could sign and already knew about deafness, but not necessarily about SUD treatment, while Friday's audience were comfortable with treatment but were not knowledgeable about deafness. The split focus allows the presenter to tailor the sessions in such a way that is not possible with a single presentation. The presenter can address clinical work from the perspective of someone who is very knowledgeable about deafness on the first day and address deafness and tailoring treatment given by non-signing professionals on the second. Kristi Simmons told ***SOMH***, "The workshop did just as the name said- brought an understanding of the unique needs of a deaf individual with a substance abuse disorder. It also provided activities for a substance abuse program that can not only be used for deaf individuals, but for any person participating in the program."

One of the points that was driven home was how few treatment programs exist that are truly "deaf-centric." In most cases, treatment consists of providers attempting to work through interpreters. In many cases, the provider is not skilled at working with interpreters or familiar with the specific challenges deaf people face. Similarly, interpreters are often not trained in working in substance abuse treatment settings. The results are generally less than optimal.

Some places are trying to change that. Kathy Thompson, Assistant Director of Human Resources at Bryce Hospital commented, "I feel as if I am gaining a greater understanding of the deaf/hard of hearing community. I hope that will be reflected in my duties of hiring Deaf Care Workers." Consumer Advocate Melissa Munthali noticed, "The main problem found is there are not enough resources available for our deaf population. We don't have enough interpreters."

Deafness professionals, such as rehabilitation counselors, educators and social services professionals, are sometimes not aware of how prevalent Substance Use Disorder really is nor are they aware of how challenging it can be to find appropriate treatment. They then become frustrated when their clients seem not to improve and may view the client as "not cooperating".

In Alabama, even though the ODS is making interpreter services available to any Department of Mental Health contract SUD treatment provider, deaf people are still significantly underrepresented in treatment. "We hope by

*(Continued next page)*

### *Annual Deafness and Clinical Training*

*(Continued from page 4)*

making professionals in social service settings aware of the issues that there will be increased referrals to treatment," said Steve Hamerdinger, ODS Director. "One of the things that was stressed at the training was that we had to be able to mobilize resources quickly when an addict was ready to enter treatment. We are not good at getting deaf consumers into treatment quickly."

Deb Guthmann, Ed.D, worked for the California School for the Deaf for 17 years as the Director of Pupil Personnel Services where she was responsible for all clinical services. She is the founding Director of the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals which is one of the first inpatient treatment programs for Deaf and Hard of Hearing Individuals in the country. Dr. Guthmann has made over 200 national and international presentations, written numerous articles and several book chapters focusing on ethical issues, substance abuse and treatment models to use with the Deaf and Hard of Hearing. She is also a nationally certified interpreter through the Registry of Interpreters for the Deaf.

Cindi Sternfeld, Ed.S, maintains a private counseling practice in Lambertville, NJ. She has a Master's degree in Mental Health Counseling with a post Master's certification in Addictions Counseling. Her Ed.S. is in Marriage and Family Therapy. She has extensive Sex Therapy training, is a Level II EMDR Therapist, possesses National Counselor Certification and is a Master Addictions Counselor.

*Team building activities brought together participants from various agencies. Left to right: Kevin Henderson (Hope House, Atlanta, GA) Jason Hurdich (Instructor, Troy University ) Stacey Grey (Deaf Support Specialist, ADRS, Birmingham), Wendy Lozynsky (Case Manager, AIDB Regional Center, Birmingham, ) and Melissa Norred (VR Counselor, ADRS, Birmingham)*

# Critchfield Is New Region III Clinician

A. Barry Critchfield, Ph.D joins ODS as Region III therapist, filling a position that has been vacant since 2008, it was recently announced. He is slated to begin his duties April 18.

Critchfield has had a long and storied career in deaf mental health care, including stints as the Director of Deaf and Hard of Hearing Services at the South Carolina Department of Mental Health and Director, Office of Deaf Services, Georgia Department of Behavioral Health and Developmental Disabilities. He has also served as the

Executive Director of the Missouri Commission for the Deaf and Hard of Hearing, the position from which he retired.

He is coming out of retirement to accept this position, Critchfield says, because "I want to work with deaf people. I have no interest in administration these days."

Critchfield received his doctorate in Educational Psychology from Brigham Young University in 1982. He worked in a variety of clinical settings over the next several years. In 1988, he became the director of Deaf and Hard of Hearing Services in South Carolina, and over the next 18 years built that program into one of the nation's top programs.

When Alabama was working to set up the Office of Deaf Services, Critchfield was one of the consultants that help design the model. He has been responsible for the development of several programs around the country.

When asked why he wanted to move to Alabama, Critchfield told SOMH that, "I have had some great professional connections over the years with the Office of Deaf Services staff, Ending my career with these people would be an excellent summation to my work with deaf people."

He is the author of several publications, including the highly influential 2002 publication, Meeting the Mental Health Needs of Persons Who Are Deaf.

Over the years, Dr. Critchfield has worked with Deaf people in the states of Indiana, California, Utah, Louisiana, South Carolina, Missouri, and Georgia, as well as Alabama.

# Remembering Deaf Mental Health Pioneer Allen Sussman

Dr. Allen E. Sussman passed away on January 8, 2016. He was 83 years old. Born to deaf parents, and was raised in Brooklyn. In 1947, he graduated from J.H.S. 47 School for the Deaf and Hard of Hearing and then attended New York School for the Deaf (Fanwood) briefly. He then graduated from Gallaudet College in 1955.

After a brief stint as an athletics coach at Ohio School for the Deaf, he obtained his master's degree in 1967 and then his doctorate in 1973, both from New York University. His professional career included serving as an adjunct assistant professor in psychology at NYU, the director of a community mental health center for the deaf in Brooklyn, a professor of counseling at Gallaudet University and a licensed psychologist. He also served as director of Gallaudet's counseling center, and then the Dean of Student Affairs. He retired from Gallaudet and private practice in 2002.

Sussman's time at Gallaudet was momentous. He had an immeasurable influence on mental health care of deaf people. Through his publications and presentation and through his teaching counseling, he influenced a generation of counselors and psychologists working with deaf people. As Dean of Students, he was also deeply involved the "Deaf President Now" protest, which roiled the campus in March of 1988, and led to the appointment of I. King Jordan as Gallaudet's first deaf president. Some people credited him with being one of the primary instigators.

Sussman was a favorite teacher of many Gallaudet students. ODS Director Steve Hamerdinger, who took courses under Sussman, recalls he loved lively debates in class and was likely to take the most "Deaf-centric" side. "Dr. Sussman was not above pushing his students to defend comments in class. Woe betide the student who made an unthinking remark that put down deaf people! I think it made us better. We had to be prepared." Shannon Reese, ODS Services Coordinator, said, "While he was my professor, he taught me about humility-he was one of the pioneers in mental health and deafness field but he did not show it. I would guess that quite a few former students have similar war stories to tell from their own classroom encounters with Allen. In time, we all grew to realize that he was pushing us so hard precisely because he cared so much about each of us personally."

He received his doctorate in Rehabilitation Counseling from New York University in 1973, . His studies included enough coursework in Psychology to be license-eligible, so he became one of the earliest deaf people to hold a license as a psychologist. He was a tireless advocate for increasing mental health services for deaf people and increasing the number of deaf people in the profession.

His interests were broader than just mental health, however. He was concerned about the lives of deaf people in general. He fought against the "debilitating attitude" of those who thought that deaf people were inherently more psychologically fragile and promoted the idea of the Psychologically Deaf Person" (reprinted elsewhere in this issue).

Sussman was inducted into the Hall of Fame by the "47" Alumni association of the Deaf in recognition and appreciation of his extraordinary leadership to the Deaf Community. In addition to deaf community activities, he served as the vice-chair of the successful Deaf Seniors of America (DSA) conference, in Baltimore, Maryland in August, 2013. More recently, he served as a board member of Maryland Deaf Senior Citizens, Inc, (MDSC) where he was responsible for leading the Town Hall meeting to develop future plans for MDSC as well as develop cultural and educational activities for its monthly MDSC events.

He is survived by his wife Claudia and his three children, Juniper Sussman (and her daughter Mariasha), Jeff Sussman (and his wife Debbie), and Vicki Sussman (and her daughters Carlee and Kai). The family requests that contributions be made to the Allen E. Sussman, '55, Counseling Scholarship Fund in care of the Office of Development, Gallaudet University, 800 Florida Ave, NE. Washington, D.C. 20002, or click https://giving.gallaudet.edu/sussman for online donations) or to his church Bethany Community Church (15720 Riding Sable Road, Laurel, Maryland, 20707).

Compiled from various sources, including https://www.gallaudet.edu/daily-digest/dr-allen-sussman-obit.html.

# The Characteristics of the Psychologically Healthy Deaf Person

*by Alan Sussman, Ph.D, Professor Emeritus, Gallaudet University, Washington, D.C.)*

1. Positive Self Concept
    - There is no vagueness about who they are-They see themselves as a person first who happens to be deaf.
        I. They do not let the spread effect work in their lives to warp their perception- they know who they are in relation to their hearing loss.
        II. They know that they are not hearing people and don't try to act like it.
2. Positive Psychological Acceptance of Deafness
    - Some deaf people are resigned to deafness- "I'm deaf, can't do anything about it so I won't try."
        I. Frequently shows up as Reaction Formation or the behavior of acting the opposite of what you feel.
    - Some deaf people truculently accept it- "I'm deaf and the world owes me because of it"
        I. Shows up most often in passive aggression or neurotic behaviors
    - Positive acceptance is when you realize that it is irreversible, but you can have a good life. "Deafness will not stifle my growth and development."
3. Ability to Effectively Compensate For Deafness
    - You cannot compensate effectively if you no not have a positive acceptance of deafness.
    - The development of coping skills may have to be taught- many deaf people need to learn them
        I. A major goal of counseling should be this
4. Ability to Cope with Negative and Evaluative Attitudes
    - We have to learn how to get a job in spite of the discrimination, prejudice, etc, of the hearing people.
        I. It is a tribute to the resilience of the deaf that we can have the psychological strength to deal with those d--- hearies
5. Assertiveness
    - Survival skills that make it possible to put up with the crap from the hearing world
        I. Again, these are skills that need to be taught
        II. They help build psychological strength
        III. They include awareness of our civil rights and how to preserve them
6. Ability to put Speech in Perspective
    - Even though they can't talk well, they realize their other abilities
        I. It does not mean to disregard the importance of speech, but they can still grow even if they can-not talk.
7. Ability to Keep Hearing in Perspective
    - Same basic idea as above- however, it also includes the ability to make use of a hearing aid if it is helpful and not feel inferior if it does not help.
8. Positive Attitude Toward Sign Language
    - Deaf need to feel pride in the beauty and utility of their language- not feel ashamed of it.
9. Effective Interpersonal Relationship and Social Skills
    - One aspect- the need to feel part of their group, whether at work or not. They need to learn how to co-exist with hearing co-workers.
        I. Not all deaf agree that they need to have anything to do with the hearing world, but this is not realistic view.
            1. Important to remember that interaction strain works both ways
            2. Not to learn how to get out of uncomfortable situations gracefully
    - Another important aspect- the ability to effectively socialize within the deaf community
- Ability to be Self Reliant
    - Having independence is a mark of the healthy deaf person
        I. Many truculent deaf people are that way because they hate being dependent on others
11. Ability to Ask For And Use Assistance Where Appropriate
    - Keep things in prospective- admit when you need help and don't feel guilty for using it- You are OK even if you need help once and a while.

# Physicians Gain from Providing Language Access

***By David B. Hunt, J.D. President and CEO*** *of Critical Measures. Reprinted with permission of the author.*

More physicians are seeing patients who do not speak English. Nationally, 97 percent of physicians have at least some non—English—Speaking Limited English Proficient (LEP) patients.

Nearly half (48.6 percent) of all U.S. physicians in 2008 reported that difficulty communicating with patients because of language or cultural barriers was at least a minor problem affecting their ability to provide high quality care.[1] Language barriers are associated with poor quality of care in emergency departments; inadequate communication of diagnosis, treatment and prescribed medication; and higher rates of medical errors.

According to the Joint Commission, fully half of LEP patients who reported adverse events experienced some degree of physical harm — compared to less than a third of English-speaking patients. The same report found that the rate at which LEP patients suffered permanent or severe harm or death was more than twice that of English-speaking patients.[2]

**48.6% OF ALL U.S. PHYSICIANS**

In 2008 Reported That Difficulty Communicating With Patients Because Of Language Or Cultural Barriers Was At Least A Minor Problem Affecting Their Ability To Provide High Quality Care.

Two kinds of patients have language access rights under American law. LEP patients have such rights under Title VI of the Civil Rights Act of 1964. Deaf and hard of hearing patients have language access rights under the Americans with Disabilities Act.[3] Providers may not be aware that violating either of these laws constitutes civil rights violations which are not covered by medical malpractice insurance. Denying interpreters or written translated materials to LEP patients can constitute a form of national origin discrimination.[4] Finally, American courts have held that an LEP patient's informed consent will be invalid where not obtained by a qualified interpreter.[5]

Physician offices and clinics that receive federal funds from Medicare, Medicaid or other programs (SCHIP) are legally obligated to provide language access services.[6] The exception to that requirement is providers or clinics that only participate in Medicare Part B.[7] If providers are required to provide language access services then they must provide them to patients who qualify as "LEP" — patients who, by their own estimation, speak English "less than very well." Providers must be aware that the obligation to provide language access services can also extend to family members under certain circumstances and to LEP patients who are not U.S. citizens.[8]

Title VI requires that providers, as recipients of federal funds, take reasonable steps to ensure that LEP persons have "meaningful access" to their programs — at no cost. "Meaningful access" means that communications between the LEP patient and the provider are effective in promoting mutual understanding.[9] Several factors can increase or decrease provider's legal duties to LEP patients. If providers serve markets that have higher concentrations of LEP patients, see LEP patients more frequently, provide services for highly acute patients and have greater financial resources, then they will have greater language access obligations under the law. If physician offices and clinics accept federal funds, then they have two primary duties toward LEP patients. First, they must provide access to qualified interpreters at no cost. Second, they must provide written translated materials in the patient's preferred language.

Providers have many options in providing qualified interpreters. These options include qualified staff interpreters, contract interpreters, telephonic or video interpretation service as well as bilingual staff or community volunteers.

Both the Department of Health and Human Services and its CLAS standards "discourage" the use of family members and friends as interpreters.[10] Research has shown that untrained family members and friends make an average of 31 interpretation mistakes per doctor-patient visit — over two-thirds of which could have negative clinical consequences for patients.[11] The law does not expressly forbid the use of family members and friends as interpreters but their use should generally be limited to extreme emergencies where no other language access options are available. Similarly, the use of minor children is not prohibited but "extreme caution" is advised when using them as interpreters for adult family members. (Some states now prohibit the practice altogether.)[12] *(Ed. Note: Alabama Department of Mental Health Community Program Standards also prohibits this practice.)*

*(Continued on page 9)*

### *Physicians Gain from Providing Language Access*

*(Continued from page 8)*

Beyond these requirements, every physician should receive instruction on how to work with LEP and deaf and hard of hearing patients through qualified interpreters (including American Sign Language interpreters). Providers would also benefit from instruction on federal and state language access laws.

## Common Title VI Violations

- Failure to provide **any** language access services.
- Failure to provide **competent** interpreters.
- Failure to provide language access in the **correct language**.
- Failure to provide language access services in a **timely** manner.
- **Charging** patients for language access services.
- **Insisting that patients provide their own interpreters.** (Conditioning the receipt of medical services on patients providing their own interpreter or sending patients home to return with a family member or friend to act as an interpreter.)
- **Failing to inform** patients of their legal right to language access services at no cost to them.
- **Failing to provide language access services where the interpreter's fees exceed the physician's own hourly charge.** In a 2008 New Jersey case with national significance, a physician refused to honor a patient's request to employ an American Sign Language (ASL) interpreter because the interpreter's charges would exceed the physician's hourly rate. The physician was required to pay a $400,000 jury verdict including $200,000 in punitive damages as a result.[13]

### References


1. *Modest and Uneven: Physician Efforts to Reduce Racial and Ethnic Disparities*, Reschovsky, JD and Boukus, ER; Issue Brief Center for Studying Health System Change; 2010 Feb; (130): 1-6. Available online at: http://www.rwjf.org/files/research/4427.pdf.
2. Wilson-Stronks, A; Galvez, E; *Hospitals, Language, and Culture: A Snapshot of the Nation*. Oak Brook, IL: Joint Commission on Accreditation of Healthcare Organizations, California Endowment; 2007. (Citing research from Divi, C; Koss, RG; Schmalz, SP; Loeb, JM. *Language Proficiency and Adverse Events in U.S. Hospitals: A Pilot Study*. Int. J. Qual. Health Care. 2007:19;6-67. Available online at: http://intqhc.oxfordjournals.org/content/19/2/60.abstract?ijkey=38e63d716f97a5f7e996186ac7af91f8bc08f86&keytype2=tf_ipsecsha.
3. 42 U.S.C § 2000d. The legal foundation for language access lies in Title VI of the 1964 Civil Rights Act, which states: "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance." Discrimination on the basis of language is regarded as a form of national origin discrimination under American law. See also: Americans with Disabilities Act of 1990; Pub.L. 101-336, 104 Stat. 327, enacted July 26, 1990, codified at 42 U.S.C. §12101.
4. Lau v. Nichols, 414 U.S. 563 (1974).
5. See: Quintero v. Encarnacion, Lexis 30228, 10th Cir. 2000; Snyder v. Ash, 596 N.E.2d 518 (1991) Both cases are cited for the proposition that a Limited English Proficient patient's informed consent will be regarded as invalid under American law unless obtained by a qualified interpreter.
6. Department of Health and Human Services regulations, 45 CFR 80.3(b)(2), require all recipients of federal financial assistance from HHS to provide meaningful access to LEP persons. See also: Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons ("Revised HHS LEP Guidance"). (August 30, 2000) ("Recipients of HHS assistance may include, for example: physicians and other providers who receive Federal financial assistance from HHS.")

7, 8, 9, 10. Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons ("Revised HHS LEP Guidance"). August 30, 2000. ("Recipients of HHS assistance do not include, for example, providers who only receive Medicare Part B payments" at footnote 4. The LEP Guidance clarifies that "HHS's Title VI regulations do not apply to (i) Any federal financial assistance by way of insurance or guaranty contracts, (ii) the use of any assistance by any individual who is the ultimate beneficiary under any program which receives federal financial assistance, and (iii) any employment practice, under any such program, or any employer, employment agency, or labor organization, except as otherwise described in the Title VI regulations. 45 CFR 80.2.")

11. Flores, G; Laws, MB; Mayo, SJ; et. al. Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters. Pediatrics. 2003; 111(1):6-14.

12, 13. Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons ("Revised HHS LEP Guidance"). August 30, 2000. (The Guidance states as follows: "Extra caution should be exercised when the LEP person chooses to use a minor as the interpreter. While the LEP person's decision should be respected, there may be additional issues of competency, confidentiality, or conflict of interest when the choice involves using minor children as interpreters. The recipient should take reasonable steps to ascertain whether the LEP person's choice is voluntary, whether the LEP person is aware of the possible problems if the preferred interpreter is a minor child, and whether the LEP person knows that a competent interpreter could be provided by the recipient at no cost.") Note: the state of Rhode Island bans minors under the age of 18 from acting as medical interpreters. The state of California has introduced similar legislation but it has not, as yet, passed.

15. Gerena v. Fogari, N.J. Sup. Ct., App. Div. (2009)

# As I See It

*Mindfulness is the combination of awareness, centering, and being present. It is the awareness of your thoughts, emotions, actions, and energy. It is the ability to get centered and stay centered in all situations. And it is the ability to be present, not letting internal and external distractions take you from the current moment. This leads to the development of empathy, compassion, love, balance, and harmony. (http://hlfinc.org/about-us)*

George Bernard Shaw once remarked that "The power of accurate observation is commonly called cynicism by those who have not got it." I am reminded of this every time I see an article or presentation on "mindfulness". There were at least three at the recent Breakout conference (see page 13 of this issue).

Now, I spend a good percentage of my "off" hours being in the present, centering my thoughts, wondering from where the next threat to our consumers will come. It's not the boogeymen under beds that worry me. That would not be very mindful, would it?

No, it's the very real and present concern that people in places of power and influence will do things to advance their agendas that are hurtful to the deaf consumers we serve. Some examples, in no particular order:

- Raiding the Dual-Party Relay Fund – which was specifically established for the benefit of the Deaf Community – of three and a half million dollars. This is money that could have gone to the interpreter training program. That could have funded a crisis response hotline for the Deaf Community. Instead, it was used for a one-time bandage to cover budget shortfalls that were the result of not being willing to make the hard decisions needed to balance the budget honestly. Better to hurt deaf people who can't fight back than to risk angering the elitists, who "have theirs" and will not have anyone touch it.

- Close-minded political correctness substitutes for substantive critical thinking among people in deafness around the country. No, Alabama is not a hotbed of racism. Compared to those liberal utopias like Baltimore or St. Louis, Alabama ***IS*** utopia. We are not what the mass media portraits us to be. But, thanks to the misinformation and falsehoods, it's hard to recruit.

- Since the beginning of the establishment of our office, at least one professional got all wee-wee'ed up when I did not hire said person program as s/he assumed I would. Rather than coming to me in a professional manner, or analyzing their own issues which prevented them being the choice for hire, they have made ongoing personal and professional efforts to defame the person I did hire, the rest of the staff, the program, etc., no matter how much it hurts the people we serve.

- The crab theory (especially when intentionally encouraged and prodded by the above) prompts the spreading of rumors, misconceptions, fairy tales and outright lies that both make it harder to recruit staff and scare away deaf people who need mental health services.

- After years of trying to make mental health centers follow minimal standards for deaf access, we see that progress tossed into a blender called managed care, run by corporations who, at the end of the day, are more concerned about making money than about serving deaf people appropriately.

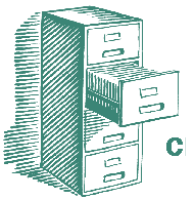
So why this Dennis Miller-ish rant? Why am I sounding like a grumpy cynic? Maybe it is because of watching daily the kabuki theater of the state budget making process, where everyone has an assigned role to play. The whole thing is supposed to convince us *hoi polloi* that those we entrust with the public fisc (go look it up!) sincerely are looking out for what is best for us. It is becoming quite tiresome.

Maybe it is because, after more than 30 years of watching people working in deafness, especially interpreters and leaders of deaf organizations, eat each other up for the sole purpose of self-aggrandizement or to appease hurt feelings, regardless of the cost to deaf people or other professionals.

Maybe it is because, as an old deaf man once told me, "deaf people never win." Every time I see someone object to hiring a qualified deaf applicant because he or she is deaf (see the Lauren Searls story on page 15) it makes me want "to spit on my hands, hoist the black flag…" as H.L. Mencken once wrote. (The full quote, however much I to print it here, like it, would require a "trigger warning" in today's ultra– PC world.)

Or maybe it is not that I am becoming cynical, but I have developed the power of accurate observation.

But probably it is because one tires of fighting the same battles over and over. Ecclesiastes 1:9 tells "What has been will be again, what has been done will be done again; there is nothing new under the sun." *As I See It*, though, we struggle on because to do otherwise is giving up. And that is something deaf people throughout history just do not do.



# From the ODS Case Files:

## Challenging Cases, Creative Solutions

*(Identifying information including names, settings etc. have been altered for the privacy of those involved).*

**Sometimes communication assessments and observations provide a clear picture of the person's language abilities and weaknesses. This helps to differentiate lack of language exposure from language related issues tied to cognitive abilities or mental illness. Sometimes there are such a myriad of possibilities that teasing out one potential cause from the other can become difficult.**

This consumer is the one that interpreters see frequently in social services agencies. He is the one that comes into appointments and getting information that is needed for intakes is difficult. It isn't that he doesn't have language or that he's intellectually challenged, but the details are difficult to obtain, due to his own unique dysfluency related to language and potential fund of information deficits. He also has a mental illness, which may contribute to some of his language challenges.

Larry is a 40 year old African American male with a bi-lateral profound hearing loss. The cause of deafness is unknown. He is the only Deaf person in his family – that we know about.

Larry is diagnosed with schizophrenia and has diabetes that is not controlled by diet and medication.

OBSERVATIONS RELATED TO LANGUAGE (As demonstrated through his BEST language - Sign Language)

- Responses are lengthy and sometimes derail as if attempting to maintain control of the conversation. This may mean that he has difficulty understanding information signed to him and this is an effort to cope. Possibly better expressive than receptive skills.
- Sign production is clear, although he does have some issues with arthritis in his hands which influences production. Prosody is natural and easy.
- Receptive ability is limited to concrete concepts and requires significant expansion of concepts or questions. Incorporation of gestures is especially beneficial.
- Responds best to medical and/or mental health professionals when a procedure is first explained and permission sought. Efforts to approach him without explanation can result in setting him off.
- He will disengage eye contact when not actively involved in conversation. But may monitor out of the corner of his eye and becomes upset if he feels that others are talking about him.
- Frequently fingerspells common words such as TODAY, MAYBE, HOSPITAL.
- Remembers names of places that he has been well and will often respond in a more formal response. Example: Where are you? A typical response would be "the doctor's", He is more likely to respond, "I am at the M-A-I-N S-T-R-E-E-T D-R. O-F-F-I-C-E.
- Uses some initialization that is not standard, but also does not seem to indicate a mainstreamed environment.
- Repeats signs and concepts for no obvious linguistic reason.
- Displays elements of grammar such as space referents, identification of individuals within space, eye gaze used for locations, compare/contrast, verb directionality, and some classifiers (SASS, instrument, etc.).
- He demonstrates weakness in connecting thoughts/ideas and in changing topics.
- Facial expressions are primarily emotive and do not show linguistic markers.
- Uses past and current tenses appropriately, but struggles with future concepts.

DISCUSSION

This case is particularly difficult because there are numerous considerations:

- Potential lack of adequate language exposure
- Fund of information deficits
- Unknown history
- Presence of diabetes which can be highly uncontrolled and impacts his language significantly

Diagnosis of schizophrenia can affect language significantly when not stable.

Although not all individuals are impacted the same way, individuals who are deaf and have schizophrenia, may present in ways that are different than individuals who are hearing and have schizophrenia. There may be some areas of symptomology that have a different significance. These differences can include language and behavioral differences such as:

- ASL users with schizophrenia can demonstrate psycholinguistic errors similar to hearing individuals. However the way that it is expressed will be visually based rather than auditorilyy.
- The way that ASL is used and certain aspects of Deaf

*(Continued on page 14)*

# ODS Therapist Thornsberry Leads Deaf Advocates Training

In today's society, more and more deaf/hard of hearing/deafblind people are starting to realize their own power and potential for making changes for the better. The world has changed since the 1990, when the Americans with Disabilities Act was signed. Prior to then, Deaf/HH/Deafblind people did not have equal access as the hearing community had. With ADA, that changed significantly-hence more and more people did not understand fully what their rights were.

Deaf Self-Advocacy Training (DSAT) "Train the Trainer" was held in Birmingham, Alabama, February 27 and 28, at the Alabama Institute of Deaf and Blind Birmingham Regional Center. The workshop, led by Kim Thornsberry, drew 17 participants from around the state. Thornsberry, who is one of 14 original DSAT master trainers, committed her weekend because she felt it was important to educate, share, and empower as many Deaf/HH/Deafblind people as possible.

*ODs Regional Therapist, Kim Thornsberry (Front row center) with the participants of the DSAT training*

The DSAT curriculum was developed by the National Consortium of Interpreter Education. According to the NCIEC website, the organization works to, "offer training and technical assistance to regional stakeholders including curricular resources for interpreting education programs, educational opportunities for interpreters at all levels of experience, consumer self -advocacy training, and new interpreter recruitment". In addition, NCIEC explained that the goal is best achieved by working partnership with others, by forging collaborative links, facilitating practice and product-sharing among interpreter education service providers, practitioners, educators and consumers nationwide.

In 2005, a grant from RSA was given to the NCIEC where they designed a curriculum to be taught by Deaf, Hard of Hearing, or DeafBlind trainers to the consumers in that population. For example, one of the findings is that many interpreters saw that they could not do much for the deaf/hard of hearing/Deafblind people in the field. They wanted to empower the community to advocate for themselves in terms of getting effective interpreting services rather than receiving nothing and creating frustration.

Curriculum used over the weekend consisted of teaching advocating for one's self and others, self-esteem, self-determination, working with interpreters, ethics of working with interpreters, interpreting services using video technology, preparing for self-advocacy, and utilizing resources for action. In addition, DSAT curriculum is designed as a peer-led training. The training also brought together resources from which participants could benefit, such as Alabama Institute for the Deaf and Blind and its subunits, Alabama Department of Mental Health's Office of Deaf Services, Troy University and others. It was fantastic to see what they could offer to each other in terms of sharing resources and information. According to NCIEC, more than 2,000 Deaf, hard of hearing and DeafBlind consumers have attended a DSAT consumer training and more than 250 Deaf, hard of hearing, and DeafBlind individuals have been trained a DSAT Trainers.

The training venue was made available through the support of Jessica Edmiston, Regional Center Director and Wendy Lozynsky, Social Worker. The Alabama Association of the Deaf to provided refreshments during the two—day training.

The passion in the trainers is enough to spread awareness all over Alabama. You may contact these trainers if you are interested in having someone come and educate the Deaf/Hard of Hearing/Deafblind community. You can look for your nearest DSAT Consumer Trainer/Master Trainer at http://www.interpretereducation.org/deaf-self-advocacy/find-a-trainer/

For more information Deaf Self Advocacy Training curriculum for Alabama, contact Kim Thornsberry at kim.thornsberry@mh.alabama.gov. You can view www.interpretereducation.org/deaf-self-advocacy/ for more information.

# ODS Staff Well-Represented at National Deaf Mental Health Conference

Breakout, a biennial conference that focuses on mental health care of deaf, hard of hearing, late-deafened and deafblind people, was held March 16 – 19 in Colorado Springs. There were 257 people in attendance, drawn from around the country. Office of Deaf Services staff members, Charlene Crump, Steve Hamerdinger, and Shannon Reese all had presentations accepted.

This year, the conference was held at the Cheyenne Mountain Resort in Colorado Springs, Colorado. Conference chair, Ric Durity and his team, largely drawn from the Mental Health Center of Denver, did an outstanding job of organizing the confab.

Demonstrating the efficiency of modern technology in numerous ways such as electronic materials instead of paper and a keynote presentation offered remotely (see https://mhcd.org/adarabreakout2016/), Breakout served as a reminder that mental health services are changing.

Twenty-seven breakout sessions were spread over two and a half days. The topics ranged from Advocacy to Yoga for self-care. Because of the focus of the conference, all sessions touched on Deaf Mental Health Care in some way.

The Conference Keynote, also called the McCay Vernon Lecture, "Choice, Person-Centered and Options=Change" was presented by Darlene Zangara, PhD, Olmstead Implementation Office, State of Minnesota. The biennial lecture honors McCay Vernon, a psychologist whose work revolutionized deaf mental health care. (See SOMH Volume 10, Issue 3.)

*Above: Shannon Reese and Steve Hamerdinger take questions from the audience. Above right: Charlene Crump and Roger Williams present on the Communication Skills Assessment they jointly authored.*


One of the few physicians in the world who is deaf, Dr. Michael McKee, gave a well-received plenary address on "Integrating Behavioral Health into Primary Care - Addressing the Well-Being of Deaf and Hard of Hearing Patients."

Reese and Hamerdinger presented on Language Proficiency Requirements and Standards of Care on Thursday. On Friday, Crump co-presented on Communication Assessments with Roger Williams and Romy Spitz. Hamerdinger also had a Friday session on Integrated Health Care: Implications for Existing Best Practices and Policy.

The conference originated as a breakout session from the International Association of Psycho-Social Rehabilitation Services Conference. The first stand-alone conference was held in 1989. Breakout has enjoyed a 27 year run with 13 conferences held in various parts of the country. From 1989 to 2006, they were stand-alone conferences run independently by host committees.

No one volunteered to host a 2008 session and the conference tittered on the brink of extinction. At the urging of several members of the ADARA board of directors, the conference resumed in 2010 as a project of ADARA. ADARA is also the fiscal agent and co-sponsor of the Mental Health Interpreter Training Program.

# History Of Breakout at a Glance

**ODS staff members, individually and collectively, have had a long history of direct and active involvement in Breakout**

| | | | |
|---|---|---|---|
| **1989** | **September 27-28** | **Breakout : The First National Conference on Community-Based Alternatives for Deaf Persons with Mental Illness** | **Washington, DC** |
| **1992** | | **Breakout II: Innovations in Psychosocial Rehabilitation for the Deaf** | **Washington, DC** |
| **1994** | **April 7-9** | **Breakout III: Psychosocial Rehabilitation for Persons who are Deaf and Mentally Ill** | **Charleston, SC** |
| **1996** | | **Breakout IV: Psychosocial Rehabilitation and Deafness Conference** | **Chicago, IL** |
| **1998** | | **Breakout V: Psychosocial Rehabilitation and Deafness Conference** | **Washington, DC** |
| **2000** | **May 11-13** | **Breakout VI: National Conference on Psychosocial Rehabilitation and Deafness Gateway to a Culturally Affirmative Millennium** | **St. Louis, MO** |
| **2002** | **April 4-6** | **Breakout VII: National Conference on PsychoSocial Rehabilitation and Deafness: Community Interventions: Preserving our Roots.** | **Raleigh, NC** |
| **2004** | **September 4-8,** | **Breakout VIII: (in conjunction with NAMI Convention)** | **Washington, DC** |
| **2006** | **June 15-17** | **Breakout IX: National Mental Health and Deafness Conference** | **Columbus, OH** |
| **2008 No Conference** | | | |
| **ADARA adopts Breakout Conference in 2010** | | | |
| **2010** | **June 17-19** | **Breakout X: Effective Mental Health Services for Deaf and Hard of Hearing Persons** | **Atlanta, GA** |
| **2012** | **June 28-30** | **Breakout XI: Effective Mental Health Services for Deaf and Hard of Hearing Persons** | **Atlanta, GA** |
| **2014** | **March 13-15** | **Breakout XII: Bridging Gaps in Behavioral Health Service Delivery for People who are Deaf, Deaf-Blind, or Hard of Hearing"** | **Pittsburgh, PA** |
| **2016** | **March 16-19** | **Breakout XIII: A National Conference Promoting Well-Being in the Deaf Community** | **Colorado Springs, CO** |

## *From the ODS Case Files*

*(Continued from page 11)*

culture which are normalized within the deaf community, can emulate psycholinguistic errors typical of a hearing person with schizophrenia.

- Errors or choices in interpretation can emulate psycholinguistic errors typical of a hearing person with schizophrenia.
- Visual perception and recognition slowed and less accurate.
- May have special meaning assigned to color or patterns
- Will not perceive facial expressions the same way that deaf people without schizophrenia will perceive them. There is also a difference in the way that deaf people with schizophrenia vs hearing people with schizophrenia understand facial expressions.
- Poor eye contact.
- Make longer pauses.
- Flat affect.
- Signing is too slow or overly fast.
- Too much emphasis on particular sign movements.
- Experience impaired language comprehension.
- Difficulty with increased complex grammatical structures.
- Show reduced syntactic complexity in their production.
- Impaired access to word meanings.
- Less ability to utilize closure skills.
- Less clear referents and transitions.
- Fewer structural links.
- Talking to themselves.


*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.*

**It's About Time!**

> *NAD and Gogo LLC Agree to Make Closed Captions Available on In-Flight Entertainment Systems*
>
> *Deaf and hard of hearing airline passengers will soon have closed captioned, on-demand in-flight entertainment videos. The National Association of the Deaf (NAD), a non-profit civil rights organization of, by, and for deaf and hard of hearing individuals, and Gogo LLC, the global leader in providing broadband connectivity solutions and wireless entertainment to the aviation industry, have reached a historic agreement for Gogo to make closed captioning available for 100 percent of programming content sourced by Gogo and streamed through its on-demand in-flight entertainment service, Gogo Vision.*

When the Americans With Disabilities Act was passed, several industries were specifically exempted from compliance. Airlines were given specific exemptions. So were Motion Picture Producers. Later, as captioning became a requirement for TV, the MPAA successfully fought against being required to caption their productions.

Over time, the FCC tightened requirements on television broadcasters until there was an expectation of universal captioning. Movies, however, were not required to caption their products, although many did anyway. That must have led to some interesting discussion about licensing and copyright issues when the "Movie of the Week" was required to caption a movie they wanted to show on TV that did not already have captions.

Captioning on broadcast television has been around for over 25 years. We suppose it is good that the airlines are finally catching up. Grudgingly… Of course, the airlines are spinning it as a beneficent gesture!

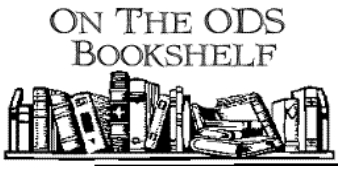
Here is a bit of trivia for you. The very first show ever captioned, way back in 1972, was an episode of "The Mod Squad. How fitting…

**This definitely qualifies as a "What the ****…?"**

> *Lauren Searls is a deaf registered nurse (RN), who has used American Sign Language (ASL) interpreters during her nursing education and works at Rochester Strong Memorial Hospital. She graduated from the Johns Hopkins School of Nursing and completed her education at Johns Hopkins Hospital (JHH). She performed admirably during her clinical rotations at JHH, and was offered a position as a clinical nurse. JHH rescinded the job offer following her request for ASL interpreters, citing direct threat to patient safety and cost. Searls filed a complaint of discrimination under the Americans with Disabilities Act. On January 21, 2016, the United States District Court in Maryland ruled in favor of Searls, granting partial summary judgment. United States District Judge Catherine Blake found that Searls has the right to accommodations, including an ASL interpreter, on the job regardless of cost as long as the job duties are not altered or shifted unfairly to colleagues. The overall operating budget of the hospital is relevant, not merely the department or nursing budget to financing the addition of ASL interpreters. Furthermore, the Court found that Searls' track record of working in Rochester did not support the Defendant's contention that her deafness posed a direct threat to patient safety. Blake also struck down JHH's expert witness testimony on the basis that these expert witnesses were in fact unable to provide qualified testimony in Searls' case because they lacked any experience with deafness and deaf healthcare professionals. Searls' trial will proceed only to determine the issue of damages. The defense for JHH may consider appealing some or all of Judge Blake's rulings. https://amphl.org/breaking-deaf-nurse-wins-court-case/*

Let's unpack this. Searls graduates From Johns Hopkins School of Nursing and completes her training at Johns Hopkins Hospital (apparently with some distinction), is offered a clinical position because she impressed them, and the offer was promptly rescinded because she requested an interpreter? You mean Johns Hopkins didn't know she was deaf after she got her degree? Or while she was doing her field work? Bean counters = peak stupidity.

Yeah, we know that there are people out there who cannot bear the idea that anyone other than a hearing person should be in healthcare, but give us a break. She did so well that the Hospital offered a job only to yank it back when they figured out she was deaf? How stupid is that?




## Important Recent Articles of Interest

*Peterson, C. C., O'Reilly, K., & Wellman, H. M. (2016). Deaf and hearing children's development of theory of mind, peer popularity, and leadership during middle childhood. Journal of Experimental Child Psychology.*

This study had two primary aims. First, we compared deaf and hearing children during middle and late childhood on (a) cognitive understanding of basic and advanced theory of mind (ToM) and (b) social dimensions of peer group relations, including popularity, isolation, leadership, and the disposition to interact positively with peers. Second, using correlational analyses, we examined ToM's connections with these social variables to see whether and how ToM impacts children's social lives. A total of 57 children (36 deaf children of hearing parents and 21 hearing children) 6 to 14 years of age completed a 6-step developmental ToM Scale, and their teachers reported on the social variables. Hearing children outperformed deaf children on ToM and all teacher-rated variables. For deaf children, popularity correlated positively, and social isolation correlated negatively, with ToM even after controlling for age, gender, and language ability. For hearing children, the only ToM link was a weak correlation with leadership. Possible reasons for the differences between deaf and hearing groups are discussed, together with the likelihood of bidirectional causal links and implications for deaf children's social development in school.

*David, A. E. (2016). A phenomenological study on feelings of competence among counselors of deaf students with emotional challenges (Doctoral dissertation, CAPELLA UNIVERSITY).*

The purpose of this qualitative phenomenological study was to gain a greater understanding of the subjective experience of counselors working with the deaf and hard of hearing. The researcher collected narrative discourse from 10 counselors servicing deaf and hard of hearing students with emotional challenges. Participants were employed from schools of the deaf or mental health facilities that addressed the clinical needs of deaf and hard of hearing children in New England states of MA, CT, and NY. The participants were working as counselors for no less than three months consecutively in the field of counseling, and came from a pool of regional or community mental health centers. Reputational and snowball sampling was implemented to select participants, whereby, the researcher made contact with clinical directors or clinical supervisors for input regarding potential participants for the study. The data obtained in the study helped reveal common themes among counselors' experiences. The counselors' perceptions revealed in order to adequately service deaf and hard of hearing students with emotional challenges, clinicians believed professional support, communication, trust, culture, training, and challenges were contributing factors to the success or failure of clinical services. The study presents two theories pertinent to counselor attrition of those who serve deaf and hard of hearing students: (a) communication, and (b) deaf culture. The subsequent theoretical framework narrows the reader's "field of vision" (Roberts, 2010, p. 129) providing practical suggestions in the education of counselors who desire to work with this population (Roberts, 2010).The extrapolation of emergent themes led to an essential structure used to develop several recommendations toward servicing deaf and hard of hearing students with emotional challenges. Recommendations included: (a) developing a strategic operation plan that supports the transition of clinicians into the field, (b) implementation and mandatory attendance of workshops relative to cultural sensitivity, and (c) create opportunities for professional collaboration among clinicians who service deaf and hard of hearing students with emotional challenges. The findings and recommendations presented can be used as a foundation for future research when attempting to improve clinicians' ability to develop self-efficacy and empowerment among clients of the deaf and hard of hearing.

*Rego, M. F., Duarte, I., & Nunes, R. (2015). Hearing impairment and nightmares: a theoretical insight. SpringerPlus, 4(1), 1-8.*

The aim of this article is to address the issue of nightmares in the deaf population, given that there are no documented studies on this matter to the best of our knowledge. The study of nightmares in the deaf population is of high relevance given their specific characteristics (impossibility of verbalization) and the lack of studies with this population. Nightmares are dreams of negative content that trigger an awakening associated with a rapid return to a full state of alert and a persistent feeling of anxiety and fear, which may cause significant distress. Various studies show that the deaf population has dreams with more negative imagery and emotions, are more exposed to interpersonal traumas and have higher rates of dissociation, than hearing people. These concepts seem to be connected given that, in the presence of traumatic events, dissociation may act as a defense mechanism and nightmares may operate as an adaptive coping strategy.

*Watson, M. A. (2016). Exploring the experiences of deaf employees working in deaf and hearing workplaces: A phenomenological study (Doctoral dissertation, CAPELLA UNIVERSITY).*

This phenomenological study sought to explore the experiences of Deaf employees working in deaf and

*(Continued on page 17)*

## On the ODS Bookshelf

*(Continued from page 16)*

hearing workplaces regarding job satisfaction, relationships with hearing supervisors and co-workers, relationships with their hearing or Deaf supervisors and co-workers who knows sign language, and overall success in employment. Capital 'D' in this paper signifies a group of people with hearing loss who share a common social, linguistic, and cultural identity. Research has shown that qualitative research is viewed to be the most appropriate and beneficial for studying disability issues because this type of study provides more insight on multifaceted experiences narrated by the individuals who have a disability. Phenomenological qualitative methodology was employed to learn from 10 Deaf adults who worked in both, deaf and hearing, workplaces. Equity and social exchange theories guided this study to understand the Deaf employees' perspectives regarding the level of equality and social exchange experienced in both workplaces. Qualitative data were collected from videotaped semi-structured interviews formulated by the researcher resulting in 22 nomothetic themes. The themes for the hearing workplace are: (a) pride in completing tasks ahead of others, (b) positive compliments and recognition by supervisor, (c) communication was a challenge, (d) feeling alone/excluded, (e) no feedback from supervisors, (f) missed information from co-workers and supervisors, (g) received promotion, (h) infrequent encounter with supervisor, (i) minimal or no socialization with hearing co-workers, (j) socialization with other Deaf co-workers was available, (k) literacy skills make a positive difference, (l) assertive is necessary to get needs met. Themes for the deaf workplace are: (m) communication was accessible, (n), received feedback from supervisors, (o) accommodations were already in place and readily available, (p) supervisor provided positive recognition, (q) able to share knowledge and experience, (r) direct communication with supervisors using sign language, (s) supervisors were easily accessible, (t) supervisors encouraged professional growth, (u) mixing personal and work lives creates problems, (v) socialization impacts completion of job duties. Future research should be conducted to expand on deaf workplaces to explore the perceptions, thoughts and experiences of Deaf people in managerial positions and front-line staff.

Cannon, J. E., Guardino, C., Antia, S. D., & Luckner, J. L. (2016). Single-Case Design Research: Building the Evidence-Base in the Field of Education of Deaf and Hard of Hearing Students. American Annals of the Deaf, 160(5), 440-452.

The field of education of deaf and hard of hearing (DHH) students has a paucity of evidence-based practices (EBPs) to guide instruction. The authors discussed how the research methodology of single-case design (SCD) can be used to build EBPs through direct and systematic replication of studies. An overview of SCD research methods is presented, including an explanation of how internal and external validity issues are addressed, and why SCD is appropriate for intervention research with DHH children. The authors then examine the SCD research in the field according to quality indicators (QIs; at the individual level and as a body of evidence) to determine the existing evidence base. Finally, future replication areas are recommended to fill the gaps in SCD research with students who are DHH in order to add to the evidence base in the field.

*Rosellini, Barrymore, "Exploring mindfulness as a culturally sensitive intervention for the Deaf community" (2015). Doctoral Papers and Masters Projects. Paper 65.*

Mental health issues are as prevalent in the deaf community as the hearing community, if not more. Yet, Deaf individuals are often treated by mental health professionals less frequently and less effectively. Many systemic barriers exist that influence the lack of services provided to the Deaf community, primarily related to a lack of cultural understanding rooted in perceptions of Deaf individuals. However, the Deaf community may be best understood as a cultural minority, a unique community sharing a distinct culture, history, and language. This paper investigates the effects of systematic barriers and cultural misunderstanding among mental health professions regarding the Deaf community, explores the historical and current mental health problems Deaf individuals most commonly struggle with, and proposes a potential culturally sensitive intervention for the Deaf community based on these factors. To examine these issues, the author conducted a thorough review of Deaf cultural history and values, as well as a review of peer-reviewed articles regarding both Deaf mental health and mindfulness outcome studies. Based on this review, mindfulness may be an effective, culturally sensitive intervention that addresses both cultural and psychological components while working with the Deaf population.

## Notes and Notables

*Katherine Anderson*, staff interpreter at Bryce Hospital, who recently passed her National Interpreter Certification exam has been promoted to Mental Health Interpreter I. Congratulations.

After working 8 years as a regional interpreter, *Wendy Darling* has moved on to the Alabama Department of Rehabilitation Services to be their statewide interpreter coordinator. Her absence will be greatly felt by ODS and the consumers we serve.

Several members of the ODS family are back in school working on various degrees. Stay tuned for more!

# Help Wanted Join Our Team

## Office of Deaf Services, Alabama Department of Mental Health

**MH Interpreter Trainee**
**SALARY RANGE:** 67 ($30,724.80 - $46,615.20)

**WORK LOCATION:** Tuscaloosa

**QUALIFICATIONS:** Associates degree with full-time experience (24 months or more) as an interpreter or Bachelor's Degree in any field. Graduation from a recognized interpreter training program is preferred. ***Preference will be given to applicants who are recipients of the ADMH Interpreter Training Scholarship.***

**NECESSARY SPECIAL REQUIREMENTS:** Possession of permit or permit eligible by the Alabama Licensure Board of Interpreters and Transliterators. Must be able to acquire a license by the Alabama Licensure Board of Interpreters and Transliterators within 36 months of hire. Permitted individuals must pass the Sign Language Proficiency Interview (SLPI) at an Advanced or higher level. Must be able to be certified as an interpreter by the Registry of Interpreters for the Deaf or National Association of the Deaf at a level 4 or 5 or Board of Evaluation of Interpreters (BEI) Level III or BEI Advanced or higher or equivalent. Certification must be obtained within 36 months of hire. Successful candidate must be certified or eligible to receive certification as a QMHI (Qualified Mental Health Interpreter) or its equivalent. QMHI Certification must be obtained within 24 months of acquiring license by the Alabama Licensure Board of Interpreters and Transliterators. Must have a valid driver's license to operate a vehicle in the State of Alabama.

**KIND OF WORK:**

This is professional trainee level work in providing specialized services to patients who are deaf or hard of hearing (D/HH) with co-occurring disorders of mental illness and chemical dependency in a state mental health hospital, as well as within community settings. Work involves interpreting under supervision of a Qualified Mental Health Interpreter (QMHI) between deaf or hard of hearing consumers and staff of the Alabama Department of Mental Health, DMH facilities or service providers. Work may be performed in a variety of different settings. Supervision is provided by the DMH State Coordinator of Interpreter Services. Assists in teaching standardized sign language and alternative or augmentive communication methods to dysfluent individuals with functional hearing losses. Assists in coordinating and working with other interpreters in teaching ASL to non-signing staff.

**REQUIRED KNOWLEDGE, SKILLS, AND ABILITIES:** Knowledge of American Sign Language. Knowledge of deafness and deaf culture. Knowledge of telecommunication devices and their use. Ability to interpret between consumers using a variety of dialects and fluency levels. Ability to communicate effectively both orally and in writing. Ability to utilize computer, internet resources and various software packages. Ability to provide training in American Sign Language, Deaf Awareness, Interpreting and the use of adaptive technology. Ability to work a flexible work schedule to include nights and/or weekends as needed.

**MH Specialist I (Communication Specialist)**
**SALARY RANGE:** 70 ($33,086.40 - $50,119.20)

**Work Location**: Bryce Hospital, 1651 Ruby Tyler Parkway, Tuscaloosa, AL 35404

**MINIMUM QUALIFICATIONS:** Bachelor's degree in Communications, Psycholinguistics, Deaf Studies or a human services field plus experience (24 months or more) interpreting, working with language dysfluent clients, communication specialist work or working with individuals who are mentally ill.

**OR**

Considerable (48 months or more) programmatic experience in the field of deafness with the Department of Mental Health, plus experience (24 months or more) interpreting, working with language dysfluent clients, communication specialist work, or working with individuals who are mentally ill.

**NECESSARY SPECIAL REQUIREMENTS:** Native or near-native signing skills equal to superior level or higher of signing skills in American Sign Language, as measured by a recognized screening process (SLPI). Certification in either sign language (RID), in teaching American Sign Language (ASLTA-Q or ASLTA-P), or equivalent must be obtained within three (3) years of employment. Must be able to obtain licensure or be exempt from licensure to interpret according to Alabama Licensure Board of Interpreters and Transliterators (ALBIT).

**KIND OF WORK:** Works within the Office Deaf Services of the Department of Mental Health providing culturally and linguistically affirmative services to deaf and hard of hearing (D/HH) to include consumers with disorders of mental illness and/or chemical dependency in inpatient, community and DMH related settings. Responsibility includes providing the specialized services of a communication assessment and facilitation of language for D/HH individuals. Participates as a member of an interdisciplinary treatment team, assisting in the development and implementation of treatment and discharge plans. Provides advisory services on sign language and alternative communication issues to D/HH individuals and professional staff. Teaches standardized sign language and alternative or augmentative communication methods to dysfluent individuals with functional hearing losses. Coordinates and teaches ASL to non-signing staff. Other work duties involve research and development of non-verbal or limited verbal types of communication tools and teaching materials. Provides some interpreting in conjunction with a Mental Health Interpreter.

**HOW TO APPLY:** Use an official application for Professional Employment (Exempt Classification) which may be obtained from this office, other Department of Mental Health Facility Personnel Offices, or visit our website at www.mh.alabama.gov. Only ***work experience detailed on the application will be considered.*** Additional sheets, if needed, should be in the same format as the application. Resumes will not be accepted in lieu of an official application. Applications should be returned to Human Resource Management, Department of Mental Health, P.O. Box 301410, Montgomery, Alabama 36130-1410 or RSA Union Building, 100 North Union Street, Montgomery, Alabama 36104. Copies of License/ Certifications should be forwarded with your application. An official copy of academic transcripts is required and must be forwarded by the school, college, or university to the personnel office at the above address.

*(Continued on page 19)*

## *Other Positions Open in Deaf Services*

*(Continued from page 18)*

## Community Programs

**MENTAL HEALTH TECHNICIANS**

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

Positions Available:

| |
|---|
| Part-time position Schedule: Sat-Mon 8a-4p |
| Full-time position Schedule: Tues-Sat. 12a-8a |

Candidates must possess proficiency in American Sign Language

**Duties:**
Provide personal, direct care for consumers with mental illness diagnosis who are also deaf or hard-of-hearing.
1. Pass medications under the direction of a Medical Assistance LPN.
2. Provide transportation to day habilitation and/or consumer appointments.
3. Provide basic living skills training and assistance.
4. Provide communication assistance to the consumers through the use of Sign Language or language of the consumer's preference. Ensure that consumers have access to assistance by a qualified interpreter.
5. Maintain policy of confidentiality.

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

For more information go to our webpage or contact
Judy Towner
Executive Assistant
Chilton-Shelby Mental Health Center
jtowner@chiltonshelby.org
office: 205/668-4308
cell: 205/914-6969

## 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
Susan Faltenson, Colorado
Mistie Owens, Utah
Claire Alexander, Minnesota
Amanda Gilderman, Wisconsin

# 14th Annual Mental Health Interpreter Training

## July 25 — 29, 2016

## Montgomery, Alabama

### MHIT Is:

A 40 - hour course designed to provide a sound basis for interpreters to work effectively in mental health settings as part of a professional team. It includes lectures, demonstrations, exercises, evaluation and discussion to develop knowledge, skills and resources to ensure that services are linguistically and culturally appropriate. It will include introductions to Medical and mental health systems and culture, Sources of communication breakdown associated with mental illness and treatment, Interpreters' roles, tools, and resources, Severe language dysfluency and Visual - Gestural Communication, Psychiatric emergencies, Support groups and Community Mental Health Services, and Demand-Control Theory applied to mental health interpreting.

The Institute is a collaborative effort between the Alabama Department of Mental Health's Office of Deaf Services ADARA and Troy University Interpreter Training Program.

### Presenters Include:

Bob Pollard, Robyn Dean, Roger Williams, Steve Hamerdinger, Charlene Crump, Carole Lazorisak, et. al.

### Special Alumni Track Featuring:

Angela Kaufman, Amanda Somdal, Kent Schafer, and others to be announced.

### Cost Of Training:

| | Feb 16 - April 13 | April 13 — May 31 | After May 31 | Day Rate |
|---|---|---|---|---|
| Participants | $340 | $390 | $425 | $100 |
| Alumni | $215 | $265 | $310 | $85 |

**A MINIMUM OF 4.0 RID CEUS WILL BE OFFERED**

**For complete information and to download an application visit www.mhit.org**