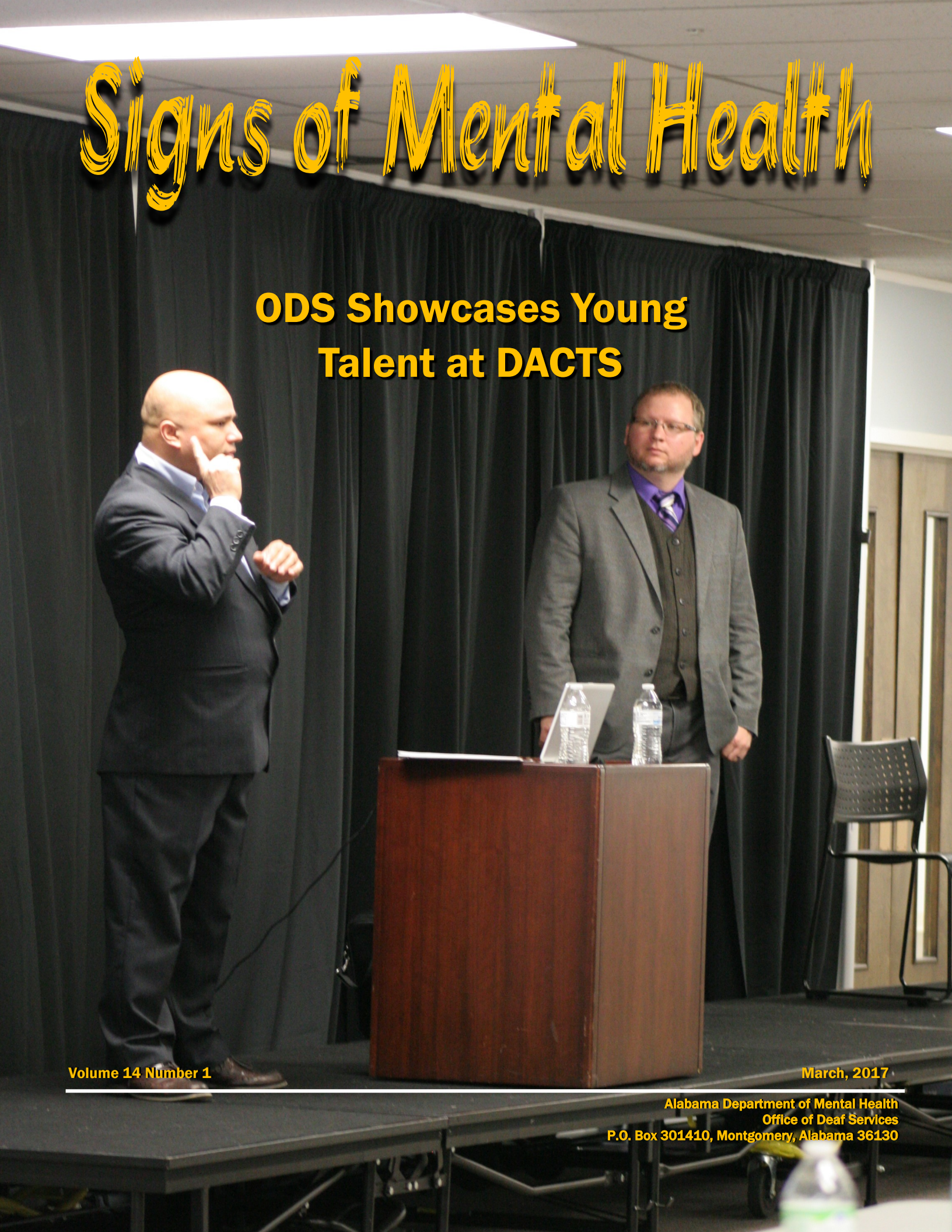
Signs of Mental Health



ODS Showcases Young Talent at DACTS

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In This Issue

Signs of Mental Health
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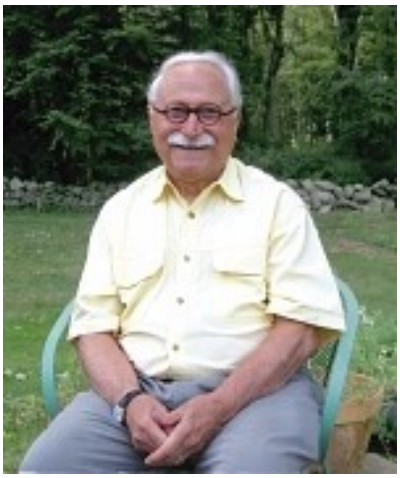
On The Cover:

Jag Dawadi (left) and Kent Schafer were the presenters at the 2017 Deafness and Clinical Training event. (See story on page 4.)

In Memoriam – Joseph J. Bevilacqua, Ph.D. 1931 - 2017



When people talk about deaf mental health, some names immediately come to mind. Hilde Schlesinger. Luther Robinson. Alan Sussman. Robert Pollard. Neil Glickman. Irene Leigh. Debra Guthmann. These are all pillars upon which mental health services for deaf people has been built. One does not work in the field long without becoming very familiar with their work. But there are other pillars as well, hidden pillars that few people know about, but nevertheless are central to the edifice.

One of those "hidden pillars" upon which Deaf Mental Health service is built has died. Joseph Bevilacqua, 85, passed away on February 18 at his home in Little Compton, Rhode Island. It can be fairly said that without Dr. Bevilacqua, there would have been no South Carolina Deaf Services. Without South Carolina Deaf Services, there likely would not be Alabama's Office of Deaf Services. The unique model used by South Carolina, Alabama, Minnesota, and adapted to various degrees by several other states, developed because of Dr. Bevilacqua's advocacy for community-based services and insistence that it could be adapted to work in the deaf community.

From his obituary (http://www.currentobituary.com/obit/204698):

> *Born October 20, 1931 to John and Grace Bevilacqua, he grew up in Elmira, NY. Joe graduated from Canisius College in 1952 and earned a Master's Degree in Social Work from the University of Buffalo in 1955. Drafted into the Army in 1956, he was stationed at Fort Bragg, N.C., where he met his future wife, Mary Ann, an Army Nurse; they married in 1958. He remained on active duty until 1971, and served as a Reserve Officer until 1986, when he retired as full Colonel.*
>
> *Joe received his PhD in Social Policy and Administration from Brandeis University in 1967. After leaving active military duty, Joe became Deputy Commissioner for Mental Health in Virginia in 1971, which led to his ongoing work as an advocate on behalf of persons with mental illness. In 1975 he became Commissioner of Mental Health, Retardation and Hospitals in Rhode Island. Under the leadership of Gov. Joseph Garrahy, Joe and a very dedicated staff began the challenging task of placing institutionalized individuals into community group homes. In 1981*

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he was hired as Commissioner of Mental Health in Virginia, and in 1986 became Director of Mental Health in South Carolina, serving under three Governors, until 1996.

In each of these positions, Joe was a pioneer in advocating for strong support of mental health consumers and their families, including creating paid roles for consumers in provider organizations, both public and private. He worked tirelessly for mental health parity legislation and was involved in numerous legal cases defending the civil rights of the institutionalized mentally ill. The most outstanding of these was the Dixon Committee, which after years of litigation, brought much needed improvement for clients at St. Elizabeth's Hospital in Washington, D.C.

In his last formal role he served as Director of State Initiatives at the Bazelon Center for Mental Health Law in Washington, DC. He was twice elected as President of the National Association of State Mental Health Commissioners, and served as a volunteer and board member for countless organizations around the nation. He was known as a giant in his field.

Indeed, he was. Hidden among all rightful honors and accolades Dr. Bevilacqua received, is a place among the pantheon of heroes who have bettered the lives of deaf people with mental illness. Dr. Bevilacqua became the Commissioner of the South Carolina Department of Mental Health in 1989, right at the time the South Carolina Association of the Deaf and the South Carolina Protection and Advocacy for People with Disabilities began to take action fighting for the treatment of deaf people with mental illness. His background and passion for deinstitutionalization made him acutely sensitive to the plight of consumers in general and treatment of deaf people in particular. He was on the board of the Protection and Advocacy organization and supported their efforts with SCAD to take action, which eventually led to a complaint to the Office of Civil Rights (OCR), which in turn led to the establishment of SCDMH's Deaf Services. While the OCR complaint focused on services in the inpatient facilities, Dr. Bevilacqua was adamant that any solution provide for community services and a push for deinstitutionalization. At the time, it was the first truly statewide program for deaf people and its regional service concept became a model for other state to emulate.

Dr. Bevilacqua supported the Deaf Services Program throughout his tenure at SCDMH, pushing for the creation of the McKinney House as part of the efforts to get deaf patients out of the hospital and endorsing the use of clinicians fluent in sign language. While Dr. Bevilacqua was known for a fiery temper, he was also a fierce advocate. He took the time to travel to Gallaudet to speak about the importance of state mental health programs meeting the needs of the Deaf community. And he never shied away from meeting with Charlie McKinney, the SCAD Executive Director, who, at 6'5", towered over the much shorter Dr. Bevilacqua.

Over the decade that Dr. Bevilacqua led SCDMH, Deaf Services earned a national reputation for effectiveness. Alabama's Office of Deaf Services owes a debt of gratitude to South Carolina and the two programs seem, at times, intertwined. Dr. Barry Critchfield, who is currently working as a therapist with ODS was hired to be the first director of Deaf Services, and Roger Williams the current director, is a faculty member of the Mental Health Interpreter Training project. Both men had great influence on ODS Director, Steve Hamerdinger, shaping how he thought about mental health service to deaf people. What exists today, exists because Dr. Bevilacqua shared the vision that mental health services are best delivered by people fluent in American Sign Language and that community based programs run by deaf people for deaf people are the best of all.

Did You Know... Prevalence Of Mental Illness

- Approximately 1 in 5 adults in the U.S.—43.8 million, or 18.5%—experiences mental illness in a given year.
- Approximately 1 in 25 adults in the U.S.—9.8 million, or 4.0%—experiences a serious mental illness in a given year that substantially interferes with or limits one or more major life activities.
- Approximately 1 in 5 youth aged 13–18 (21.4%) experiences a severe mental disorder at some point during their life. For children aged 8–15, the estimate is 13%.
- 1.1% of adults in the U.S. live with schizophrenia.
- 2.6% of adults in the U.S. live with bipolar disorder.
- 6.9% of adults in the U.S.—16 million—had at least one major depressive episode in the past year.
- 18.1% of adults in the U.S. experienced an anxiety disorder such as posttraumatic stress disorder, obsessive-compulsive disorder and specific phobias.
- Among the 20.2 million adults in the U.S. who experienced a substance use disorder, 50.5%—10.2 million adults—had a co-occurring mental illness.

From: http://www.nami.org/Learn-More/Mental-Health-By-the-Numbers

Deafness and Clinical Training Series Offers 10th Edition

The 10th edition of the Deafness and Clinical Training series, headlining Office of Deaf Services staff members Kent Schafer and Jag Dawadi, was held February 24, 2017 before a capacity crowd in Montgomery, Alabama. Their topic was "Strategies for Working with Deaf Consumers with Behavior Disorders and/or Mental Illness."

Jag Dawadi and Kent Schafer were the featured presenters at the 2017 Deafness and Clinical Training event.

The series, which began in 2006 and has run in its present configuration since 2011, annually draws close to 200 people. Usually it is split over two days, Typically, one day is focused on Deaf or sign-fluent participants and the second day on individuals who do not sign, but are interested in learning how to work with clients who are Deaf. This year was held on a single day, resulting in a capacity crowd of 188 participants.

The training was intended to give participants an understanding of strategies used to modify behavior as it pertains to language dysfluency and distortion among the Deaf population and their unique service needs. A major goal was to help prepare participants for working with deaf and hard of hearing persons through appropriate therapeutic approaches by focusing on several content areas. These included:

- Develop population specific skills in recognizing thoughts, behaviors, and cultural influences of language dysfluency in the deaf population,
- Discuss the barriers that are present for the deaf population,
- Recognizing and shaping thought processes
- Noticing behaviors that are unique to the language dysfluent or distorted consumer,
- Differentiating cultures of the deaf and hearing populations,
- Discussing interpreting/counseling dilemmas that emerge from this field of work.

Participants came from several surrounding states, including Alabama, Georgia, Mississippi, Tennessee, and Illinois. The represented a wide variety of clinical disciplines including 24 social workers, 26 counselors, a psychologist, 5 audiologists, 3 nurses, and 43 interpreters. The balance of the audience declined to give specific disciplines.

Schafer, who is the statewide Psychologist for ODS, and Dawadi, who is the Region III therapist, both bring years of experience working with behavior-challenged deaf youths.

Schafer worked as the school psychologist for the Wisconsin School for the deaf from 2009 to 2015, when he joined the ODS staff. He currently is a nationally certified school psychologist and holds dual masters in alcohol and substance abuse and in education psychology. He consults on mental health policy and interventions at a variety of youth-based programs.

Dawadi, who worked in ever-increasing responsible positions at the National Deaf Academy in Mount Dora Florida from 2004 to 2016. He started as a therapist and rose

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Deafness and Clinical Training Series Offers 10th Edition

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to become the clinical coordinator. He holds a Master of Science in Community Mental Health, along with being a certified Master Addiction Counselor.

The DACTS series has featured a variety of presenters over the years, from the internationally famous to hidden gems. This year was the third time that in-house staff presented. Previous sessions were:

- 2006: Steve Hamerdinger - Overcoming the Communication Barrier: Working with Hard of Hearing Consumers.
- 2006: Barry Critchfield - Cultural Implications of Assessment.
- 2008: Steve Hamerdinger and Joseph Murray Batino – Serving Kids who are Deaf and Emotionally Disturbed.
- 2011: Amanda O'Hearn and Sharon Haynes – DBT and Deaf Populations.
- 2012: Angela Kaufman and Amanda Somdal - Abuse in the Deaf Community: Victims and Abusers.
- 2013: Michael Harvey - Trauma Informed Care in the Deaf Population.
- 2014: Alexis Greeves – Play Therapy and the Deaf Population.
- 2015: Neil Glickman – CBT and Deaf Populations.
- 2016: Deb Guthmann and Cindi Sternfeld – Substance Abuse and the Deaf Population.

The DACTS series became part of the Mental Health Interpreter Training project in 2011. Prior to that, it was funded by the Division of Mental Illness. The funding for all Deaf Services training was pulled in 2008 as a result of budget challenges and shifting division priorities. That move by the division resulting in MHIT becoming a free-standing partner with ADARA. That change led to the addition of DACTS series to MHIT.

The single-day format was a departure from the usual two-day agenda and the response caught ODS official by surprise. "We really didn't expect demand to be so high for this training and thought one day would cover it," said ODS director, Steve Hamerdinger. "It was a pleasant surprise. We will go back to the two-day training going forward."

Top: Dawadi works with a small break during a breakout exercise. Bottom: Schafer offers suggestions to a group working on the afternoon exercise.

FCC Adopts Rules to Implement Real-Time Text Messaging Standards for the Deaf and Hard of Hearing Community

By Christy Malik, Senior Policy Associate, National Association of State Mental Health Program Directors

Ed. Note: Last fall, ODS director, Steve Hamerdinger, and psychologist, Kent Schafer, have teamed to author a technical report, Promising and Emerging Approaches and Innovations for Crisis Intervention for People who are Deaf, Hard of Hearing, and Deafblind, for the National Association of Mental Health Program Directors about the issue of suicide in the deaf community and how technology might be used to help reduce it. It was published in September, 2016. The following article was published in the March 3, 2017 edition of the NASMPHD Weekly Update. Repreinted with permission.

In his final days as Federal Communications Commission (FCC) Chair, Tom Wheeler, announced, on December 15, 2016, the adoption of FCC Rule 16-169, requiring phone carriers to transition from analog text telephone communications (TTY) devices to real-time text messaging standard (RTT).

Advocacy by the deaf and hard of hearing community and an AT&T petition alerted the FCC that an overwhelming proportion of the deaf and hard of hearing community uses cell phones to communicate with friends and family.

Under the new rule, wireless phone carriers and device manufacturers are required to support RTT technology by December 2017. This new interoperable technological standard will allow the deaf and hard of hearing community to facilitate a more natural conversational communication, based on the following features:

- Voice-to-Text and Text-to-Voice—Typed messages will be voiced to the hearing caller, permitting real time communication during a call. The text-based capacity allows the deaf and hard of hearing community to call and receive phone calls from the hearing community.

- Real-time texting—Recipients will be able to instantly see letters and characters as they are being typed, before the person texting pushes the "send" button. This function allows 911 responders to receive incomplete messages in a medical emergency or crisis situation, such as an active suicide attempt. The 911 responder can quickly identify the person's location and dispatch help by using the cell phone's IP address and geolocation.

- Quicker Communication—Because each person can view what the other person is typing, recipients can respond quicker than with traditional SMS texting platforms.

Former FCC Chair Wheeler stated at the agency's December 2016 meeting, "We now have the opportunity—as we design our new communications system that is based on internet-protocol—to finally make our nation's communications systems accessible to everyone."

Steve Hamerdinger, Director at the Office of Deaf Services at Alabama's Department of Mental Health, says "As a practical matter, this ruling opens up options for crisis responders and for deaf people who are living with mental health. Real time text means help can be summoned much easier than with existing methods. It will not replace video relay service, but will supplement it for times when a relay service cannot be reached and simply dialing 911 on a cell phone and hoping responders can find you is not enough."

The RTT apps have been tested and have shown minimal error rates, compared to the obsolete TTY. RTT is expected to become the mainstream text-messaging standard.

What is Real Time Text?

With some fanfare, the Federal Communication Commission released FCC Rule 16-169, which adopts amendments to its rules to facilitate a transition from outdated text telephone (TTY) technology to a reliable and interoperable means of providing real-time text (RTT) communication for people who are deaf, hard of hearing, deaf-blind, or have a speech disability over Internet Protocol (IP) enabled networks and services. The rule was announced on December 15, 2016 in the waning days for former FCC chairman Joseph Wheeler's administration. It became effective February 16, 2017.

RTT is not a new technology. It has its roots in 1980s vintage Unix-based chat programs. Those programs were the foundation of ubiquitous chat programs. The same technology drives live captioning and IP-relay.

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What is Real Time Text?

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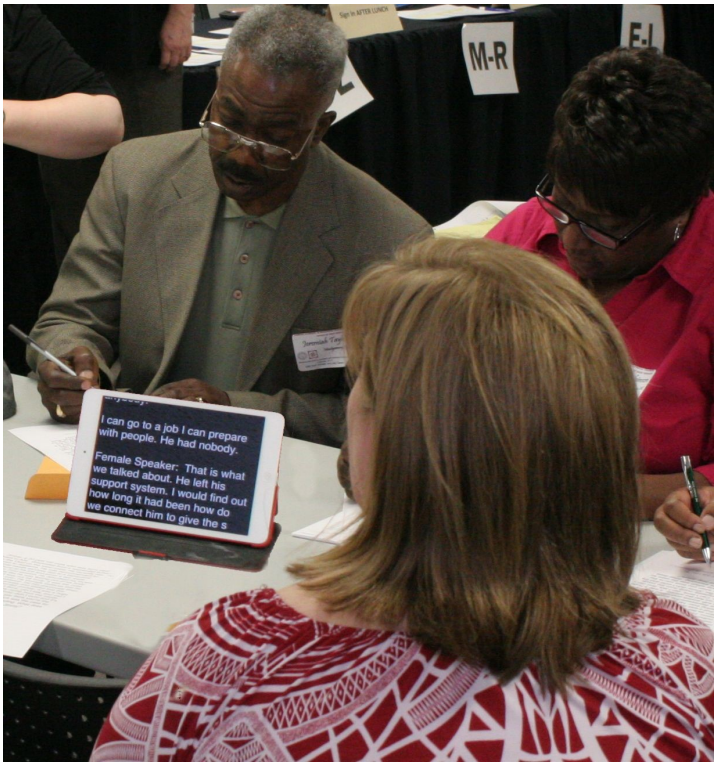
What make RTT different from Short Message Service (SMS) is that RTT text is transmitted instantly while it is typed or created. Recipients can immediately read the message while it is being written. This provides for a more conversational feel than SMS. (For a demonstration, see http://www.realjabber.org.). Unlike TTYs which used a five-bit Baudot code and were not truly full-duplex, RTT does allow for simultaneous typing with both streams kept live and separate.



Two particular applications are useful for mental health provider purposes. The first is crisis response. The live, interactive nature of the conversation allows for a better feel than is possible from standard SMS. The second application is live captioning.

It is important to remember that the ability of the consumer to read and comprehend the text is an important factor in determining whether the technology is appropriate for that person. Misunderstanding due to not comprehending what was typed or cultural interpretations of the typed text is an ever-present danger.

Nevertheless, the possibilities are exciting. Consider the ease of providing live captioning for a single participant in a training event. As long as the captionists have adequate audio, they could be anywhere in the world and use RTT to stream the captions to a deaf participant on a mobile device. No need to pay travel costs or set up a projector and screen.

Crisis intervention is another area where RTT has potential. Sign fluent therapists are able to do crisis intervention by videophone. It's not the best method, of course, but it's far better than nothing at all. In reality, ASL-accessible crisis services are extremely rare, leaving one to depend on less effective approaches. Those approaches now generally involve some type of relay, which means the clinician is getting information second hand. There is a danger that the assessment of risk will be inaccurate. This inaccuracy increase tremendously when the relay is text-based (meaning TTY or IP-relay) instead of video relay. The difference is that with VRS, there is an interpreter who should be able to pick up cues about emotional state by watching the deaf person and, if properly training as a mental health interpreter, be able to pass that information on to the assessing clinician.

By contract, the relay agent of a text-based relay does not need to know ASL at all, and text-to-speech/speech-to-text software is increasingly being used to replace live people on those relays. This lack of human intervention combined with poor English skills, puts the deaf communicant at risk of being misunderstood and the crisis service exposed for liability.

RTT would take the intermediary out. The clinician would have direct contact with the person in crisis. Far from ideal, its significantly better than the current arrangement.

Additionally, RTT provides a real-time option in areas that do not have broadband internet coverage. For people living in rural areas, mobile service may not be broadband and wired broadband services may not be available at a reasonable cost either. Since RTT can run on standard cell phone connections, it is not dependent on broadband. It is generally cheaper as well.

Undoubtedly, mental health providers will need to examine their policies and clinicians will need to consider English language competency apart for mental illness in order for RTT-based crisis intervention to become widespread. But for now, the possibility of more timely response makes RTT a promising approach.

Crump and Hamerdinger Publish Article

Charlene Crump and Steve Hamerdinger published a new article in the *Journal of Community Mental Health* last month. The article, "Understanding Etiology of Hearing Loss as a Contributor to Language Dysfluency and its Impact on Assessment and Treatment of People who are Deaf in Mental Health Settings" can be found online.

The article discusses how multiple influences such as mental illness, medical conditions, language deprivation and the etiology of deafness can impact how a person acquires and uses language.

Things People Ask Us

Real Issues—Real Answers

Dear Kent,

I am a sign language interpreter working with a young boy who has many diagnoses, but we will go with developmentally disabled. He has a hearing loss and was given had a new device. It looks like a hearing aid sitting on that bone behind the ear. It is not anchored, just held on by headband. Any way, the young kid is starting to hit people and throw stuff. He seems frustrated to me. I asked the parents if he signs and it seems he has some language. They brought me in for a doctor appointment to ask him some questions but he would not answer. So how do they go about addressing this complicated issue. His dad doesn't sign; mom does all the signing and advocacy. They just want to find out why is he hitting and hurting himself banging his head and throwing things. Maybe he's frustrated about something that happened a few months ago is when this new behavior started. I don't know if I will ever see them again. And as an interpreter, what was my flexibility for input and advocacy for the family? How can I work with them as part of a team? Do I suggest they go to local advocacy agency for support? What else could I have done? -Concerned Interpreter

Dear Concerned,

The device is called a bone-anchored hearing aid (BAHA) or bone-anchored hearing device. It is a type of hearing aid based on bone conduction. It is primarily suited for people who have conductive hearing losses, unilateral hearing loss, single-sided deafness and people with mixed hearing losses who cannot otherwise wear 'in the ear' or 'behind the ear' hearing aids. It is a less invasive approach to help a person use some residual hearing. It uses that processor like you describe to use sound vibrations to bypass the canal. Sound is converted into some sort of electrical impulse that stimulate the follicles inside the ear. These impulses will travel to the brain as a form of sound. It can be difficult to measure effectiveness the child cannot accurately express what they are hearing or if the "foreign" noise helps. Static much?

I am glad that you are considering the role of an interpreter as a practicing profession and not limiting yourself to be only a "conduit for language". The best answer will always be "it depends." Now, what was the goal of the session? Did you as an interpreter align yourself to the goal?

The hitting you describe has two possibilities. Is the child trying to 1) escape or 2) obtain something? If he is trying to escape something, that may indicate something unpleasant is happening that he would like to avoid. Perhaps the child has been traumatized by the experiences of doctor visits? The inability to communicate or receive information indicates that the child may have trust issues. Imagine waking up one day with a throbbing pain in the side of the head, with no way to explain it or understand what is happening.

Some children cope with the decisions people make, other children struggle with understanding what is going on. If he trying to obtain attention, negative behavior is often rewarded by giving attention to the child in order to stop the behavior.

It can also be a way of redirecting pain. Consider how interference from a hearing device may actually provide more frustration and the child is trying to use acting out behavior to distract from the stimulation he is receiving from the noise. Imagine the still of a night, then suddenly someone is turning up the volume on the radio when it's nothing but static. You'd be uncomfortable as well.

There is always the chance there was some traumatic event that occurred to trigger the child. Let us hope not.

Developmental Disability means more challenges. Without knowing the level of cognitive function or adaptive skills, I can only offer a few things to consider.

- Eye gaze: are you capable of obtaining his attention? He may have a modified functional field of vision and require adjustments to capture their attention before transmitting language. OHI may indicate inattention if properly diagnosed.

- Rigor: Does he have a specific pattern or OCD-like compulsion that he must engage in? There is a possibility that he would not engage until he finished his routine. When he couldn't complete this routine, he shuts down. The same behavior can occur if the child recognized or wanted something. Imagine shopping with a two-year old kid who wants a toy they saw on the shelf. When told no, cue the meltdown. Most people understand that is a normal phase of development for toddlers. Some people with DD never grow out of it. This rigor may manifest from a picture, memory, or experience that occurred a while ago and have not

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Things People Ask Us

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Parents and clinicians will have to problem solve trying to figure out what the child is trying to express.

- Language: Has the child been exposed to visual language besides the mother? If so, chances are that the child may not recognize your signing style because the mother is his only language model. You did not use the same signs that the mother used. The child may have been in a DD classroom designed for students with multiple handicaps using a teacher who speaks first (hence, the BAHA) and not a deaf-centric program that uses visual language as the primary form of communication. Inconsistent signing styles and skills may hinder learning. You may as well have been Sasquatch flailing his arms around to this child. The child may not have an extensive vocabulary skillset especially if spoken language is the primary form of communication in school and home and the BAHA is helping detect noise but not providing enough clarity for speech recognition. It may actually be hurting the child more than helping.

A good possible resource is the Picture Exchange Communication System. The use of pictures may help the student express more information to be measured. A white erase drawing board may be of use for quick drawing attempts. I would also recommend considering therapists who are well versed in play therapy. If you are aware of sign language classes that will accept mother and son to attend, this would be a neat tool to share. Explore alternative acceptable sensory behavior to stimulate the child. It will be critical to establish the following concrete examples for the child (if it hasn't happened already) (1) Yes/No, (2) Happy/Sad, (3) 1st/2nd, and (4) Right/Wrong. If there is a local residential school in your area or outreach programs, it may help to have the name, address, and a point of contact. Creating a quick handout listing the basic Q/A and references for local resources that you can immediately pull out of your bag to share with the family/team will help point them in the right direction. - *Kent Schafer*

Gallaudet Intern Finds Real World Experience Exciting

My name is Miranda Nichols and I have been interning with the Office of Deaf Services since late August, 2016. I am a student in the clinical mental health counseling program at Gallaudet University, expecting to graduate in May of this year. I met Steve Hamerdinger at the ADARA Breakout conference last March and was instantly drawn to the wide range of exposure and learning experiences that the internship opportunity had to offer me. I have been working with consumers in Region V, and at Bryce Hospital; all of whom have provided me with experiences more valuable than I ever expected.

I grew up in Harrisburg, Pennsylvania and graduated from Towson University located near Baltimore, Maryland in 2013 with a double major in Psychology and Deaf Studies. I had known that I wanted to pursue a Psychology-based career since I was in middle school, and continued to pursue it after I took a Psychology AP class in high school. During my time at Towson, I followed my interest in learning American Sign Language, which lead me to majoring in Deaf Studies where I learned about the need for direct mental health services with deaf populations and ultimately drove me to be where I am today. During my undergraduate career, I had internships at Sheppard Pratt Health Systems in Baltimore and at Baltimore Medical System in their Deaf Services office. After I graduated, I decided to take a break from school to work and gain some experience. During this time, I worked for a local psychiatric rehabilitation program in Baltimore that worked with consumers mainly located in the inner city. During my time there, I did a lot of "behind the scenes" work which consisted mostly of filing. Needless to say, this break was short lived and soon had a strong desire to go back to school and pursue a higher degree.

I decided on a master's degree in counseling at Gallaudet University so that I could be further exposed to ASL and Deaf culture on a daily basis and have loved my experience with my program. The faculty and staff I was surrounded by have been a great support system and push me to be dive deeper into my learning every day. At Gallaudet, I did my practicum with their academic advising office working with undergraduate students who were at risk and absolutely loved working with the students.

I have a passion for crisis and trauma and hope to continue to pursue a career path with that focus. I would love to be able to volunteer with the Red Cross someday to help with those who are in need when disaster strikes and ultimately would love to be able to incorporate a therapy dog into my practice and to contract with various hospitals and programs to provide a therapy dog every so often with clients. I am fascinated and have a strong desire to learn more about how trauma is different in deaf populations versus hearing populations. During my internship here, I have gotten the opportunity to learn a little more about this through the clients I have worked with. I am looking forward to continuing to learn and grow with the Department of Mental Health. I am so grateful to have been given this opportunity to work with such an amazing team.

As I See It

Relating to deaf and hard-of-hearing children; to require the State Department of Education and the Alabama Department of Rehabilitation Services in consultation with the Alabama Institute for Deaf and Blind to jointly select language developmental milestones to monitor and track expressive and receptive language acquisition and developmental stages toward English literacy…"

Thus begins House Bill 253, which as we go to press is before a select subcommittee of the Alabama House of Representatives Committee on Education Policy. What appears to be a fairly straightforward and innocuous desire to ensure that deaf children acquire functional language at age-appropriate stages has touched off a battle royal between the deaf community, cochlear implant promoters joined by those who believe sign language inhibits learning and various educational and government agencies caught in the middle.

In a hearing held on March 1, the committee was exposed first-hand to a feud that its roots in the Victorian era Eugenics movement. At the core is the passionately held belief on one side that Sign Language is the source of all that is wrong with deaf people, and an equally passionate belief held on the other that failure to expose deaf babies to visual language from birth on is tantamount to child abuse.

In 1884, Bell published a paper *"Upon the Formation of a Deaf Variety of the Human Race,"* in which he warned of a "great calamity" facing the nation: deaf people were forming clubs, socializing with one another and, consequently, marrying other deaf people. Bell wasn't concerned so much with whether deaf people acquired functional English, but rather that they be prevented from bonding together.

> *The most promising method of lessening the evil appears to lie in the adoption of preventive measures. In our search for such measures we should be guided by the following principle: (1.) Determine the causes that promote intermarriages among the deaf and dumb; and (2) remove them.*

> *The immediate cause is undoubtedly the preference that adult deaf-mutes exhibit for the companionship of deaf-mutes rather than that of hearing persons. Among the causes that contribute to bring about this preference we may note: (1) segregation for the purposes of education, and (2) the use, as a means of communication, of a language which is different from that of the people.*

> *These, then, are two of the points that should be avoided in the adoption of preventive measures. Nearly all the other causes I have investigated are ultimately referable to these.* (page 46, https://archive.org/stream/gu_memoirformati00bell/gu_memoirformati00bell_djvu.txt)

Bell's primary strategy for achieving his aims was to ban the use of sign language. The tactics he used included playing on the fears of parents, policy makers, and fellow eugenists, painting in the most derogatory light the future of deaf people who sign.

> *They think in gestures, and often translate into written English with the idioms of the sign language. The constant practice of the sign language interferes with the mastery of the English language, and it is to be feared that comparatively few of the congenitally deaf are able to read books understandingly unless couched in simple language (page 42, ibid).*

Bell was merely justifying the infamous 1880 Milan Conference (Second International Congress on Education of the Deaf) which resulted in a resolution to ban sign language in schools. The 21st Congress, meeting in Vancouver, BC in 2010, finally retracted that resolution, saying:

> *Therefore we:*
>
> - *Reject all resolutions passed at the ICED Milan congress in 1880 that denied the inclusion of sign languages in educational programs for Deaf students;*
> - *Acknowledge and sincerely regret the detrimental effects on the Milan conference; and*
> - *Call upon all Nations of the world to remember history and ensure that educational programs accept and respect all languages and forms of communication.*

So, 130 years later, even the ICED recognized the damage they did. What I found interesting was how many negative comments appeared on sites that mentioned the resolution. What part of "respect all languages and forms of communication" did they find so objectionable?

> *"I noticed that Cole uses gestures to help himself be understood. Let me caution you, don't use them back. Gestures won't help him find his place in a hearing world." (Dr. Sorenson, Mr. Holland's Opus)*

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AS I See It

(Continued from page 10)

When I was a pre-teen, some 50 years ago, my parents were flatly told by the otorhinolaryngologist at Johns Hopkins that "Only dumb deaf people use sign language." The implication was that I was to struggle without visual language until I failed. Parents today are getting pretty much the same advice.

> *The more easy-going and natural approach of auditory-verbal therapy coupled with its elimination of visual cues makes it the best developmental solution for the hearing-impaired child. However, if residual hearing is particularly bad, the use of visual cues and the more structured nature of the Auditory-Oral approach may be of help. Attempt the high road first, and only compromise if you have to*! http://www.auditory-verbal.org/avt/auditory-verbal-therapy-vs-auditory-oral-approach/#more-21

The fail first philosophy permeates education of deaf children, but that is a topic of another column. Research we have today does not support the notion that ASL and English are mutually exclusive.

> *Sign language and speech reading are thought to cause the deaf brain to reorganize (sic) in a way which makes cochlear implants (CI) ineffective, and clinicians often advise against using visual language with deaf children. This is a problem as the visual modality is the only way in which deaf children (without CI or hearing aid) can access language. Researchers at DCAL (Deafness Cognition and Language Research Centre) have examined the evidence for this advice. Studies reporting links between sign language use and poor outcome with CI often confuse other factors such as age and how long a person has been deaf for with the effect of sign language. There is more convincing evidence that visual language experience improves CI outcome, and that the effects of early language deprivation are permanent and severe. Research, particularly with animals, has caused researchers and clinicians to think about CI outcome only in terms of auditory development. Here, we emphasize the role of language development in contributing to CI outcome.* (http://www.ucl.ac.uk/dcal/dcal-news/research_report_CI)

Research refuting the notion that using sign language will inhibit learning English is piling up. At the same time, the concept of Language Deprivation Syndrome based on work from notable researchers such as Sanjy Gulati, MD of Harvard, and Wyatt Hall, Ph.D. of Rochester University, is increasing awareness that society is causing actual harm, antagonists on both sides attempt to make the debate zero sum. It does not have to be all one or all the other.

According to Debra Nussbaum of the Cochlear Implant Education Center at Gallaudet University, "Some children may start out using sign language as a foundation to early language development, with sign use diminishing as spoken language skills emerge. Some children may continue to utilize a combination of sign and spoken language. Some students may focus on spoken language with some sign language as a support. Some students may be sign language communicators with spoken language developed as a support to sign use. Where a child falls on the auditory-visual continuum is unique to the characteristics of each child, and planning for each child must be done on an individual basis."

Which brings us back to HB253. Why would anyone oppose the idea of measuring a deaf child's progress toward acquiring language? The opposition seemed to be coming primarily from a coalition that promotes cochlear implants and auditory-verbal only approaches and from agencies that might be charged with measuring progress or lack thereof. Could it be that such measurement would call too much attention to failing programs that do little more than create profit for the staff and shareholders at the expense of deaf kids' future?

> *I have found that one of the BIGGEST misconceptions still floating around when it comes to choices in deafness is in thinking that sign language and cochlear implants are mutually exclusive. They are not. Actually, it is our family's experience that Leah's success with her cochlear implant was because she was already fluent in American Sign Language* when she got her implant AND because we have continued to sign with her. We never stopped signing. (*She was also already fluent in written English by that time)* http://www.rachelcoleman.com/2011/09/07/my-two-cents-cochlear-implants/

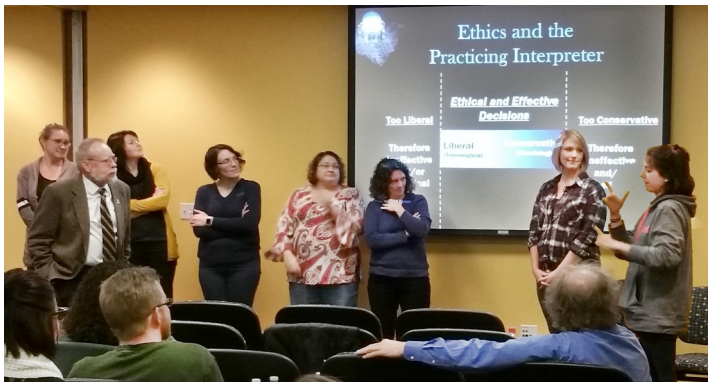
Deaf children need to get a fair chance at acquiring language (as opposed to just English) and the system seems not too motivated to see that happen. Whether it is because of deep-rooted beliefs that deaf people are "useless eaters" or prioritizing the corporate bottom line over the lives of deaf kids, there are significant and powerful interests that see set on protecting the status quo. (See related story at here.)

Language deprivation, and its attendant learning deprivation, experienced by so many deaf kids, causes lifelong challenges and psychological trauma. These children grow to be adults without effective coping skills who are then further abused by society that failed to teach them effective life skills. ***As I See It***, that's a shame. But at least because of the efforts of people like A.G. Bell and those who followed his trail, there will always be work for deaf mental health specialists.

ODS Staff Share Knowledge

While the Office of Deaf Services staff are always busy with consumers, paperwork, and other tasks, they still find time to share knowledge with others. This sharing is part of the ethos of ODS and cover a wide range of topics from neuroscience to art therapy.

Some of the presentations are small-group hands-on affairs. Others are lectures before large audiences. Staff mentor and supervise both interpreter and clinical interns. Some trainings are focused directly on consumers we serve; others are meant for broader community education.

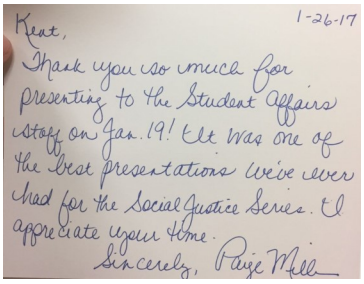


ODS Director Steve Hamerdinger has spent several days in Ohio doing basic training on mental health interpreting at difference cities around the state. Those presentations, averaged around 50 people per session (Picture above from the December training at Wright State).

Charlene Crump is frequently asked to train people on the new *Communication Skills Assessment* that she co-developed with Roger Williams. In addition to training people how to use the tool in Alabama, other states, such as Michigan and Texas, have ask her to train people there.

Kent Schafer has been working a lot with the University of Alabama, hoping to improve their football program. No, not really. But he has been working with them to make the campus more "deaf-friendly" and to open minds to the lived experience of being deaf. Through several presentations over the past two months, Kent has been making a name for himself. His presentations include Grand Rounds under

the Winternitz Series, "Establishing L1: A Cultural and Linguistic Minority Approach", and "The Deaf Learner: Autonomy and Resilience." Katherine Anderson has been a part of some of these presentations as well. The presentations have been well received by all reports.


1-26-17

Kent,

Thank you so much for presenting to the Student Affairs staff on Jan. 19! It was one of the best presentations we've ever had for the Social Justice Series. I appreciate your time.

Sincerely, Paige Mill

Kim Thornsberry is involved with Language Equality and Acquisition for Deaf Kids (LEAD-K), which is working to promote language acquisition for deaf children, There is currently legislation in the Alabama House of Representatives (HB 253) that is intended to address this issue. (See column on page ten.) Many people do not understand the pervasive impact of language deprivation on deaf kids.

Kim is also a master trainer for the Deaf Self-Advocacy Training curriculum. In that role, she trains other people to provide self-advocacy workshops. Kim has taught Shannon Reese to do DSAT training at the community level and Shannon did one in Dothan on February 25 that drew 25 people. The picture at the top of the next page shows a group of attendees at a session conducted by Shannon Reese.

(Continued on page 13)

ODS Staff Share Knowledge

(Continued from page 12)

Kim has presented self-advocacy sessions to the Deaf Community, both statewide and local. She has even adapted this for training at the group home level and has been doing monthly sessions with the residents of Jackson Place.

Jag Dawadi did a "Beating the Holiday Blues" workshop for the Deaf Community in Mobile on December 8th, which was well attended. He teamed up with Kent to do the DACTs training featured on page four. He is also active in community events. Such community education activities are one of the mandates of ODS.

Kim and Jag have been working with Miranda Nichols, our counseling intern, while Brian McKenny and Sereta Campbell have spent much of the fall and winter mentoring interpreters pursuing their certification as Qualified Mental Health Interpreter.

Did You Know?

"We observed that professionals working in specialist Deaf services, or with experience working with the Deaf community, had intersectional understandings of assessments: the ways in which cultural, linguistic, sensory, and social factors work together to produce diagnoses. Working with a diagnostic system that focuses heavily on 'norms' based on populations from a hearing culture was a key source of frustration for professionals. We conclude that recognizing the intersectionality of mental health and Deaf culture helps professionals provide sensitive diagnoses that acknowledge the multiplicity of D/deaf experiences."

Brenman, N. F., Hiddinga, A., & Wright, B. (2017). Intersecting Cultures in Deaf Mental Health: An Ethnographic Study of NHS Professionals Diagnosing Autism in D/deaf Children. Culture, Medicine, and Psychiatry, 1-22.

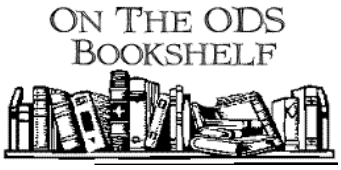
Current Qualified Mental Health Interpreters

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
Stacy Lawrence, Florida
Sandy Peplinski, Wisconsin
Katherine Block, Wisconsin*
Jamie Garretson, Wisconsin*
Steve Smart, Wisconsin
Stephanie Kerkvliet, Wisconsin
Nicole Kulick, South Carolina
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
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.
Scottie Allen, Wisconsin
Maria Kielma, Wisconsin
Erin Salmon, Georgia
Andrea Ginn, New Mexico
Carol Goeldner, Wisconsin
Susan Faltinson, Colorado
Crystal Bean, Arizona
Mistie Owens, Utah
Claire Alexander, Minnesota
Amanda Gilderman, Minnesota
Jolleen Hudson, Washington State
Melissa Marsh, Minnesota
Bridget Sabatke, Minnesota
Adrienne Bodisch, Pennsylvania
Beth Moss, Tennessee
Jasmine Lowe, Georgia
Pam Hill, Georgia
Lori Erwin, Georgia
Jenae Hanson, Minnesota
Katherine Anderson, *Tuscaloosa*
Christina Healy, Oregon
Becky Lukkason, Minnesota
Leia Sparks, Wisconsin



Important Recent Articles of Interest

Crump, Charlene J., and Stephen H. Hamerdinger. "Understanding Etiology of Hearing Loss as a Contributor to Language Dysfluency and its Impact on Assessment and Treatment of People who are Deaf in Mental Health Settings." Community Mental Health Journal (2017): 1-7.

Abstract: Working with individuals who are deaf in mental health settings can be complex work, necessitating consideration for the difference in language abilities. These differences include not only the language differences of American Sign Language (ASL) and English, but also the range of heterogeneity within the Deaf Community. Multiple influences such as mental illness, medical conditions, language deprivation and the etiology of deafness can impact how a person acquires and uses language. This article will discuss how various causes of deafness create the potential for specific language dysfluencies with individuals who are deaf in mental health settings. The article will also discuss the use of communication assessments to examine specific language dysfluency patterns and attempt to offer possible corresponding interventions.

Hall, W. C., Levin, L. L., & Anderson, M. L. (2017). Language deprivation syndrome: a possible neurodevelopmental disorder with sociocultural origins. Social Psychiatry and Psychiatric Epidemiology, 1-16.

Abstract: There is a need to better understand the epidemiological relationship between language development and psychiatric symptomatology. Language development can be particularly impacted by social factors—as seen in the developmental choices made for deaf children, which can create language deprivation. A possible mental health syndrome may be present in deaf patients with severe language deprivation.

The clinical specialty of deaf mental health appears to be struggling with a clinically observed phenomenon that has yet to be empirically investigated and defined within the DSM. Descriptions of patients within the clinical setting suggest a language deprivation syndrome. Language development experiences have an epidemiological relationship with psychiatric outcomes in deaf people. This requires more empirical attention and has implications for other populations with behavioral health disparities as well.

Brenman, N. F., Hiddinga, A., & Wright, B. (2017). Intersecting Cultures in Deaf Mental Health: An Ethnographic Study of NHS Professionals Diagnosing Autism in D/deaf Children. Culture, Medicine, and Psychiatry, 1-22.

Abstract: Autism assessments for children who are deaf are particularly complex for a number of reasons, including overlapping cultural and clinical factors. We capture this in an ethnographic study of National Health Service child and adolescent mental health services in the United Kingdom, drawing on theoretical perspectives from transcultural psychiatry, which help to understand these services as a cultural system. Our objective was to analyze how mental health services interact with Deaf culture, as a source of cultural-linguistic identity. We ground the study in the practices and perceptions of 16 professionals, who have conducted autism assessments for deaf children aged 0-18. We adopt a framework of intersectionality to capture the multiple, mutually enforcing factors involved in this diagnostic process. We observed that professionals working in specialist Deaf services, or with experience working with the Deaf community, had intersectional understandings of assessments: the ways in which cultural, linguistic, sensory, and social factors work together to produce diagnoses. Working with a diagnostic system that focuses heavily on 'norms' based on populations from a hearing culture was a key source of frustration for professionals. We conclude that recognizing the intersectionality of mental health and Deaf culture helps professionals provide sensitive diagnoses that acknowledge the multiplicity of D/deaf experiences.

Anderson, M. L., Craig, K. S. W., Hall, W. C., & Ziedonis, D. M. (2016). A Pilot Study of Deaf Trauma Survivors' Experiences: Early Traumas Unique to Being Deaf in a Hearing World. Journal of Child & Adolescent Trauma, 9(4), 353-358.

Abstract: Conducting semi-structured American Sign Language interviews with 17 Deaf trauma survivors, this pilot study explored Deaf individuals' trauma experiences and whether these experiences generally align with trauma in the hearing population. Most commonly reported traumas were physical assault, sudden unexpected deaths, and "other" very stressful events. Although some "other" events overlap with traumas in the general population, many are unique to Deaf people (e.g., corporal punishment at oral/aural school if caught using sign language, utter lack of communication with

(Continued on page 15)

hearing parents). These findings suggest that Deaf individuals may experience developmental traumas distinct to being raised in a hearing world. Such traumas are not captured by available trauma assessments, nor are they considered in evidence-based trauma treatments.

Anderson, M. L., Sortwell, A., Craig, W., Kelly, S., & Ziedonis, D. M. (2016). Symptom Patterns of Posttraumatic Stress Disorder among Deaf Trauma Survivors. JADARA, 50(1), 3.

Abstract: Details about Deaf people's pattern of posttraumatic stress disorder (PTSD) symptoms remain relatively unknown due to inaccessible methods used in most epidemiological research. We conducted semi-structured American Sign Language interviews with 16 trauma-exposed Deaf individuals to explore their PTSD symptom patterns. Half met criteria for current PTSD, a rate higher than the general population. Underlying this disparity may be heightened rates of dissociation and psychogenic amnesia reported by many Deaf trauma survivors. Future research with large samples of Deaf survivors is needed to clarify this hypothesis, and to inform interventions that more accurately target Deaf people's pattern of trauma symptoms.

Niclasen, J., & Dammeyer, J. (2016). Psychometric properties of the strengths and difficulties questionnaire and mental health problems among children with hearing loss. Journal of deaf studies and deaf education, 21(2), 129-140.

Abstract: More knowledge is needed about the characteristics of mental health problems among deaf or hard of hearing (D/HH) children. This study investigates the factor structure of one of the most widely used screening tools, the Strengths and Difficulties Questionnaire (SDQ), and the prevalence of mental health problems among D/HH children. Our data were derived from two independent samples of D/HH children, one from 2007 of children (N = 334) in bilingual/bicultural educational programs and another from 2014 of children (N = 233) in mostly mainstream oral educational programs with cochlear implants. Teacher-SDQs were collected for the 2007 sample and parent-SDQs for the 2014 sample. The factor structure of the SDQ was examined from both Exploratory Factor Analytic (EFA) and Confirmatory Factor Analytic (CFA) perspectives and internal consistency was examined. Mean problem scores were presented. The five-factor structure of the SDQ was overall found for both the 2007 and the 2014 samples using EFA. However, problems with the Conduct scale and the reversed items loading onto the Prosocial scale were observed. The five-factor model was superior to a one- and a two-factor model from a CFA perspective in both samples. Better internal consistency was observed for the 2007 sample rated by teachers. Both samples showed higher mean scores on all SDQ problem subscales compared to a cohort of Danish children without hearing loss. The five-factor structure of the SDQ is recommended to be used among D/HH children.

Boness, C. L. (2016). Treatment of Deaf Clients: Ethical Considerations for Professionals in Psychology. Ethics & behavior, 26(7), 562-585.

Abstract: Providing therapy to deaf clients raises important ethical considerations for psychologists related to competence; multiple relationships and boundary issues; confidentiality; assessment, diagnosis, and evaluation; and communication and using interpreters. In evaluating and addressing these, psychologists must consider the APA's Ethics Code and other relevant issues (e.g., ADA) necessary to provide ethical treatment. The current article provides background, ethical considerations, principles and standards relevant to the treatment of deaf clients, and recommendations to support psychologists, training programs, and the field. Psychologists have the responsibility to guarantee that the benefits of mental health treatment are fairly and justly provided to this traditionally underserved population.

Costas, Beverly. (2017) Team Effort – Training Therapists to Work with Interpreters as a Collaborative Team. International Journal for the Advancement of Counselling. March 2017, Volume 39, Issue 1, pp 56–69

This paper considers components of a framework for relational training for counsellors who work with interpreters. Where counsellors and clients cannot be linguistically matched, they will need to incorporate an interpreter into their therapeutic relationship. Counsellors are often unprepared to work in this way. 'Mothertongue multi-ethnic counselling service', a UK counselling agency has developed and piloted an in-house training for counsellors and interpreters. Components of this training in how to work collaboratively with interpreters are considered in this paper. These components address the need for a collaborative relationship between counsellor and interpreter, consideration of dynamics in a triangular relationship and a clear delineation of responsibilities. Recommendations are made for the development of a training curriculum and models of clinical supervision for counsellors and interpreters who want to work together

Interpreter Development Strategies

By Brian McKenny, NIC, QMHI-S

Studies and practical experience have shown that interpreters working in rural settings (as well as those working in Video Relay Service settings) experience the potential for far greater health risks than their peers working in community settings. This is arguably also true for interpreters working in mental health settings. The use of a form of supervision, similar to that used in clinical settings, may serve to help ameliorate this need. Through an established and ongoing supervision arrangement, interpreters, particularly those working in rural settings, often in a solo capacity, may engage in continuous quality improvement of their technical skills in American Sign Language and the interpreting process. Techniques for navigating the distress that comes while working without peers is also a necessary component for the continued health and well-being of the practitioner.

Before we delve into the use of supervision for interpreters, we must first identify three key terms: mentoring, clinical supervision, and preceptoring. Mentoring is "a teaching-learning process acquired through personal experience within a one-to-one, reciprocal, career development relationship between two individuals diverse in age, personality, life cycle professional status, and/or credentials" (Mills, Francis, & Bonner, 2005). Mills et al. goes on to identify the mentoring relationship as a task oriented one, with a set timeline for acquiring specific skills, often sequentially. Mentors in the interpreting field are regularly tasked with the development of technical skills; vocabulary development, sign production, interpreting methodologies, etc. Interpreters may work with a number of mentors throughout their career. As language competencies of students mature, so too does the need for adaptation in interpretation provision. Mentorship can, and should, enhance the professional interpreter.

Clinical supervision is a term familiar to those in the field of mental health. This functions as "a support mechanism for practising (sic) professionals within which they can share clinical, organisational (sic), developmental and emotional experiences with another professional in a secure confidential environment in order to enhance knowledge and skills" (Mills, Francis, & Bonner, 2005). Supervision differs from mentorship in that it is predominantly an ongoing process involving peer interactions and reflective practice. It is a consistent dialogue between practitioners for the improvement of the work as a whole. Confidentiality, long believed in the field of interpreting to mean private, or secret (the ASL sign even shows this), actually takes its roots from the verb "to confide in" or to entrust. In the practice of supervision, this confidential relationship is extended to the supervisor. In the interest of enhanced interpreting work, information is shared between the two with the intention of increased practical skills.

Some interpreters learn their craft on the job, through the use of a preceptor, an "experienced practitioner who teaches, instructs, supervises and serves as a role model… for a set period of time" (Mills, Francis, & Bonner, 2005). This master-apprentice relationship gives real-world experience from the beginning. What the apprentice misses in formal training, he or she makes up in real-world application of the work. Preceptoring may be effective for those persons that have already attained a level of language competency yet need to learn the professional skills necessary for the field.

The concept of supervision as it applies to the interpreting field was first promulgated in Rudser (1986) and Atwood (1986), among others. Rudser suggests borrowing the concept from the mental health field's practice approach. He felt that work with another professional could help alleviate confusion that was being found between what the Registry of Interpreters for the Deaf's (RID) Code of Ethics said and what was actually done in practice. He goes on to state that this confusion often leads to conflicts where there should have been none. Many interpreters at the time held a very conservative approach to the code, seeing it more as rules more than guidelines. Goldhammer (1969, in Atwood, 1986) proposed that "peers, not supervisors (as per the traditional understanding of the term), may serve as better agents to encourage positive changes." Atwood goes on to outline the process of clinical supervision as it applies to the practical aspects of interpreting. Unlike mentorship, where the approach is more focused on skills development, supervision takes more of a focus on the soft, or practical skills of being an interpreter. Medical students go through years of medical school, honing the technical aspects of their trade, yet it is not until residency and beyond that they learn what it is to be a doctor. The ability to interpret alone is not sufficient. One must learn how to "be an interpreter." Supervision is an avenue to that end.

There are numerous models of supervision that have found promise among interpreters working in a variety of settings, including the Vygotsky Method, Gish's Mentee-Centered Learning Model (Gish, 1997), the Socratic Method, and the Observation-Supervision Method (Dean & Pollard, 2004). While each has merit in its own right, the true decision comes dependent on the needs of the interpreter being supervised in this sense. The Vygotsky and Gish models are

(Continued on page 17)

Interpreter Development Strategies

(*Continued from page 16*)

very effective toward those with well-developed self-analysis skills; those that are able to recognize areas to improve in themselves without the assistance of outside input, where the Socratic Method guides that person in a discovery of their own. This method seeks not to answer the question posed, but to guide through reflective listening and interaction, resources that help resolve such questions. Pollard and Dean's work in Observation-Supervision, based heavily in Demand-Control Schema (Dean, Pollard, & English, 2004; Dean & Pollard, 2011; Dean, 2012), provides a strong guided framework for identifying issues, or demands, and the development of not one answer, or control, but a myriad of right answers that one might consider when faced with the challenges that come with the job of interpreting. No one method is a perfect match for any person in any given situation; so careful selection is important to successful outcomes.

In addition to the aforementioned technical skills development, this technology may also be used for clinical supervision of those interpreters working in these settings. The practice of being an interpreter goes well beyond proficiency of American Sign Language interpretation skills. Much like other practice professionals, including doctors, therapists, and police officers, the technical skills serve as entry-level skills. It is the practice that makes interpreters qualified. As practitioners grow, so too do the standards of interpreting work. Such changing standards can be found in the Standard Practice Papers of the Registry of Interpreters for the Deaf, such as those outlined In *Interpreting in Mental Health Setting*s (2007). The application of such best practices is best implemented through the collaborative work of those in the field; however, the solo nature of many rural interpreters often makes this unattainable, and such settings fall behind the norm.

Kennedy and Kennedy (2010) call for a "Community of Inquiry" approach to adult learning in any setting, though this certainly has application to the field of interpreting. As other practice professionals are called to be life-long learners in order to keep up with the growing wealth of knowledge in the world, so too must interpreters be kept abreast of such knowledge. The community of inquiry is a pedagogical model that may include a social learning system; that is, one in which peers and colleagues learn from each other. This form of relationship puts aside the master-apprentice or superior-inferior relationships of old in favor of the many working together for the betterment of the whole.

The history of continuing education among interpreters involves the attendance of a two to six-hour workshop with the naïve belief that such acts can change the practice. There is a movement toward more long-term training, including the use of peer groups to enhance both individual skill and the practice of interpreting as a whole. Supervision is one such tool that can enhance interpreters in the implementation of that practice. Where access often abounds in larger cities and areas where large interpreter and deaf populations center, this same access must be made available to those living outside those bounds. Where the individual workshop approach has failed this underserved segment of our interpreting community, continuous supervision can instill a mentality of constant learning that can only improve the quality of those practitioners, as well as the outcomes to the clients they serve.

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Help Wanted - Join Our Team

Office of Deaf Services, Alabama Department of Mental Health

MH Interpreter I Huntsville
SALARY RANGE: 73 ($37,389.60 - $56,685.60)

WORK LOCATION: Region I (Huntsville) Bryce Hospital (Tuscaloosa)

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. .

Deaf therapists (MH Specialist III) Birmingham
SALARY RANGE: 78 ($47,757.60-$72,686.40)

WORK LOCATION: ODS Region V based at JBS MHA

QUALIFICATIONS: Master's degree in a human services field with considerable experience (48 months or more) working with deaf individuals in a human service setting, OR current permanent status (24 months or more) as a Mental Health Specialist II working with deaf individuals in a human service setting.

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

KIND OF WORK: This is advanced professional and administrative work 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, works closely with the Office of Deaf Services Regional Interpreter to arrange 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. .

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.

Communication Specialist (**MH Specialist I**)
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.

Community Programs

MENTAL HEALTH TECHNICIANS
Deaf Services Group Home (Clanton, AL)
SALARY RANGE: Competitive

Positions Available:

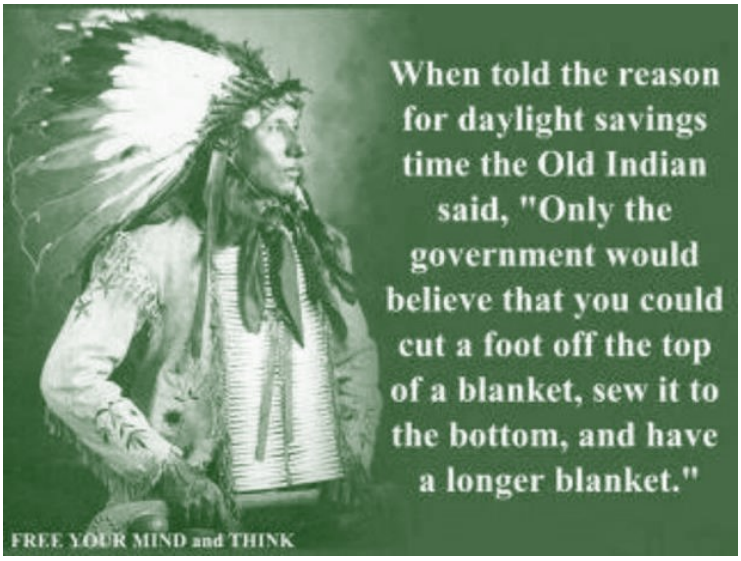
Part-time position Schedule: Sat-Mon 8a-4p
Full-time position Schedule: Tues-Sat. 12a-8a

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



DEAF SERVICES DIRECTORY

Alabama Department of Mental Health
(Mailing Address) P.O. Box 301410
(Physical Address) 100 North Union Street, Montgomery ,Alabama 36130

Central Office

Steve Hamerdinger, Director, Deaf Services
Steve.Hamerdinger@mh.alabama.gov
Office: (334) 239-3558
Text: (334) 652-3783

Charlene Crump, State Coordinator Communication Access
Charlene.Crump@mh.alabama.gov
Office: (334) 353-7415
Cell: (334)324-1972

Shannon Reese, MA Service Coordinator
Shannon.Reese@mh.alabama.gov
VP: (334) 239-3780
Text: (334)-294-0821

Joyce Carvana, Administrative Assistant
Main Number: (334) 353-4703
FAX: (334) 242-3025

Region I

Kim Thornsberry, MA, CRC, ALC, Therapist
Kim.Thornsberry@mh.alabma.gov
WellStone Behavioral Health
4040 South Memorial Pkwy
Huntsville, AL 35802
Office: (256) 217-4308
Text: (256) 665-2821

Interpreter, Vacant

Region II

Kent Schafer, Therapist
(See Bryce based)

Sereta Campbell, Interpreter
Sereta.Campbell@mh.alabama.gov
Taylor Hardin Secure Medical
1301 Jack Warner Parkway
Tuscaloosa, AL 35404
Cell: (334) 328-7548

Region III

Jag Dawadi, Therapist
Jag.Dawadi@mh.alabama.gov
Region III DD office
3280 Dauphin Street, Building B, Suite 100
Mobile, AL 36606
Office: (251) 234-6038
Text: (251) 721-2604

Lee Stoutamire, Interpreter
Lee.Stoutamire@mh.alabama.gov
AltaPointe Health Systems
501 Bishop Lane N.
Mobile, AL 36608
Office: (251) 461-3447
VP: (251) 281-2258

Region IV

Barry Critchfield, ***Ph.D., Therapist***
Barry.Critchfield@mh.alabama.gov
Montgomery Area Mental Health Authority
2140 Upper Wetumka Road
Montgomery, AL 36107
Cell: (334) 430-2449

Brian McKenny, Interpreter
Brian.Mckenny@mh.alabama.gov
P.O. Box 301410
Montgomery Alabama 36130
Cell: (334) 462-8289

Region V

Therapist (Vacant—Recruiting)
Intern: Miranda Nichols
Miranda.Nichols@mh.alabama.gov
JBS Mental Health Authority
604 27th Street South
Birmingham, Alabama 35233
Text: (334) 324-4066

Katherine Anderson, MSW, LGSW, Interpreter
Katherine.Anderson@mh.alabama.gov
Bryce Psychiatric Hospital
1651 Ruby Tyler Parkway
Tuscaloosa, AL 35404
Office: (205) 409-4858

Bryce Based

Bryce Psychiatric Hospital
1651 Ruby Tyler Parkway
Tuscaloosa, AL 35404

Kent Schafer, MA, MSE, NCSP, Statewide Psychologist
Kent.Schafer@mh.alabama.gov
Office: (205) 409-4858

Interpreter Hired: Announcement coming soon

Summer LeCain, Mental Health Interpreter Trainee
Summer.LeCain@mh.alabama.gov
Office: (205) 507-8493

Communication Specialist, Vacant

15th Annual Mental Health Interpreter Training

July 31 — August 4, 2017

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, et. al.

Special Alumni Track Featuring:

Angela Kaufman, Kate Block, Kendra Keller, Kent Schafer, Mistie Owens and others to be announced.

The Main Track is now full. Applications can be submitted to be waitlisted for this year or to be considered for early acceptance for next year.

The Alumni Track still has a few slots open. Apply soon.

Cost Of Training:

	Through March 31	April 1 — May 31	After May 31	Day Rate
Participants	Main Track is "Sold Out"			
Alumni (Full Institute)				
Alumni Track Only*	$40 a day, $150 for the week. Fee Waived for QHMI Certified Interpreters			

*The alumni track will not completely meet the 40-hour pre-practicum requirement. It will meet annual CMP requirements for QMHI renewal.

A Minimum of 4.0 CEs Will Be Offered in the Main Track
Approximately 2.5 CEs in the Alumni Track
Clinical CEs are Pending

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