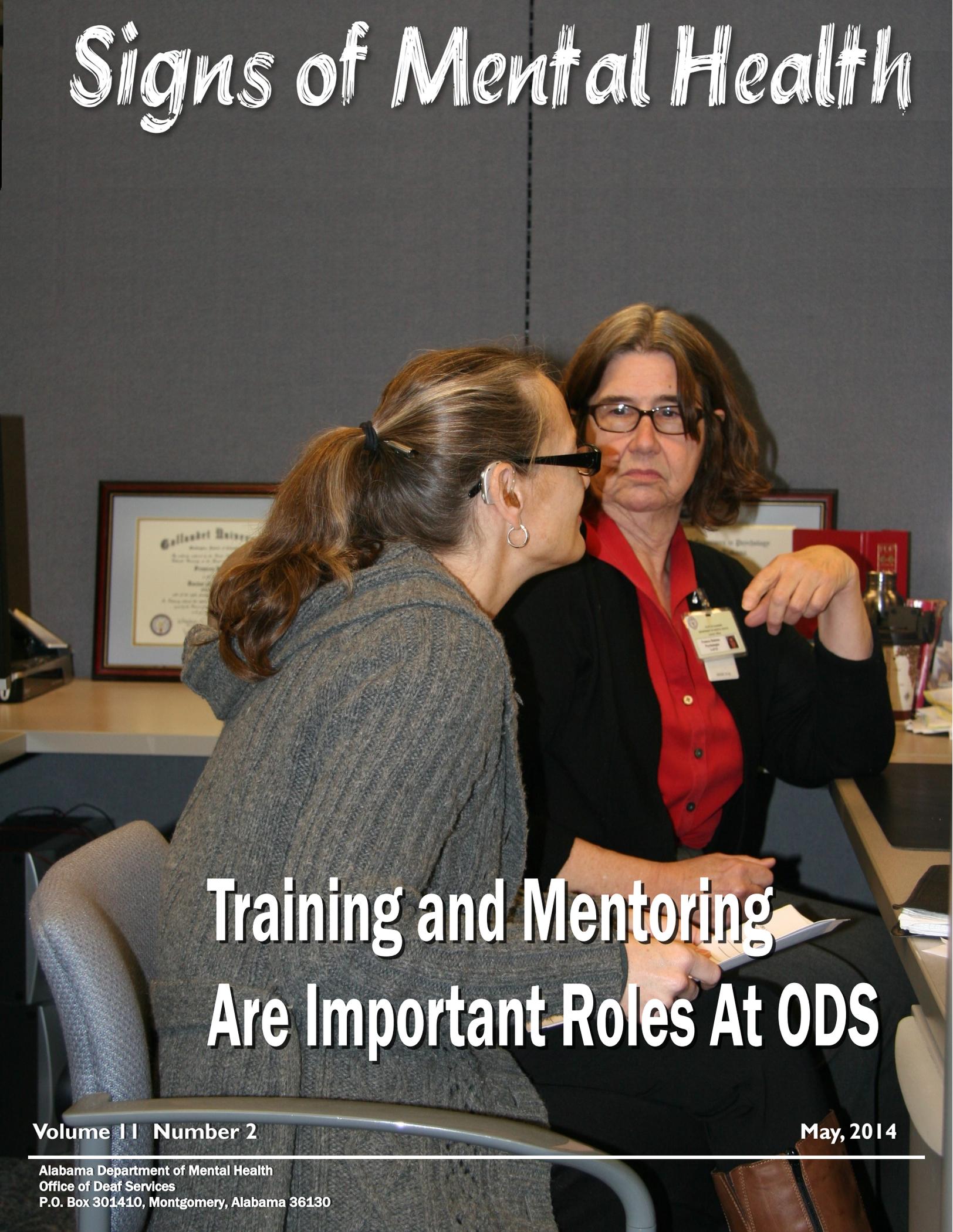


Signs of Mental Health



Training and Mentoring Are Important Roles At ODS

Volume 11 Number 2

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



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Signs of Mental Health
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On The Cover:

Illeen Moore, a counseling intern from Alabama State University worked with Dr. France Ralston, ODS Psychologist. This month SOMH features work with interns and practicum students.

Important Position Announcement

PSYCHOLOGIST I (Office of Deaf Services) SALARY RANGE: (\$52,663.20-\$80,287.20)

JOB LOCATION: Department of Mental Health (Tuscaloosa Bryce Hospital Complex)

QUALIFICATIONS: Graduation from an accredited college or university with a Doctorate degree in Psychology.

SPECIAL REQUIREMENTS: Possession of or eligibility for licensure as issued by the Alabama Board of Examiners in Psychology. **Proficiency in American Sign Language at "Advanced Plus" or higher** level of signing skills as measured by a recognized screening process, such as SCPI.

The employee in this position will be responsible for providing clinical services to deaf and hard of hearing (D/HH) consumers at our Tuscaloosa facilities and in West Alabama. This position works within the Office of Deaf Services, Division of Mental Health and Substance Abuse Services, providing culturally and linguistically appropriate psychological testing and assessment to deaf consumers throughout the state. Works with inter-disciplinary treatment teams in the development, implementation, and review of patient treatment plans. Conducts group, individual, and family therapy. Develops, implements, reviews, and supervises behavioral and milieu treatment programs. Maintains accurate documentation as required by policy as well as departmental and mental health center guidelines. Performs related duties as assigned.

Please request complete announcement <http://www.mh.alabama.gov/ADHR/ExemptJobs/Search.aspx>. Questions can be directed to Steve Hamerdinger, Director of Deaf Services.

Steve.hamerdinger@mh.alabama.gov or VP (334)239-3558



At the 2014 Helen Keller Lecture. Left to Right: Dr. Jack Hawkins, Troy Chancellor; Charlene Crump, ODS Statewide Interpreter Coordinator; James Reddoch, AMDMH Commissioner; Anindya (Bapin) Bhattacharyya, 2014 Helen Keller Lecturer; Chelsea Jones, Interpreter; Dr. Beverly Bell-Shambley, Associate Commissioner for Mental Health and Substance Abuse; Steve Hamerdinger, ODS Director.

Bryce Deaf Care Worker Feted at Consumer Conference

Robin Bishop, a Deaf Care Worker at Bryce Hospital, received the 2014 RESPECT Award at the 22nd annual Consumer Conference at Shocco Springs on April 8. She provides communication access, empathy, and support, as well as daily living help for the Deaf and Hard of Hearing patients at Bryce Hospital.

RESPECT awards are presented to caregivers, whether professional, family, friend, or fellow consumers, who are consistently respectful to persons with a mental illness. The winners are selected by a panel of consumers. The RESPECT Award has become a high honor for those who are involved in mental illness activities in Alabama.

Bishop was surprised and honored by the recognition. "This award will always be cherished by me and it means a whole lot to me," she said. "I promise you I will continue to do my job better and keep working as hard as I can to [help] my patients and give them the best care I can. I want to help them get better so they can go home or to a group home. They deserve a better life."



Robin Bishop,
2014 RESPECT Award Winner

Her colleagues are impressed with her as well. Her award citation included this:

Mrs. Bishop goes above and beyond to make sure the Deaf and Hard of Hearing patients' needs, desires, and goals are being understood and received. She provides perspective to the Deaf and Hard of Hearing patients to help them better understand their mental illness and hearing loss; while also encouraging the patients to not let their mental illness or hearing loss limit or define them. The Deaf and Hard of Hearing patients at Bryce consistently express their confidence in, respect for, and appreciation of Mrs. Bishop.

Mrs. Bishop is the living embodiment of the Respect Award. Not only is she responsive, encouraging, sensitive, perceptive, expediting, caring and thoughtful; she is also respectful, supportive, empathetic, hard-working and trustworthy. Mrs. Bishop makes sure her patients are receiving the best care and deserves to be honored with the Respect Award.

We agree. It is a well-deserved huzzah. A Deaf Care Worker since 2012, she has won the trust and respect of not only deaf people in the ward, but hearing patients as well.

Bishop is the second deaf services staff person to be so honored. Dawn Vanzo was recognized in 2007. 

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Interns, Practica, Trainings, Oh My!: Preparing Practitioners for the Future

Over the years, scores of talented people have spent time with ODS in training capacities, either as interpreters or clinicians. As of press time, 12 people have advanced their training under the tutelage of one of the ODS staff during the fiscal year 2014.

Each year some of the participants in the annual Mental Health Interpreter Training program's Interpreter Institute come back to Alabama to do a 40-hour practicum. This year, as of press time, nine have and five more are due before the next MHIT. At 14, the 2013 group is the largest cohort to go through practica since the beginning of MHIT in 2003. They have been effusive in their praise. Michael Klyn, from Riverside California, did his practicum in March "Even with 10 years interpreting experience under my belt, NAD and RID certifications, being on the state list and a graduate of an ITP, there's no comparison to the education received. There's a definite sense everyone wants you to succeed."

For Rhiannon Sykes-Chavez from Albuquerque New Mexico, a 2012 participant, it was a career-changing experience. "I left with a passion for mental health interpreting and have provided significantly better services because of MHIT."

Since MHIT draws participants from all over the country, they sometimes have a cultural epiphany. Andrea Nelson (see story on page 5) found Alabama to be quite different from what she thought it would be. "Alabama may not be traditionally known as a progressive state, but it leaps and bounds above its counterparts in the rest of the country in terms of mental health services for Deaf people," she told **SOMH**.

Nelson, who lives in Portland, Oregon, found out that working in a rural state with a low-incident population meant a lot of driving. This also creates time for supervisors to discuss and analyze assignments in depth and to have a little fun. "It left time for a crash course in the nuances of "ma'am" versus "miss" and the difference between granny, grandma and me-maw!" Don't forget the true meaning of "Bless your heart," and the difference between a redneck and a good ol' boy!

On a more serious note, it also leaves time to discuss how to handle language deprivation and how to recognize and handle different types of dysfluency. Brian McKenny, who by far leads the ODS staff in the number of people he has mentored, observed that, "Deaf Services works with many consumers whose language has suffered greatly as a result of their illness. As a result, practicum participants develop

hands-on tools for working with this specialized population. "

Altogether, more than 50 people have gone through all or part of their practicum since the first class in 2003. As would be expected, the largest group of participants are Alabama interpreters. The next largest group is from Wisconsin, a state that early on bought into the ideas MHIT teaches. Wisconsin is one of the places where MHIT has established distance practica, with Kate Block and Jamie Garrison being approved supervisors.

QMHI supervisors are essential to this process. Currently there are eight, four of whom are MHIT faculty. In addition to McKenny, Charlene Crump and Sereta Campbell are in-state



QMHI-S Class of 2013: Standing, L-R: Steve Hamerdinger, Charlene Crump, Brian McKenny, Kate Block, Lynne Lumsden, Roger Williams. Seated: Jamie Garrison, Sereta Campbell, Nichole Maher (from Australia, auditing course only) and Kendra Keller

QMHI-S. They are joined by Roger Williams of South Carolina, Kate Block and Jamie Garrison of Wisconsin, Kendra Keller of California and Lynne Lumsden of Washington. To become a QMHI-S, veteran "Qs" take additional training and pass examination by peers. Lumsden remarked that, "I value my QMHI and QMHI-S perhaps even more than my RID certification because of the practicum hour requirements, knowing my work was observed, my reflective practice guided and discussed and my required studies supervised and then all approved of prior to sitting for the exam."

All interpreters who go through the MHIT practicum are certified interpreters. ODS also has an interest in helping develop beginning interpreters coming out of interpreter training programs. This year, ODS provided internships for two seniors, both of whom are on mental health stipends. Erin Grooms and April Headley, both seniors in the Troy University Interpreter Training Program, worked with Brian McKenny

(Continued 14)

We Aren't In Oregon Any More....

By Andrea, Nelson, QMHI



I didn't do so well in Geography class, but I do know Montgomery, Alabama is a long way from Portland, Oregon. Even so, when I boarded the Boeing-737 at Portland International Airport last August, I had no idea the 2,570 mile flight was only the first leg of what would prove to be one of the most profound journeys of

my career.

I've long been interested in mental health interpreting, and for the past several years it's been a focal point of my career. I waited patiently for my CEU cycle to renew and then eagerly registered to attend this "Alabama mental health thing" I'd heard was so great. I'm a tad embarrassed to

admit I did very little research into the program. I assumed my colleagues' enthusiasm was endorsement enough and figured I'd learn when I got there just what this MHIT stuff was all about.

As he welcomed us to the week, Steve told us it was only the beginning. He went on to explain observations, practicum and the written exam. He told us about the "Q".

"The what?" I said to myself with growing excitement.

Lately, I've thought a lot about how to take my career to the next level. I like the idea of getting a specialist certificate, but pursuing the SC:L frankly doesn't interest me much. Learning about psychiatric disorders and therapeutic approaches on the other hand? I could do that all day! After hearing about the practicum and the "Q" certification, I immediately knew the next step on my career path.

(Continued on page 15)

Troy Interns Spend Semester at ODS

My name is Erin Groomes and I will be graduating from Troy University's Interpreter Training Program May 9, 2014. I was fortunate enough to be offered an internship with the Alabama Department of Mental Health Office of Deaf Services. In my opinion I had the most amazing internship that I could have had. I learned so much in my short time with the Department of Mental Health and I had so many great opportunities.



Erin Groomes

All of the staff in the Department of Mental Health were so supportive of me and wanted me to learn and get all of the experiences that I could, especially the staff in the Office of Deaf Services. I worked with several of their interpreters but most of my time was spent with Brian McKenny, who is one of their staff interpreters. The mentoring interpreters I worked with were amazing and very willing to help me in any way they could. They were willing to share their experiences with me so I could learn from the things that they have done. They all offered me opportunities to interpret in so many different settings. I was given the opportunity to interpret in

(Continued on page 14)



April Headley

As internship quickly approached in January of this year my driving force of motivation was success. Being a senior in Troy University's Interpreter Training Program, I had knowledge from teachers, books, an extensive network of professionals, and the Deaf community itself. One might say I was ready for the workforce after reading my transcript of classes and trainings I had attended. However there is one crucial piece to my puzzle that no class could prepare me for, which is experience. The Alabama Department of Mental Health (DMH) gave me just that.

I was privileged to work with so many wonderful people within the department this semester, yet my guiding light, A.K.A. mentor, was Wendy C. Darling. Her dedication to my future went above and beyond anything I could have asked of her. She truly set a standard of excellence and I was adamant on following in her footsteps. The looming cloud of success and fears of doubt were abundant in the beginning of my internship, at times hindering my morale. However, I quickly learned that with Wendy by my side and the support

(Continued on page 15)

Providing Access Or Shirking Responsibility? Using VRI for Clinical Services

By Angela Kaufman, ADA Compliance Officer, City of Los Angeles

"I am excited that our counseling agency is offering counseling for Deaf clients. Using the video relay service (VRS) for therapy sessions is how we provide sign language! It is cost effective, as the therapist does not have to pay for an interpreter. VRS is free for both the Deaf client and the therapist. As far as I am aware it does not create any legal violations."

This is the second of two-part series looking at the growing use of videoconferencing as an alternative to face-to-face interpreters. Part one looked at the difference between video relay services (VRS) and video remote interpreting (VRI) and discussed a few of the more significant challenges and problems with VRS as an "alternative" to live interpreting. This installment will look at VRI and discuss its strengths and deficits. Suggestions for getting the most possible benefit from VRI are also offered.

Other suggested reasons for establishing using VRS has been that in small areas, "some of the interpreters know the therapy clients personally, so there is a belief that is a "violation" of the therapy client's confidentiality, so they recommend that they use the VRS system, which would allow for interpreters regardless of geographic location."

As argued in the previous installment, this is, at best, an abuse of the VRS system, and could be construed as a violation of the Americans with Disabilities Act. In addition, if the therapist bills Medicaid or Medicare (Federally funded programs) then it could also be construed as a violation of §504 of the Rehabilitation Act, requirements for accommodating consumers with a disability.

Instead of fraudulently using the video relay service to provide services, the therapist should establish a contract with a VRI provider agency or with independent contractors for their on-going remote interpreter coverage. This could allow the therapist to have more control over the necessary competency of the video interpreter and their qualifications, be sure the same interpreter would be there the full session, be able to schedule the same interpreter for ongoing sessions, give the therapist the ability to have a short meeting before the session with the interpreter to discuss their goals for the session or to update the interpreter if something occurred between sessions, and would provide

an opportunity for the interpreter to debrief with the therapist as needed after a session.

Establishing a contract for VRI services instead of utilizing VRS will go much farther to protect the consumers and therapists. The therapist can set minimal qualifications required for an interpreter, such as National or State approved Certifications and include specialized training requirements for domestic violence, rape, sexual assault, stalking, mental health, etc., the therapist would be able to speak with the VRI interpreter prior to and after a session to address goals of the session or any issues the VRI interpreter is experiencing, therapists and VRI interpreter can discuss how to inform the therapist of what they are actually seeing versus what is being signed.

The contract can also stipulate that interpreters who are assigned to these sessions have other specialized training, such as Alabama's Mental Health Interpreter Training, which equips interpreters for highly specialized assignments that call for greater use of professional judgment and knowledge.

There are two ways we will address using VRI services. The first will address the provision of "therapy" over the videophone through a VRI in which the therapist and consumer are in different locations and the second will address VRI when the therapist and consumer are in the same room.

Videophone VRI: Therapy with the therapist and consumer in different locations

There are some significant caveats, and not every type of therapy session would be effective and/or safe over a video connection. One major area of concern would be any clinical contact over a videophone that involves domestic violence. These can lead to many bad outcomes for the consumer, including increasing the risk of lethality. (This is especially true when using VRS due to the limitations in the videophone call).

In using VRI, the therapist (who would be a hearing person) would not be able to see the consumer. This poses several serious problems. One of the biggest one is that the therapist can only "see" what the interpreter provides. To some extent, this problem exists in all interpreted sessions. In live

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The Battle for Accessible Housing

By: SOMH Staff, reporting based on based on information from National Association of the Deaf and other sources.

In the last issue, reporting of on-going battle between Deaf Community advocates and the Federal Department of Housing and Urban Development (HUD). This installment, developed from original reporting as well as various sources such as the National Association of the Deaf, Mary Vargas, and others, give additional background information.



HUD's heavy-handed treatment of Apache ASL Trails has been so egregious that it caught the attention of Oklahoma Senator Tom Coburn, who included it in his 2013 "Wastebook"

The City of Tempe, Arizona wanted to make a difference for underserved people in the area. They set aside 30 low-income vouchers for deaf folks so they could move into Apache ASL Trails, an apartment complex especially designed to be "deaf-friendly". But in what Mary Vargas, an attorney fighting HUD, said "can only be described as retaliation against those who assert the right of the deaf community to choose to live in barrier free housing that respects language and culture," HUD continues to discriminate against deaf people. "Two weeks after withdrawing the letter of finding, HUD officials met with Apache folks and the State and told them that Apache was going to be permanently barred from ever receiving project based vouchers," Vargas explained that, "Project based vouchers ... are critical for this population because so many of the people who most need this housing don't have the financial means necessary to choose accessible housing."

The Arizona Department of Department of Housing has stated:

In the United States, experts estimate that there are less than 400 units of low income housing that

are accessible for individuals who are deaf. Apache ASL Trails was designed by a deaf architect and great care was taken to ensure that the community would be accessible and open to all.

Even the Federal Department of Housing and Urban Development recognizes the need as outlined in a report, titled, *Against Persons with Disabilities: Barriers at every Step*, from their own Office of Policy Development and Research (http://www.huduser.org/portal/publications/pdf/DDS_Barriers.pdf).

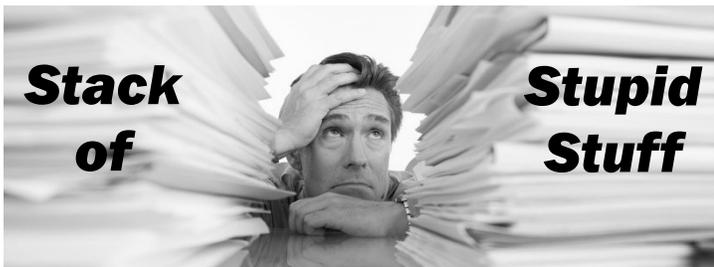
The research found the level of discrimination faced by both deaf persons and persons in wheelchairs to be extremely high, substantially greater than the levels of housing discrimination experienced by African Americans and Hispanics in the Chicago housing market. People who are deaf and use the TTY relay system to inquire about advertised rental units were refused service in one out of four calls.

In most forms of housing, code requires that there are auditory notifications, such as door bells and fire alarms. These need to be modified if the unit is to be equally accessible to deaf and hard of hearing residents. Additionally, many communities and apartment buildings have security systems with involve intercoms. Hearing residents, of course, can screen who comes to visit them using this intercom system and can then "buzz" their visitors in. Deaf people are not able to do this because there usually is no visual method of identifying calls or knowing when the door has been unlocked. As a practical matter, this means that deaf people can neither call on other people in security-controlled buildings or have visitors if they happen to be residents. This barrier was specifically mentioned in In the *Barriers* report.

This lack of visual alert can have tragic consequences. Laura Snyder-Gardner, 48, a beloved teacher at Gallaudet University in Northeast Washington, and her 16-year-old daughter Mary Ann, a junior at the high school on the Gallaudet campus were killed in a house fire that consumed their residence in the early morning hours of January 24, 2013.

This is not an isolated case. [In California, two deaf people were killed](#) and a third severely injured when their mobile home caught fire. [In Arizona, another deaf man](#) was killed in yet another mobile home. Concerns are not limited to the southwest either. [In Chicago, an 11-year-old deaf boy](#) was kill in an apartment fire. The [South Carolina Fire Marshals stated in a report](#) that "Fire Safety is a much overlooked problem among people who are deaf or hard of hearing."

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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.

You Don't Have Enough Faith!

Pat Robertson says you must be doing something wrong if you can't "heal" your son of deafness. After all, Robertson himself has healed deafness before, he said on the 700 Club today. Responding to a question from a mother who asked why her hearing impaired son hasn't been healed despite her prayers, Robertson said that her son may be hindered by a "spirit of deafness."

"I have dealt with people who are deaf and you rebuke the spirit of deafness and they get healed," Robertson said. "I don't know what you're doing wrong."

"Why don't you try that and if it doesn't work, try something else," he said.

[More Here](#)

Deaf People Can't Walk (In Airports)

There's a long-running joke that Delta Air Lines, which operates +5,000 flights daily, is an acronym for "Doesn't Even Leave the Airport". But for those in the Deaf Community, it may as well be "Deaf Erroneously Lose Their Ambulation".

That's because despite the universally (or so we thought) known fact that being deaf is specific to the ears, many airlines make the faux pas of handing us a wheelchair for pre-boarding. Many a tale has been told, about telling the front desk we are deaf, only to find a nice little lady waiting at the gate holding up an iPad with our name on it, waiting to push us around in a wheelchair. (Ed. Note: We aren't sure which is more discombobulating; the fact that Delta and other airlines do this or the response in the comments that said, "I know I shouldn't complain about the wheelchair - though when I see the extreme long lines (especially at holidays!), I will take advantage of it, especially when that means I can "cut in" and that saves me time and energy. NO COMPLAINTS. Thank you very much, all airlines! :-)" What? Seriously?

[More Here](#) 

Using VRI for Clinical Services

(Continued from page 6)

face-to-face sessions, however, the therapist has the benefit of seeing the consumer and can make some reasonable guesses as to affect and congruency.

Another problem is that there could be another person in the room with the consumer, forcing, controlling or simply overseeing the therapy session, which is likely to inhibit the consumer.

If the therapist cannot see the consumer, she or he is vulnerable to being defrauded. The supposed 'consumer' could be another person, such as the perpetrator, pretending to be the consumer to gain information.

An abuser can position himself/herself so as not to be seen by the videophone camera, and oversee the conversation, with or without the knowledge of the consumer. The only way to prevent this (to some degree) is to position the consumer's videophone so that 1) no one can enter the room or watch through a doorway or window without the consumer being able to see them; and 2) the consumer must sign an agreement with the therapist that clearly states he or she understands the limitations risks of this approach.

It is important for therapists to know that the consumer's videophone automatically records the phone numbers of all calls placed and/or received. Depending on whether the consumer lists the therapist's/agency's name and phone number in the videophone contact list, the therapist's name or agency will be displayed on the video end of the call for the consumer and whomever is watching will see who is on the videophone. This information is also stored on the videophone's call log, and will be accessible to anyone who has access to the videophone. A consumer may not know how to delete a phone number or a call, or may forget. Therapists who choose to provide services through a VRI should be aware of the limitation of the medium as well as how to reduce the risks by providing safety information to the consumer, especially with emerging technology.

One way to protect the consumer's safety through video communication is for the therapist and consumer to establish a 'code' that the consumer would use if it was not safe to talk or if it becomes unsafe during the session. However, if the perpetrator has enough control, or if the consumer has decided to forgive the abuser, this safety information might be disclosed to the abuser so that can make calls in the consumers' name, or the therapist could communicate with the consumers not realizing that the abuser is also present. It is extremely important that the consumer

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Using VRI for Clinical Services

(Continued from page 8)

understands that they should never share the “code” information with anyone, even someone they may trust and who supports them.

It is essential for both safety reasons and clinical care that VRS not be used for anything other than when they would normally use a phone call for hearing consumers, such as scheduling appointments, a brief “safety check” using pre-established codes as mentioned above or in exigent circumstances. Hearing therapists who work with hearing consumers frequently state that they usually do not do “phone therapy”, however that there are times, such as an emergency or crisis situation, that the therapist would need to conduct a session or speak with a consumer to deescalate a situation through a phone call. In situations with a therapist who has a deaf consumer, it could be appropriate under the same exigent situations to utilize VRS if necessary, although VRI would allow the therapist greater controls of the session. Anything else is at best, ignoring common-sense best practices and possibly violating Federal and State disability laws.

Videophone VRI Therapy with the therapist and consumer in same location

Most therapists prefer face to face sessions and with emerging technology can now choose to utilize a live interpreter or video interpreter (the consumers’ preference for which type of service (VRI or live interpreter) is provided by the therapist should be honored). The therapist and consumer are in the same room which allows the therapist to observe and monitor the consumer’s behaviors, mood and responses. In small communities, using a VRI interpreter may be preferable due to privacy issues, safety concerns, or a lack of local qualified interpreters.

For the VRI interpreter the same demands exist for any type of video interpreting, i.e. video quality, angle of camera, if the consumer moves out of screen, audio quality, an extremely emotional or angry consumer, etc. In addition, some controls that the video interpreter may have when the therapist and consumer are in different locations may become demands when they are in the same room, i.e. the therapist will have more control of the conversation by being able to observe the consumer themselves and not through the interpreter’s lens.

Keep in mind that remote interpreting is not a panacea. Live interpreting (i.e. the interpreter, the clinician and the consumer are all in the same room) is preferable in almost every situation, or at least until the therapist and consum-

er have established their bond and communication styles. For example, if the session is breaking down, the therapist can possibly recognize that it may be that the video interpreter is having difficulty with the interpretation instead of applying the responses to the consumer.

It is worth noting that there are some signing therapists who are using videophones and providing therapy with consumers who may have moved away and still want to keep the same therapist. This has proven to be very effective as it allows the therapist to continue providing direct services and the consumer would not need to start with a new therapist. It also allows for a greater degree of anonymity than would be possible in a smaller community. There are still gray areas with this approach, and many issues still need to be resolved. This is true of telehealth in general, however, and should be considered healthy tension that creates better understanding of what works best. Ground breaking work has been done in Minnesota, among other places, for establishing effective clinical protocol.

Particular attention needs to be paid to crisis intervention situations. What if a deaf consumer is suicidal? Is the interpreter catching all the nuances, are they providing an accurate interpretation? Does their voice and intonation really match the deaf consumer? Does the interpreter freak out? How can a clinician who is located in one state do an involuntary hold or commitment for a consumer who needs hospitalization in another state? How can the clinician send assistance or a wellness check? These questions take on even more urgency as more and more deaf people are using mobile devices and a variety of apps for video communication. How can the clinician send for an emergency response to the consumer when they are not at home?

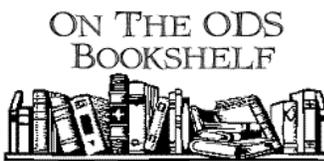
Finally, best practice for mental health and crisis response interpreting, as previously mentioned, dictate debriefing with the clinician after a session. This debrief is critical not only for the clinician-interpreter team, but also to allow the interpreter to share paralinguistic information that was not readily available to the non-signing clinician.

Abraham Maslow once said, “When the only tool you have is a hammer, every problem begins to look like a nail.” Video remote interpreting offers one more tool for clinicians to place in their tool box. Just as it is ineffective to use a hammer to drive in a screw, there are situations when it is inappropriate to use VRS or VRI with therapist and consumer in different locations. You would not throw out a hammer just because it is not the right tool for that job. Nor should VRI be totally discounted. Properly used, it can be a powerful way to broaden access to appropriate services and retain effective services if moving out of the area. ✍



As I See It

Steve Hamerding



Important Articles You Must Read

George Washington once said, “If the freedom of speech is taken away then dumb and silent we may be led, like sheep to the slaughter.”

I am frequently reminded of how disempowering, indeed humiliating, it is to be “struck dumb” by society’s inability or refusal to make communication access a priority. Last January I was admitted to a large teaching hospital here in Alabama for a heart procedure. I thought I did everything right, including making sure that the surgeon’s office called for an interpreter for pre-surgery consultation (which they did – I was there when they did it!) and to schedule an interpreter for the day of the surgery. To the best of the evidence I can find, they did. But when I showed up at 5:00 am for intake... Well, you can guess the rest.

The receptionist at the intake desk had no idea what I was talking about and definitely didn’t have “no sign language person.” They expected me to be able lipread them through the whole thing. I told them that was not acceptable. They then insisted my daughter, who bless her, is as loving as the day is long, but is definitely no interpreter, “explain all this” to me.

To say I was agitated would be similar to calling a category 5 tornado a bit of wind. It took them more than 6 hours to actually get an interpreter on site for a surgery scheduled two months before and the surgeon **told the hospital we needed one!**

I have written (ranted?) about this in this space before. The fast-coming freight train of managed care continues to barrel down the track to the Alabama Department of Mental Health and “quality assurance” officials in the medical bureaucracy who are charged with ensuring “quality” have steadfastly resisted any effort to put in even the most rudimentary quality measures related to communication access. They even downplay compliance with a host of laws related to provision of communication access, relegating it to that catch-all boiler plate “Will comply with all state and federal laws and regulations.”

This comes just a year after the ruling by Judge Richard Story of the U.S. Federal Court in Atlanta that stated:

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Anderson, M. (2014). Intimate Partner Violence in the Deaf Community: 5 Things You Need to Know & 5 Things You Can Do. *Psychiatry Information in Brief*, 11(1), 1.

At least 500,000 people are members of the U.S. Deaf community—a culturally distinct group of people who share American Sign Language (ASL) as a primary language. For members of this community, Deaf is a cultural identity – not a disability – and is indicated by the capitalization of the letter D. The Deaf community is rarely a focus of research. Few studies have been conducted on Deaf individuals’ health and wellness, including their mental health needs, substance use, and experiences of violence and trauma. Gaps are particularly evident in the shortage of literature on Deaf people and intimate partner violence (IPV), defined as physical, sexual, or psychological harm by a current or former intimate partner or spouse (CDC, 2013). This absence wrongly implies that IPV is a non-issue in the Deaf community, an assumption that has been disproved by recent empirical and clinical findings. This Issue Brief details important facts about IPV within the Deaf community and provides specific recommendations for providers about best practices for working with Deaf clients.

Landsberger, S. A., Diaz, D. R., Spring, N. Z., Sheward, J., & Sculley, C. (2014). Psychiatric Diagnoses and Psychosocial Needs of Outpatient Deaf Children and Adolescents. *Child Psychiatry & Human Development*, 45(1), 42-51.

Deaf youth may be more vulnerable to psychiatric disorders but very little research data is available. The current study identified prevalence rates of psychiatric disorders and examined the psychosocial needs and strengths of deaf youth aged 4–17 receiving specialized outpatient mental health services for the deaf. Compared to hearing peers, deaf youth had greater rates of attention deficit hyperactivity disorder, conduct, autism-spectrum and bipolar disorders and spent three times longer in treatment than their hearing peers. In the deaf subsample, moderate-severe risk was found in social functioning (33.3 %) and suicidal behavior (14 %). Deaf youth had moderate to severe impairment in social relationships (54.8 %), school functioning (42.9 %). Over one-third of deaf youth had impaired family relationships, living situation, communication, judgment and physical health. Deaf youth present with higher rates of certain clinical disorders and have deficits in multiple life domains that may impact functioning and create a longer treatment course.

Notes and Notables

Frances Ralston, Ph.D., ODS psychologist, has announced her retirement, effective June 30. She was the first deaf psychologist in Alabama. Beginning 2004, she served at the *Bailey Deaf Unit* before it was shuttered in 2010. *SOMH* will have a full story in the next issue.



Left–right: Wendy Darling, Erin Grooms, April Headley, Mark Moore

Several branches of the Deaf Services team were on hand at the Alabama School for the Deaf Career Day. Representatives from various groups were recruiting for positions in their programs. **Mark Moore** represented Jackson Place in Woodville, while **Malissa Galliher** was on hand promoting J-B-S- Deaf Services. Civitan house was also represented by Chilton-Shelby Human Resources Director **Lori Redding**. The setting provided an opportunity for ODS interns, **Erin Grooms** and **April Headley** to work on their skills under the tutelage of **Wendy Darling**.

Steve Hamerding was asked to give the keynote address at the annual conference of NASW-Michigan. It appeared to be well-received, even earning effusive praise from NASW-Michigan staff. "Thank you for a truly memorable keynote – hands down the best one I have ever attended," said Tricia McCarthy, Office and Events manager. The conference was held on the campus of Michigan State University in Lansing. MSU, of course, enabled Auburn's entry into the 2014 BCS Championship game by beating Ohio State. Hamerding made a point to profusely thank them!

Vyron Kinson was interviewed about what it is like to be a Black Deaf man that lives in Alabama for the documentary, "Black Noise" which was created by are University of Alabama students Gabrielle Taylor, a senior, and Johanna Obenda, a sophomore. Several black deaf individuals were in it

and explored larger issues of identity, race and disability. The film was part of the 8th Annual Documenting Justice series, a project of the Center for Ethics & Social Responsibility at the University of Alabama. Documenting Justice is a nationally unique interdisciplinary course in which non-film majors create short documentaries focusing on issues of justice or injustice in Alabama. The film was screened at the Bama Theatre, Tuscaloosa, AL on April 15, 2014 at 7pm. Johanna and Gabrielle were so happy that Vyron was able to come. Vyron has no idea how thankful they are.

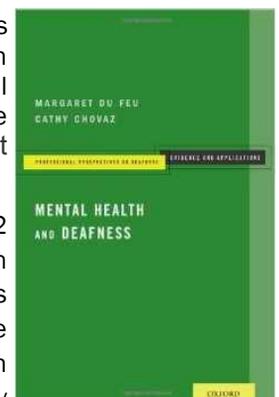


Left–right: Wendy Darling, Bapin, Carolyn Jolley

Wendy Darling was asked to work with the 2014 Helen Keller Lecturer, Anindya (Bapin) Bhattacharyya. While he was on campus for the annual event hosted by Troy University. Wendy, who is ODS's only staff person holding certification in working with Deafblind people, has a passion for working with Deafblind people.

MHIT alumnus **Cathy Chovaz** has co-authored a book, "Mental Health and Deafness: Professional Perspectives on Deafness: Evidence and Applications," with Margaret du Feu,

Chovaz, who attended the 2012 Interpreter Institute, is a Professor in the Department of Psychology, Kings University College and in the Department of Psychiatry, Schulich School of Medicine, at the University of Western Ontario. She was deafened in 1985, and uses both American Sign Language and spoken English. Margaret du Feu is a consultant psychiatrist in the



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The Battle for Accessible Housing

(Continued from page 7)



Laura Snyder-Gardner and her daughter Mary Ann, both deaf, were killed when a fire swept through their house. Their death was attributable, in part, to the lack of any visual fire alert system

Experts estimate that there are as many as 48 million people who are deaf or have a hearing loss great enough that they could suffer the same fate as Synder-Gardner. A fast-moving fire in an apartment building carries the potential to be catastrophic when there is no way for the residents to know there is an alarm.

In addition, most of the deaf and hard of hearing community now use videophones to contact one another and be able to use American Sign Language (ASL) during such calls. Video-phone technology necessarily requires high-speed Internet service, which is not readily available in low-income housing, even if the consumers had funding for the services. While deaf people can certainly live in “normal” housing units, those using HUD vouchers are unlikely to be able to afford it. Interestingly, the one federal program that made high speed internet available at little or no charge for deaf people who have limited income has been allowed to lapse. (Project Endeavor (<http://www.projectendeavor.com/Home.aspx>) was founded in 2010 on a two-year grant, which ran out in December of 2012) At the same as the Federal government is pushing to disburse the Deaf Community, they are eliminating programs that might have made such dispersal less of a psychological burden.

This burden becomes even greater when the deaf person also lives with mental illness. For them, the lack of appropriate subsidized housing can make the difference between being incarcerated and being able to live in the community. Roger Williams, the director of Deaf and Hard of Hearing Services at the South Carolina Department of Mental Health is concerned that consumers will be unable to move beyond congregate living. “It will effect our ability to develop specialized housing, which we needed to reduce group home population. We have raised the issue with HUD and how will they

balance the “money-follows-the-person” directive with the 25% set-aside.”

Many deaf and hard of hearing individuals who live in community housing are isolated from their neighbors because of communication barriers. As a result, these individuals are isolated from the world and experience serious cases of loneliness. As a result, many deaf and hard of hearing individuals who communicate in American Sign Language (ASL) simply want the opportunity to live among others who share their language.

This has led to several attempts to create housing facilities where ASL-using people can live together and enjoy ease of communication. These have been met with varying degrees of success. In most cases, projects have to be designed to be “inclusive” or HUD would shut down the project. Examples include The Columbus Colony (<http://www.columbuscolony.org>), La Vista Retirement Community (<http://www.lavistaonline.org>), and, of course, the Apache ASL Trails program. **SOMH** has attempted to get comments from each of these programs for this report. As of press time, none have responded.

Much like the Deaf community has seen with wrong-headed interpretations of “Least Restrictive Environment” that has led to the closure of Schools for the Deaf and the Medicaid Waiver rules that require Deaf people to live in placements where staff cannot communicate with them, HUD seems determined to make life as miserable as possible for people who are deaf. This combination of arrogance and truculence has earned HUD a unique recognition. It is one of the only deafness related projects to be make Senator Tom Coburn’s annual [Congressional Wastebook](#). In a chapter entitled, “Federal Government Spends Millions on Apartments for Deaf Seniors, Then Decides They Can’t Be Used by Deaf Seniors,”

HUD officials claim to have no plans to kick any of the tenants out, but their proposed actions will deny this type of supportive housing to future residents who need and would benefit from the accessibility features of the building. Also, the \$1.2 million cost of retrofitting the apartments for deaf residents will have been wasted.

All because the Federal bureaucracy has grown so large and cumbersome that it contradicts itself in ways the harm the most vulnerable people in society. ✂

Famed Deaf Actress Phyllis Frelich Dies, NAD Announces



The National Association of the Deaf (NAD) mourns the April 10, 2014 passing of Phyllis Frelich, a dear friend and supporter who has contributed tremendously to our community on many levels and helped elevate visibility of our culture to unprecedented levels during her life. Ms. Frelich was a phenomenal actress who was the first deaf person to win a Tony Award, and did so as Best Actress in the theater production of *Children of a Lesser God*. Her performances were renowned and showcased not only in the theater including with the National Theater of the Deaf but also on television with roles in series such as *Barney Miller*, *ER*, *Santa Barbara*, and *CSI: Crime Scene Investigations*, as well as

the television movie productions of *Love is Never Silent* and *Sweet Nothing in My Ear*.

Phyllis Frelich was born on February 29, 1944 in Devil's Lake, North Dakota to deaf parents and was the oldest of nine deaf siblings. She attended the North Dakota School for the Deaf, from which she graduated in 1962, and then studied at Gallaudet College. In addition to being an accomplished actress, she was also talented in quilting and donated many of her quilts to the NAD for its auctions.

Ms. Frelich's passing is a huge loss to the deaf and hard of hearing community and the world. The NAD thanks her for transforming society's perception of our community with her wonderful contributions and skills. ✂

Headley

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a better person. I am so very grateful for the opportunity to learn and develop my skills with such a great team of people. The words of encouragement I received will not be forgotten and I will continue to develop my skills so that I can be of the greatest value to our profession for years to come.

Booker T. Washington once said, "Few things can help an individual more than to place responsibility on him, and to let him know that you trust him." A great deal of trust was placed in me at the beginning of my internship and to the Alabama Department of Mental Health; I hope I made you proud. ✂

Notes and Notables

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development of Deaf Mental Health Services in Birmingham, Northern Ireland, and the Republic of Ireland. Deafened by cochlear otosclerosis, she received a cochlear implant in 1999. She uses British Sign Language (BSL), Irish Sign Language (ISL) and spoken English both personally and professionally. ✂

Just for Laughs

Overheard: "He is an oxymoron... usually without the oxy."

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, Prattville
Pat Smartt, Sterrett
Lee Stoutamire, Mobile
Frances Smallwood, Huntsville
Cindy Camp, Piedmont
Lynn Nakamoto, Hawaii
Roz Kia, Hawaii
*Jamie Garrison, Wisconsin**
Dawn Ruthe, Wisconsin
Paula Van Tyle, Kansas
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
Teresa Powers, Colorado
Melanie Blechl, Wisconsin
Sara Miller, Wisconsin

Jenn Ulschak, Tennessee
Kathleen Lanker, California
Debra Barash, Wisconsin
Tera Vorpal, Wisconsin
Julayne Feilbach, New Mexico
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

Preparing Practitioners for the Future

(Continued from page 4)

and Wendy Darling, respectively, for the spring semester. Their stories on are on page 5 of this issue

ODS has an interest in developing clinicians as well. Lance Weldgen, now Region I therapist, was a counseling intern with ODS for almost a year before he was hired on to the staff. "When I was an intern therapist, I got to enjoy the company of my supervisor, Scott "Starbuck," Staubach." Weldgen told **SOMH**. "I was able to absorb all educational discussions we had together on the road. We laughed, debated, gave feedback. The mentoring during my internship, including input from ODS's knowledgeable clinical team, was a treasure."

Working with Scott Staubach, Weldgen was able to get first-hand knowledge of how the mental health system works in Alabama and with that knowledge be better able to work with consumers who are deaf. Weldgen added, "Not until I became fully employed with the Office of Deaf Service, did I come to the realization how difficult and isolated the work could be."

This spring, Illeen Moore, a master's degree in counseling candidate at Alabama State University, spent part of her semester working with Dr. Frances Ralston. Moore, whose program focuses primarily on rehabilitation counseling, wanted to get a grounding in mental health, thinking it would make her a better rehab counselor. Instead, she found that her real passion lies in working with severely mentally ill people. "I had never met Deaf people with severe mental illness before and I realized that I have a natural skill with just talking with them, therefore, understanding what they are going through their own difficult times," Moore told



Illeen Moore

SOMH. "This made me want to help them get well as a whole person. This has increased my newfound interest in mental health because it has its own rewards when I realized that some of my consumers felt that I was helping them in some ways."

All trainees, regardless of whether they are interpreters or clinicians, receive a thorough grounding in working with people who are mentally ill and also have challenges related to language deprivation. They are all taught how to do formal and informal communication assessments. This provides a solid grounding in ODS' doctrine of understanding and addressing communication issues as a prelude to treatment.

"Without understanding the consumer's level of language competence and the origin of dysfluency, we are likely to miss important information about the consumer," said ODS Director Steve Hamerdinger. "It is easy to not only misinterpret what the consumer is saying, but we can also even cause harm by tell the consumer something in the wrong way."

With new linkage agreements in place with several colleges and a bumper crop of outstanding attendees slated for the 2014 Interpreter Institute. It looks as if the coming year will be another banner year for training and mentoring. 

Erin Groomes

(Continued from page 5)

everything from psychiatric and medical appointments to workshops. It was an eye opener to work in all of these settings that we discussed in my classes and get to experience what they are really like. In my opinion I got to work with some of the greatest mentors in the country. They were so willing to give me feedback about my interpreting skills and encourage me to become the best interpreter I can be.

I had the experience of deaf/blind interpreting which is something that I was very grateful for and happy that my first times working with deaf/blind consumers were with such a supportive and encouraging mentor. One of my favorite experiences was getting to work with the interpreters going through the Mental Health Interpreter Training practicum. It was amazing to be able to work with several interpreters from all over the country and get to discuss their experiences and to hear their feedback about my interpreting.

Another opportunity I was given was to interpret in various therapy situations in safe, non-critical situations. This was probably one of my favorite parts of working with the Department of Mental Health. I looked forward to therapy every time I saw it on our calendar. The therapists that we worked with were so willing to work with an interpreter and the deaf consumer and were even willing to work with an intern interpreter.

I had so many great experiences working with the Department of Mental Health and the Office of Deaf Services and I think that because of my time and experiences with them I will be a better interpreter. I am looking forward to going through their Mental Health Interpreter Training Program and becoming a Qualified Mental Health Interpreter! 

We Aren't In Oregon Any More....

(Continued from page 5)

That's how, this February, I found myself Montgomery bound once again. This time I knew quite a bit more about the program and had clocked many hours observing clinicians and reading volumes of articles. I buckled myself into Alaska flight 662 and headed off for whatever adventures those ODS folks had in store for me.

To be honest, I arrived at my practicum equal parts excited and frustrated. In the months since MHIT, I'd grappled with how to put my amazing new knowledge into practice at home. Alabama may not be traditionally known as a progressive state, but it is leaps and bounds above its counterparts in the rest of the country in terms of mental health services for Deaf people. There is a systemic strength and cohesion that you would be hard pressed to find anywhere else. I understood the philosophy taught at MHIT was the best practice. I knew I wanted to work this way. I just wasn't so sure it was possible.

Would the methods that work so well in the Alabamian utopia translate back home? Alabama has a team of interpreters supported by an entire department and backed by a legislative mandate. I work in an area where few interpreters know about MHIT and even fewer have attended. I would be the only QMHI in the entire state of Oregon. The approach I learned at MHIT runs counter to a lot of principles that still have a strong undercurrent in our field. I could see how it was effective, but would my colleagues and clients feel the same way? To top it all off, I only recently moved to Portland from Seattle, so I'm just getting to know the ins and outs of the landscape here. It was all very daunting.

Being the optimistic type, I was determined not to let my fears get the better of me. I made a list of questions for my supervisor, settled into my hotel room and opened myself up to learn. And boy did I ever!

Beyond the mental health aspects, this Northwest native had a lot to learn about what it means to be an interpreter in rural Alabama. First off—the driving! On the day we left at 6am to make a 9 o'clock appointment, I resolved to never again complain about commuting 45 miles to a job or hitting a little rush hour traffic. All this drive time came in handy, though. Not only did it allow for plenty of supervision hours, it left time for a crash course in the nuances of “ma'am” versus “miss” and the difference between granny, grandma and me-maw.

My supervisor and I spoke a lot about how I might apply my learning at home. We discussed ways I could offer to be a

resource for the referral agencies I work with. I laid out some of the challenges I'd faced since MHIT and we brainstormed solutions. I also came to see being new in town as an asset. The interpreters here haven't known me since I was green, which gives me the confidence to trust the work and trust myself.

Probably the greatest tool I gained from my practicum is a deeper understanding and appreciation for Demand Control Schema. I came to MHIT with little more than a cursory understanding of the concepts. I was so excited to finally find a constructive way for interpreters to talk about our work with each other! It was like a breath of fresh air. Fully incorporating it into my own self-reflective practice proved to be harder. As someone who is naturally hyper self-critical and defensive, using DC-S to analyze my own work can be a struggle. As much as it is a challenge for me, I also recognize it's what will allow me to remain true to the MHIT philosophies, even if it's difficult and even if I face criticism. It's a way to separate myself from the work and make the decisions that best serve the circumstances. In his parting words to me, my practicum supervisor reminded me to “use the tool.” Now I remind myself of that every day.

He also pointed out that best practices happen because people start doing them. Change doesn't happen unless someone does something different. I arrived home from my practicum with far more tools to pave a new road in Mental Health Interpreting here. I may find the path bumpy times, but I'm ready for the journey. ✍

April Headley

(Continued from page 5)

of DMH behind me, failure simply wasn't an option.

It is known that interpreting is a skill based profession and simply having the “know-how” without the ability to “do” will never suffice. The ability to “do” goes far beyond the communication process itself and that is exactly what my internship taught me. I learned how to be professional and how to carry myself with confidence. I learned that there is a time and place for everything whether it's a pat on the back or the shedding of tears. More specifically I learned how the department of mental health is operated and how my role as the interpreter fits in to that operation. I saw first-hand the impact of a job well-done as well as areas where I could improve and felt rewarded by both kinds of experiences.

I realize that the most important lesson I learned this semester was not how to be a success in my field; it was how to be of value. I have not only become a better interpreter but

AS I See It

(Continued from page 10)

"[T]he use of interpreters does not achieve 'equal communication' between the State's mental health care providers and deaf consumers as that between the State's providers and hearing consumers."

What keeps me up at night isn't that we can't live up to Judge's Story's vision, but that we will not even be able to get interpreters at all – let alone clinicians fluent in ASL.

Alfred Weinrib died in April 2013 without knowing he had cancer because medical facilities in Long Island failed to communicate his condition, a lawsuit filed for hospital negligence alleges. Mr. Weinrib – a deaf man – was allegedly not given access to an interpreter prior to his demise. Three different medical facilities were involved: Winthrop-University Hospital, Good Samaritan Hospital Medical Center in West Islip, and Gurwin Jewish Nursing & Rehabilitation Center in Commack. (See more [here](#))

Isolated? Hell, no. Seven deaf people have filed a joint complaint against Baptist Health systems in Florida over failure to provide interpreters. Two deaf women recently filed suit against Christus Hospital St. Elizabeth, in Beaumont, TX over the same thing. Not far away, Robert Phelps, filed against East Texas Medical Center Regional Healthcare System.

These are not isolated cases. The isolated case these days is when a deaf person *doesn't* have to fight to be "given" the basic human right to communication.

Over the couple of months, I have personally talked to at least a half dozen deaf Alabamians who have been denied interpreters or had treatment substantially delayed. Mind you, this sample is only those who have actually reached out to our office. If you are deaf and mentally ill and are taken to an emergency room, I can pretty much guarantee that you will **not** be given communication access for assessment if it's left up to the hospital. If you are admitted to the psychiatric ward, it will be days, if at all, before you have **any** interpreter service and only then it will likely be after the Alabama Disabilities Advocacy Program has called the hospital CEO.

Why does it keep happening? In part because statistically the healthcare system will get away with it. They get away with it because there is usually no substantive consequence to ignoring deaf people's request. Is not the silence of the Deaf Community at least partly the blame?

Remember back in 1999, the deaf community in Alabama sued the Department of Mental Health over lack of services. This led to the establishment of the Office of Deaf Services, the Bailey Deaf Unit (for the above mentioned crises) and the whole array of services we have or once had.

The operative phrase is "once had." Under the guise of "Healthcare reform" the state safety nets for mentally ill people are being scrapped in favor of giving money to "Regional Care Organizations" which are supposed to "manage our care." Dripping sarcasm absolutely intended.

The hard reality of the future is that decisions about our "care" are going to be made by accountants and lawyers who are disinterested in our human needs and concerned only with profit. The only way they will attend to such "trivial" matters as communication access is when it is unprofitable for them to do otherwise.

Not all profit, of course, is monetary. Sometimes unwanted attention, such as the Baptist health system in southeast Texas received, or the humiliating press visited upon those Long Island organizations might be sufficient to cause change, however fleeting.

Sometimes it is possible for litigation to effect corporate bottom lines enough that it will nudge them toward making needed changes.

All of that requires that a long-oppressed people find their voice. Thus, Washington's declaration of the inviolacy of the "Freedom of Speech" being a necessary inoculation against tyranny. Yes, the system, at best, benignly neglects Deaf people. At times, this becomes actively hostility.

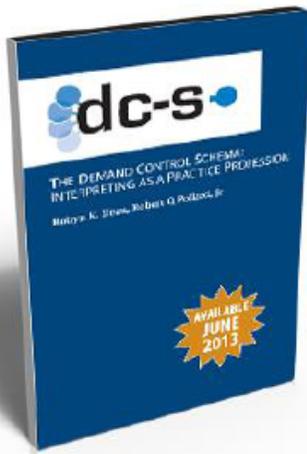
What does all this have to do with mental health? The unpleasant reality is that most of the public mental health system will be absorbed by the medical bureaucracy in the form of RCOs. As go the medical hospital, so goes mental health care—especially for those depending on community-based services. And doubly so if you do not have private insurance (Even then you have fight for access, as my case in January proved.)

Edmund Burke said, "The only thing needed for the triumph of evil is for good men to do nothing." **As I See It**, the only defense is for the Deaf Community to band together and act as one, ruthlessly opposing any and all instances where "healthcare" organizations deprive us of our right to be "heard." ✍

AVAILABLE NOW!

***The Demand Control Schema:
Interpreting as a Practice Profession***

by
Robyn K. Dean
and
Robert Q Pollard, Jr.



Dean and Pollard have been developing the demand control schema (DC-S) and their practice-profession approach to community interpreting since 1995. This textbook is the culmination of nearly two decades of work, as it evolved over the course of 22 articles and book chapters and nine DC-S research and training grants. Designed primarily for classroom use in interpreter education programs (IEPs), interpreting supervisors, mentors, and practitioners also will find this book highly rewarding. IEPs could readily use this text in introductory courses, ethics courses, and in practicum seminars. Each of its ten chapters guides the reader through increasingly sophisticated descriptions and applications of all the key elements of DC-S, including its theoretical constructs, the purpose and method of dialogic work analysis, the schema's teleological approach to interpreting ethics, and the importance of engaging in reflective practice, especially supervision of the type that is common in other practice professions. Each chapter concludes with a class activity, homework exercises, a check for understanding (quiz), discussion questions, and an advanced activity for practicing interpreters. The first page of each chapter presents a list of the chapter's key concepts, preparing the reader for an efficient and effective learning experience. Numerous full-color photos, tables, and figures help make DC-S come alive for the reader and assist in learning and retaining the concepts presented. Formal endorsements from an international panel of renown interpreter educators and scholars describe this text as "aesthetically pleasing," praising its "lively, accessible style," its "logic and organization," and referring to it as an "invaluable resource" with international appeal to "scholars and teachers." Spoken language interpreters also are proponents of DC-S and will find the material in this text applicable to their education and practice, as well.

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| Chapter 3: DC-S Rubric | Chapter 8: Consequences |
| Chapter 4: EIPI Categories | Chapter 9: Dialogic Work Analysis |
| Chapter 5: D-C Interactions | Chapter 10: The Reflective Practice of Supervision |

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2014 Mental Health Interpreter Institute

August 4 - 8, 2014

Montgomery, Alabama



A collaborative effort between the
Alabama Department of Mental
Health's Office of Deaf Services
ADARA and Troy University Interpreter
Training Program

A 40-hour course designed to provide a sound basis for interpreters to work effectively in mental health settings as part of a
Associated with Mental Illness and Treatment, Interpreters' Roles, Tools, and Resources, Severe Language Dysfluency and
Visual Gestural Communication/CDIs/Interpreters who are Deaf, Psychiatric Emergencies, Confidentiality Ethics and Laws,
Support Groups and Community Mental Health Services, Psycholinguistic Errors and Demand Control Schema for Interpret-
ing Applied to Mental Health.

PRESENTERS INCLUDE:

Bob Pollard, Robyn Dean, Roger Williams, Steve Hamerdinger, Charlene Crump, Brian McKenny, Shannon Reese, et. al.

Full Details at <http://www.mhft.org/>

**Hurry! Time is running out!
Class is getting full!**

COST OF TRAINING:

	Feb 16 - April 15	April 13 - May 31	After May 31	Day Rate
Participants	\$300	\$390	\$425	\$100
Alumni/	\$215	\$265	\$310	\$85



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