

Signs of Mental Health



Deaf Community Pitches In

Volume 7 Number 4

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Signs of Mental Health
 ADMH, Office of Deaf Services
 John M. Houston, Commissioner
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On The Cover:

Left to right: Stanley Jordon and Kathy Keeter present a check to Scott Staubach and Allen Stewart for Friend of the Baile Deaf Unit.

Putting together the Signs of Mental Health is always interesting. It is the chronicle of the ebb and flow of our work. Some weeks are quiet and the work is routine. Other weeks are ... different.

One of the most exciting things happening is watching the Deaf Community increasingly embrace those with mental illness. Stigma is a problem for all and it can be particularly acute in a small, close-knit community. To see a group of deaf people step up and do something really neat, like the ASD Reunion Group did, is heartwarming. Read about it starting on page three.

We have a new feature that we hope will be regular thing—ODS Case File Studies. We have worked with some really challenging consumers and we think other people might be able to learn something from what we have done, both right and wrong. Initially, we will address techniques that work when our consumers are very dysfluent. Since this is both a communication and a clinical challenge, we hope both interpreters and therapists can use the information. See page five for more.

Regular features are back, including a book review and our “On the ODS Bookshelf.” There are other surprises scattered through this issue as well. So enjoy it and let us know what you think.

And, of course, we all want to wish you Happy Holidays and a prosperous New Year. ✨



Shannon Reese and her father, Howard Reese were the plenary speakers at the 2010 Early Intervention Conference in Montgomery Alabama, November 18, 2010. As this was press time, a full story was not available, but more information will be in the next issue of the Signs of Mental Health.

Deaf School Reunion Group Pitch in to Help Friends of BDU

October 29, 2010 officers representing the Alabama School for the Deaf 1973 to 1985 Reunion Group presented a check for \$1,300 to the Friends of Bailey Deaf Unit. Kathy Keeter, President of Class Reunion group, Stanley Jordan, Treasurer and his wife Teresa Jordan presented the super-sized check to Allen Stewart, Director of Greil Psychiatric Hospital and Scott Staubach Unit Director of the Bailey Deaf Unit (BDU).



Allen Stewart (front right), Director of Greil Psychiatric Hospital, gives Stanley Jordan and Kathy Keeter an overview of services



Let to right: Allen Stewart Stanley Jordan Kathy Keeter Teresa Jordan, Scott Staubach, Brian McKenny

Ketter said, "We the 1973 to 1985 ASD Reunion Group are thrilled and proud to contribute to Friends of Deaf Bailey Unit and know

that the money is being used to an organization that supports deaf and hard of hearing citizens in Mental Health."

Friends of the Bailey Deaf Unit helps promote the recovery of Bailey Deaf Unit patients by providing things that the hospital cannot. It also encourages public awareness of mental health, especially in the Deaf community. Friends of the Bailey Deaf Unit also recognize individuals who have made special efforts to improve the patients' welfare and rehabilitation.

Allen Stewart remarked that "The donation from the 1973 to 1985 Reunion Group shows what concerned individuals can do as a group. A number of the residents of Bailey Deaf Unit have no income and the funds donated to Friends of Bailey Deaf Unit can be used for



The donation was the result of ground work done by Mark Moore (left) and Tony Overstreet (right), shown here with BDU director Scott Staubach

personal necessities such as haircuts, eyeglasses, clothing items or other needs. The special bond and concern shown for our deaf consumers by deaf contributors shows a great love which will make a genuine difference in the lives of those in treatment at Bailey Deaf Unit."

Afterwards, the representatives received a tour of BDU and they had an opportunity to see how the funds could be used. Keeter at-

(Continued on page 10)

DEAF SERVICES REGIONAL OFFICES

Region 1

Therapist, Vacant

Dawn Vanzo, Interpreter
Mental Health Center of
Madison County
4040 South Memorial Pkwy
Huntsville, AL 35802
(256) 533-1970 (Voice)
(256) 533-1922 (TTY)

Region 2

Therapist, Vacant

Sereta Campbell, Interpreter
Bryce Psychiatric Hospital
200 University Boulevard
Tuscaloosa, AL 35401
(205) 759-0698 (Voice)
(205) 759-0890 (FAX)

Region 3

Ben Hollingsworth, Therapist
Wendy Darling, Interpreter

Montgomery Area
Mental Health Authority
101 Coliseum Boulevard
Montgomery, AL 36109
(334) 279-7830 (Voice)
(334) 271-2855 (TTY)

Region 4

Therapist, Vacant

Lee Stoutamire, Interpreter

AltaPointe Health Systems
501 Bishop Lane N.
Mobile, AL 36608
(251) 450-4353 (Voice)
(251) 450-4371 (TTY)



SLIP Training Increases Rater Pool

On November 3-5, 2010, Alabama Department of Mental Health Deaf Services staff members Shannon Reese, Amy Peterson and Charlene Crump led a training for interviewers and raters in the Sign Language Proficiency Interview (SLPI) system, November 3-5, 2010. Wendy Darling, Region III Interpreter for the Office of Deaf Services was joined by Karen Gunter, Nancy Greer, and Alice Moss of the Alabama Department of Rehabilitation Services (ADRS) staff, and Beth Moss, of the Janice Capilouto Center for the Deaf. Deaf Services Region I interpreter Dawn Vanzo was also in attendance for part of the training, which was held at DMH Central Office in Montgomery.



Shannon Reese (left) helps Alice Moss and Wendy Darling with ratings.

The Sign Language Proficiency Interview (SLPI) is the mechanism used by the Alabama Department of Mental Health to assess the sign language skills. This tool is utilized to assess ASL fluency of future hires for DMH, ADRS and the Alabama Institute for the Deaf and Blind. It is also used to screen sign language students entering the Interpreter Training Program at Troy University, and to assess members of the community who need a marker of their conversational sign skills.

Working across divisions has allowed each agency an opportunity to expand their pool of interviewers and evaluators in their local areas. This activity is part of a collaborative effort by the agencies that work with deaf people to maximize resources.

Volunteers from the community came out to be tested so that the new SLPI team members would have an opportunity to learn how to interview and evaluate.

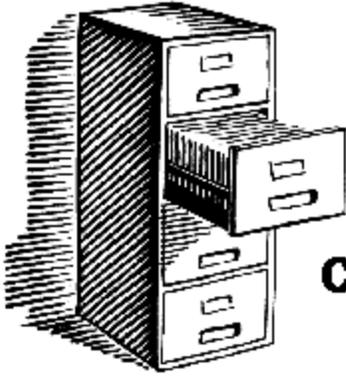
All providers under contract with DMH and working with deaf consumers need to show that they have ascertained the linguistic competence of the staff who work with deaf consumers. One of the approved ways is through SLPI evaluations. This means an increased demand for ratings and a need for more raters. At the same time, SLPI evaluations is sometimes the first contact the general community has with Deaf Services.

As part of our ongoing effort to maintain high quality standards, the Deaf Services will be offering future maintenance and enhanced learning opportunities. Whenever possible, the trainings will be videotaped and available to members of all nationally recognized SLPI teams in Alabama. This allows teams within the local communities across Mental Health, Rehabilitation and AIDB to be able to work together and improves both the consistency and validity of results within the state. DMH will also be hosting a training led by Amy Peterson on SLPI Grammar 4-5-6-7. The training will focus on grammatical aspects being evaluated on the SLPI.

ODS has also set up a listserv for all Alabama trained SLPI team members to assist with information dissemination and frequently asked questions. Additionally ODS continues to be actively involved in the national SLPI team standards and procedures, shaping the future of SLPI development. 



Training participants, seated left to right: Nancy Greer, Beth Moss, Alice Moss. Standing, left to right: Dawn Vanzo, Wendy Darling, Amy Peterson, Karen Gunter, Shannon Reese.



From the ODS Case Files: Challenging Cases, Creative Solutions

CASE STUDY

**Disclaimer. This is a composite and- does not depict an actual client.*

45 year old white female who is Deaf and uses sign language to communicate and is diagnosed with depression.

Language Usage:

Clear English-linear signing with, some initialized signs used. Initialized signs are sometimes produced incorrectly - such as using an “h” handshape for him, her, she, has, have. Client’s signing includes some misproductions where she substitutes other signs for the word she means, especially for “c” handshapes produced in neutral space (small for big, congregate/group for encourage, etc.) or signs “pinchy” for “picky” or a sign which means “superior” for “incident”. Client’s finger-spelling does not always accurately portray the word that she means. For example, she may spell “diabetes” but she means “disability.” Client is not able to fully spell proper nouns or brand names, such as medications (Lerpra for Lexapro). She uses some grammar, but shows only basic usage such as duplication of signs to show plurality, but it is not produced with native fluency. She uses pointing in space to refer to different persons, but does not identify the persons. Characters are unclear and therefore it is difficult to know if she did something or the person whom she is talking about was the doer of the action. Client attempts to use voice especially with hearing individuals, in an effort to relate, however it is not readily comprehensible. Discussions also seem to convey a fund of knowledge deficit regarding word meanings. Additionally, the client will also respond appropriately through dialogue to statements and questions, yet will re-ask the same questions multiple (4 to 5) times throughout the one hour session. Each time, the client will react as if the information is new. Client is at times fidgety and states that her joints hurt in her arms and legs. At other times, the client is lethargic and complains that there is a spirit in her hand bones. Both extremes impact language clarity.

Background Information (related to language development)

Client was mainstreamed in a rural portion of the state with an interpreter. Her husband is hearing and his sign language abilities are minimally comprehensible for basic needs according to client’s report. She is isolated in regards to communication and has no deaf or signing friends, co-workers or family members. The client is comfortable with the presence of an interpreter and attempts to engage the interpreter often into the therapy discussion and as an ally. Etiology of deafness is possibly Fetal Alcohol Syndrome (FAS).

Discussion on Language:

Language Deprivation: Some of the language misproductions could be related to potentially poor language models and extreme isolation. It is unknown if her signing ability has deteriorated since high school as no baseline is available. There also appears to be some bleed over from English influenced signing – such as word substitutions described above. The use of initialization and English based signing could be associated with a signing modality (Signing Exact English or SEE) that did not appropriately incorporate ASL grammar. Poor use of identifying markers, fund of knowledge deficits, poor vocabulary, sign features formed incorrectly, and lack of grammar are all indicative of language deprivation according to Glickman.

Etiology: FAS can cause deficits related to language such as: ability to grasp parts but not whole concepts of a message, poor short-term memory, inconsistent memory and knowledge base, poor judgment, Information-processing disorder, poor ability to perceive patterns, poor cause and effect reasoning, inconsistent ability to link words to actions, poor generalization ability, and expressive or receptive language disorders.

Isolation: Although not exclusive, it’s also unknown if the isolation created by language barriers contributes to the

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As I See It

John Hamendy

Cats and Dogs. Everyone knows the old saw about how they can't get along. Except that what everyone knows "ain't necessarily so."

I was thinking about this the other day when I was sitting in my sun room watching my dog and one of my cats working out some situation or the other. The cat was mewling and flicking her tail back and forth vigorously. The dog, being happy-go-lucky in general, assumed that this meant the cat was happy and wanted to play. After all, that's the way dogs do it. Usually this results in a general furball and a bloody dog nose followed by the animals laying in opposite corners of the room eyeing each other warily.

Fast forward - rewind, actually - to a clinical meeting I attended in another state in which I sat listening to poohbahs of both mental health services and education talking past each other. They were not at all unlike my dog and cat. Both had meaningful things to say, but both were communicating in a way that was not understood by the other. More precisely, words were used that meant different things to each group. Much like the wagging tail, there existed no common ground as to what "behavior problem," "acting out" or "depressed" meant. As Strother Martin said in *Cool Hand Luke*, "What we have here, is a failure to communicate." The meeting ultimately became a shouting match where each side was determined to be louder than the other.

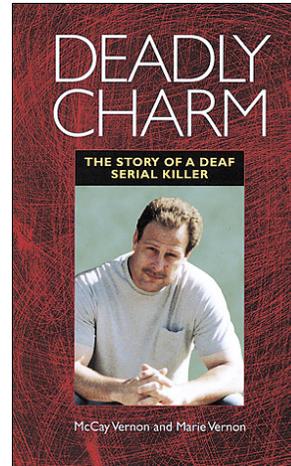
The failure to communicate is operational across several domains. Not only was there a barrier between the mental health weinies and the educational types, but also between the deaf and hearing folks. It wasn't just a language difference. It was what concepts meant to different people. As George Bernard Shaw wryly observed, "The problem with communication ... is the illusion that it has been accomplished."

No where is this problem more acute than in a multi-agency meeting to discuss services a difficult to serve deaf child needs. All too often the parties involved are talking past, not with each other. The dialog resembles nothing so much as serial territory marking. Every statement is then "heard," not

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Book Review:

Deadly Charm: The Story of a Deaf Serial Killer



Authors: McCay Vernon and Marie Vernon
Publisher: Gallaudet University Press; 1st Edition (May 31, 2010)
Language: English, 248 pages
ISBN-10: 1563684438
ISBN-13: 978-1563684432

Patrick McCullough may go down in history as the first and only deaf person to be identified as a serial killer.

McCullough was born to a military family in Alaska. The family worried about his hyperactive behavior and frequent violent tantrums and they were never able to figure out how to handle his outbursts. He was identified as being deaf around the age of four as a result of Rh factor. As was typical for that time, his parents were encouraged not to use sign language so that he could learn to lip read and succeed in the mainstream.

After his parents divorced when McCullough was five, he became a ward of the state as his father deserted the family and his mother gave him up. Already an unmanageable child, he was sent to the Maryland Institute for Children, on the campus of the Rosewood State Hospital. There, he was viewed by the other children as both a person to be feared for his strength and a person who could win others over with his good looks, endearing smile and boundless charm. He learned to exploit these traits to get out of trouble and convince others that the accumulating list of offense, large and small, were not his fault.

Initially diagnosed as mentally retarded, McCullough was later found to have an IQ of 120. This led the state try placement at the Maryland School for the Deaf, but he was soon expelled due to his continued behavioral problems. He spent time at various mental health institutions. His charm was endearing, but his incendiary temper evidenced an increasing cycle of aggression and abuse.

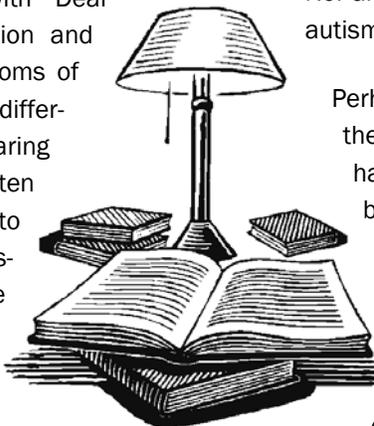
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HOT OFF THE PRESSES : IMPORTANT ARTICLES YOU MUST READ

Sheppard K, Badger T. (2010) *The lived experience of depression among culturally Deaf adults. Journal of Psychiatric Mental Health Nursing. Nov;17(9):783-9.*

Depression is a significant health concern. Psychiatric and advance practice nurses often screen patients for depression. However, culturally Deaf adults (those who communicate primarily in American Sign Language and view themselves as members of a unique culture) are rarely screened for depression. Consequently, very few Deaf adults ever receive the mental health care they need. The researcher conducted interviews with Deaf adults, who described their depression and events that led to depression. Symptoms of depression among Deaf adults are no different from symptoms experienced by hearing people. Communication barriers often make it difficult for Deaf patients to even discuss their symptoms of depression with nurses and other health care providers. Therefore, few Deaf patients receive appropriate treatment for their depression.



Vernon, M.(2010) *Deaf-blindness and autistic spectrum disorder. JADARA Volume 44 Number 1 Fall 2010*

Clinicians face awesome problems in diagnosis autism in clients who are deaf-blind for numerous reasons.

For example, two of the major symptoms of autism are impaired capacity to socially interact with others and delayed or lack of functional language. Therefore, many individuals who are deaf-blind, especially children, lack the language necessary to describe their symptoms or to communicate with the professionals making the diagnosis. While problems in some of these areas are present in the majority of those who are deaf-blind, the etiology of their disabilities is only occasionally autism.

Another difficulty in the diagnosis is that persons

who are born deaf and become blind often lack intelligible speech, cannot hear conversation and have only limited socialization skills. For these individuals, their delay in or lack of language limits communication, which is also often a feature of autism.

Further complicating the diagnosis problem individuals who are deaf-blind and autistic is that there are few IQ or personality tests adequately validate on deaf-blind people.

Nor are there medical test to detect the presence of autism in one who is deaf-blind.

Perhaps the most severe diagnostic problem is the dearth of psychologists and psychiatrist who have any experience with the syndrome of deaf-blindness and autism.

Horton, H.K. (2010) *Linguistic ability and mental health outcomes among deaf people with schizophrenia. Journal of Nervous and Mental Disease 2010 Sep;198 (9):634-42.*

Cognition has become prominent in the study of schizophrenia because of its importance for understanding the etiology of the illness and its consequences for living independently. For people with schizophrenia who are also deaf, investigations of cognition and schizophrenia are infrequent. This study examines the role of linguistic ability in relation to cognition, social cognition, and functional outcome among deaf adults with schizophrenia or schizoaffective disorder.

The primary finding is that linguistic ability is positively and significantly associated with functional outcome above and beyond the contribution of cognition and social cognition. A younger age of sign language acquisition is significantly associated with superior linguistic ability, but did not moderate the

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On The ODS Bookshelf

(Continued from page 7)

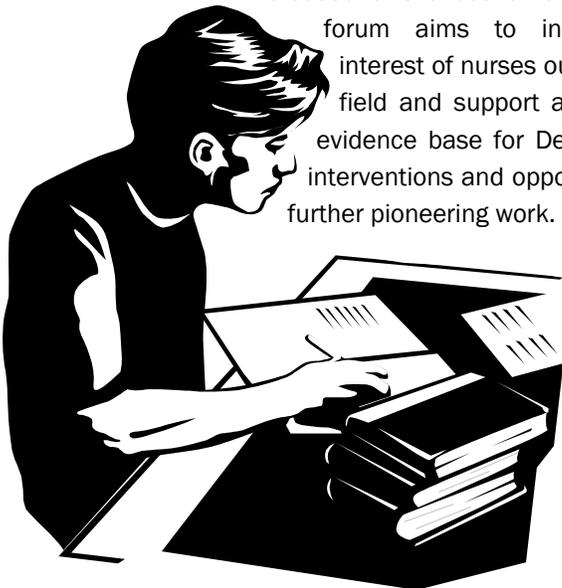
effect of linguistic ability on other domains.

Opportunities for deaf mental health consumers to participate in sign language enrichment programs and communicate with other skilled signers may be useful additions to standard psychiatric rehabilitation programming. More research is needed to clarify the consequences of deafness with regards to schizophrenia especially as it relates to language, vision, and symptoms.

Horne N, Pennington J. (2010) *The role of the Nurse Specialist in the highly specialized field of Mental Health and Deafness. Journal of Psychiatric and Mental Health Nursing.* 2010 May 1;17(4):355-358.

This opinion paper considers the need for enhanced clinical skills and knowledge to fulfill the role of a Specialist Nurse in the field of Mental Health & Deafness and informs professionals of a new group called the Mental Health & Deafness National Nurse Specialist Forum. Their knowledge and skills enable therapeutic interventions to be accessible and meaningful for Deaf people.

A case study illustrates the complex nature of assessment and treatment in Mental Health & Deafness and highlights the potential devastating consequences that may occur if a Deaf person is misdiagnosed and does not access appropriate services. An increased awareness of the field and forum aims to increase the interest of nurses outside of the field and support a developing evidence base for Deaf sensitive interventions and opportunities for further pioneering work.



As I See It

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through the perspective from which it was offered, but from through the prism of various agencies world view. The thumping tail as seen by the dog instead of the cat. "Least restrictive environment" as seen by deaf advocates versus special education types. The words sound the same, but the meaning totally opposite.

When the meeting is over, the water cooler conversation seems more of a gossip session about why "those people" can't "see to reason." This is, of course, all quite hilarious, since the exact same dialog can be heard from each of the various agencies/parties. "Those people over at XYZ won't serve this poor kid. We can't - not in our mission." The mental health center case manager sees the impulsive deaf child with Attention Deficit Disorder as "energetic"; the school sees her as a terror. Social Services just wants someone to "provide treatment." All are forgetting that the situation is interpreted through perspective world views of the meeting participants.

While this exercise is going on, what is happening to the kid?

Fifteen years ago, I was involved in an effort to set up a special program for behaviorally disturbed kids in a Midwest state. We looked at several models, growing especially interested in the program between Pressley Ridge and the Western Pennsylvania School for the Deaf. We came to see this as a model program. They invited us to a "behind the scenes" look at what they were doing. The lesson they drummed into our heads was, "You have to remember that school people and mental health people do not mean the same things when they use terms describing kids." We learned that we would have to practically develop a new way of talking. We would have to make sure that what we said was what they heard.

Ultimately, that nascent Midwest effort, like many other similar projects, failed. Not because of overt sabotage, but because we failed to recognize that we failed to communicate. As so it happens over and over. Alabama is no different than anywhere else. We are much more civil about it, on the surface. But we are no more able get past that basic barrier than the people who were screaming at each other in the meeting I attended way back then. That won't change until all of us are willing to rethink what we do with deaf kids who have emotional or behavioral problems.

As I finish this column, Frodo the dog and Pippi the cat are both sleeping contentedly on the dog bed. They worked out the "language problem." *As I See It*, we could too, if we wanted it badly enough.



Case Studies

(Continued from page 5)

depression.

Diagnosis: Depression can itself have impact on communication such as difficulty thinking, concentrating, remembering or making decisions, withdrawal from social situations, family and friends and feelings of sluggishness or slower than usual production of language.

Communication Strategies (for signing therapists and interpreters)

In communicating with client, the interpreter verified by sign (word) demonstration whenever possible to confirm fingerspelled word. While a signing therapist would be aware that this is occurring, the interpreter would need to make sure that the non-signing therapist is aware that this is occurring. The interpreter chose to state to the therapist “I need to verify the word that she fingerspelled is in reality ‘diabetes.’” Then proceeded to sign “d-i-a-b-e-t-e-s, “you mean sugar + high”?

When dealing with the sign misproductions that are used consistently, the interpreter voiced the intended meaning,

but addressed this issue in the post session by telling the therapist, “There are several signs that are produced incorrectly, for example, she signs “small” when she really means “much” or “pinchy” for “picky” – it’s a consistent error and the intent is clear. She does however seem to understand receptively when I sign the words in the correct form. This could be a result of poor language models or her current isolation, but since it could have other ramifications, so I wanted to make you aware of it. Would you like me identify those for you in the next session?”

Persons indicated by use of space where clarified by the interpreter by stating to the therapist “She is talking about an individual and work, but I am unsure who the person is, would you like me to clarify?” Then the information was clarified with the client by pointing to the same location in space and stating “Who?” or “Do you mean your supervisor?”

Brand names or medication names which are spelled incompletely or inappropriately and the interpreter chose to voice hesitantly “L-E-R-P-R-A, I’m not sure how you spell it” and the non-signing therapist clarified “Do you mean L-E-X-A-P-R-O?” When the client hesitantly nodded, the interpreter stated to the therapist “Maybe I’m not sure.” Then the therapist asked if the client had the medication with them and veri-

The Lighter Side: Come Again?

At left is an actual email we received! It’s nice that our staff is so flexible and able to step into many roles.

Of course, the all-time best is when we received a letter in an envelope addressed to the Office of Death Services—Department of Dental Health...

From: [REDACTED]
Sent: Monday, September 27, 2010 4:39 PM
To: [REDACTED]
Cc: Stoutamire, Lee; [REDACTED]
Subject: Deaf consumers

Ladies,

Please remember to notify Lee Stoutamire with **death services** when you set up an appointment for a consumer who is **death** and will require an interpreter. Lee can be reached at 461-3447 or by email at lee.stoutamire@mh.alabama.gov. Lee will need the following information:

- Consumer name
- Date and time of the appointment
- Location of the appointment
- Call back number of the Access Worker if leaving a message.

Thanks!

[REDACTED]

This electronic mail transmission may contain legally privileged and/or confidential health information. This message and/or any files transmitted with it are intended solely for the use of the addressee(s). This communication is to be treated as confidential and the information in it may not be used or disclosed except for the purpose for which it was sent. If you have reason to believe you are not the intended recipient of this communication or have received this email in error please (1) advise me immediately, (2) delete it and any files transmitted from your system, and (3) destroy any hard copies of it. You are hereby notified that disclosing, copying, distributing, or taking any action on the contents, attachments, or information herein is strictly prohibited.

Deaf School Reunion Group Pitch in to Help Friends of BDU

(Continued from page 3)

tributed the original idea for the contribution to Tony Overstreet, a Deaf Care Worker at BDU. He made the recommendation that patients at BDU could benefit from the funds raised from the class reunion. Mark Moore, also a Deaf Care Worker, supported the idea and the officers voted and passed the motion.

The monies will be utilized directly for client needs. Often patients find themselves without family or income and have no means to purchase the basics, such as clothes or hair-cuts. These funds will make a huge difference in the comfort of deaf individuals who are mentally ill.

The Friends of the Bailey Deaf Unit, which was founded in 2007, has fund raising events annually. 

Notes and Notables



Sereta Campbell was named Alabama's top interpreter by the Council of Organizations Serving Deaf Alabamians at their annual meeting, June 10th in Montgomery. Here, she receives her award from ODS Director Steve Hamerdinger.

MHIT Online Discussions Undergo Changes

Beginning January 1, 2011, there will be some significant changes in how we operate our online discussions and training. Beginning January 1, 2011, we will be using the chat function on the ADARA.org website.

Since 2005, ODS had partnered with Jacksonville State University to online training for mental health interpreters utilizing JSU's Blackboard feature. This partnership proved to be a tremendous asset to the mental health interpreting community and interpreters from around the country logged in to participate. We have had well over 200 people register at various times through the years with anywhere from 15 to 30 people participating at any given session. For a variety of reasons we will not longer have access to that resource.

For the past two years, ADARA has been our partner in conducting the Mental Health Interpreter Training Institute. This move is part of that overall collaboration.

While there are more limitations to the chat program functionality, there are other advantages that it offers that were not available to us, including the ability to open the discussions more widely. It will not be required to have a logon name and password. Pre-registration will still be required to earn continuing education credits from RID CMP, however. At this time, no CEs are available for clinical tracks, although many clinicians do participate.

Articles, URLs and supporting documents will be made available on the MHIT.org site. Go to <http://www.mhit.org/programsprojects/onlinediscussions.html>. 

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.

Charlene Crump, Montgomery
Denise Zander, Wisconsin
Nancy Hayes, Remlap
Brian McKenny, Montgomery
Dee Johnston, Talladega
Debra Walker, Montgomery
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
Vanessa Less, Wisconsin
Kathleen Lamb, Wisconsin
Dawn Ruthe, Wisconsin
Paula Van Tyle, Kansas
Joy Menges, 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

Positions Available In Deaf Services

Office of Deaf Services

REGIONAL THERAPIST, (Montgomery)

SALARY RANGE: 78 (\$47,757.60 - \$72,686.40)

Master's degree in a human services field including but not limited to the following disciplines: Sociology, Speech Education, Rehabilitation, Counseling, Psychology, Speech Pathology, Audiology, Nursing, Physical or Occupational Therapy, as well as any related academic disciplines associated with the study of Human Behavior, Human Skill Development, or Basic Human Care Needs, plus considerable experience (48 months or more) in providing direct clinical services to deaf individuals.

NECESSARY SPECIAL REQUIREMENTS: Must have near native-level signing in American Sign Language (ASL) as measured an Advanced Plus or better rating on the Sign Language Proficiency Interview (SLPI). Must have a valid driver's license to operate a vehicle in the State of Alabama. .

For more information on any of these positions, or for an application, please contact:

Steve Hamerdinger, Director, Office of Deaf Services
Alabama Department of Mental Health
100 North Union Street
Montgomery, AL 36130
Steve.hamerdinger@mh.alabama.gov
(334) 239-3558 (Voice/VP)

FACILITY-BASED INTERPRETER, (Montgomery)

SALARY RANGE: 73 (\$37,389.60 - \$56,685.60)

QUALIFICATIONS: The successful applicant will have a combination of training and experience equivalent to a two-year degree plus three years of full-time experience interpreting in a variety of different settings. The applicant must be licensed or eligible for license by the Alabama Licensure Board of Interpreters and Translators.

Copies of licenses/certifications should be forwarded/furnished with the application or at the time of interview.

NECESSARY SPECIAL REQUIREMENTS:

Must be certified or eligible to pursue certification as a QMHI (Qualified Mental Health Interpreter) or its equivalent. Certification must be obtained within 24 months of hire.

For more information on any of these positions, or for an application, please contact:

Charlene Crump, Statewide MH Interpreter Coordinator
Office of Deaf Services, Alabama Department of Mental Health
100 Union Street
Montgomery, Alabama 36130
(334) 353-4703 (Voice)
Charlene.crump@mh.alabama.gov

Deaf Services Group Homes

MENTAL HEALTH TECHNICIANS (Birmingham) (\$7.25/hr RELIEF POSITIONS)

QUALIFICATIONS: High School Diploma or GED. Must have intermediate plus signing skills in American Sign Language (ASL) as measured by a recognized screening process such as the SLPI and have a thorough knowledge of Deaf Culture. Must have a valid Alabama driver's license and car insurance.

For more information about the Birmingham positions, contact:

Malissa Cates, Program Director
JBS Mental Health/Mental Retardation Authority
956 Montclair Road, Suite 108
Birmingham, AL 35213
205-591-2212 (Voice)
205-591-2216 (TTY)
mcates@jbsmha.com

DIRECT SUPPORT PROFESSIONAL [DSP]

Volunteers of America, SE seeks Direct Support Professionals (DSP) to provide supports to individuals who use Visual Communication and who also have Intellectual Disabilities.

Volunteers of America seeks caring, experienced individuals to provide the following supports: grooming and hygiene skills; communication skills; socialization; meal planning and preparation; housekeeping skills and money management skills – all in an effort to increase the person receiving services ability to live more independently. DSP must be able to complete written documentation, assist in general housekeeping and meal preparation, as well as provide transportation as needed using company vehicle. Part-time employment is available and several shifts are needed. This position requires: HS Diploma/GED, valid Alabama Driver's License, good driving record, employment history, fluent in American Sign Language and must be at least 18 years of age. Volunteers of America, SE offers competitive pay, benefits, excellent retirement plan and is an EOE and Drug-Free Workplace.

Apply in person:

2005 North Country Club Drive
Montgomery, AL 36106
[334] 284-9372
[334] 284-5108 Fax

Deadly Charm

(Continued from page 6)

Clinton P. Riley, a boatwright, hired McCullough to work as a carpenter at his Yacht Carpentry Shop. But after they got into a dispute about payment, Riley accused McCullough of slashing his tires and stealing his dog. When Riley's remains were discovered by a hunter, McCullough told police he killed Riley in self-defense by slamming Riley's head against the wall and a door bolt. He pleaded guilty and received a reduced charge of manslaughter.

After he was convicted in the Riley slaying, police charged him with a second murder. The second person had been bludgeoned to death during a robbery and McCullough was placed at the scene. McCullough maintaining that he did not kill Myer, but acknowledging there was evidence to convict him. He was sentenced to 10 years in prison.

Yet, McCullough served seven years in prison for both murders. "Generally, prisons are isolating and especially punitive for deaf people, but McCullough had access to resources, such as part-time interpreters and assistive devices. Most deaf prisoners are passive, but in this case even the guards were frightened by him."

Once free again, he resumed his alternating pattern of charm and destruction.

McCay Vernon, a forensic psychologist, met McCullough when he was a student at the Maryland School for the Deaf. They met again when McCullough was in prison. Together with his wife, Marie, a free-lance writer, Vernon tells the compelling tale of an attractive young man, unable to control the impulses that drove him to a life - and ultimately a death - of violence. 

Review by Charlene Crump



Meet Us In San Diego

ADARA – Professionals Networking for Excellence in Service Delivery with Individuals Who are Deaf or Hard of Hearing request proposals for its national biennial 2011 conference in San Diego, California. ADARA leadership and members work to meet its mission by:

- Enhancing the professional competencies of the membership;
- Expanding opportunities for networking among ADARA colleagues; and
- Supporting positive public policies for individuals who are deaf or hard of hearing.

The 2011 Conference will have three (3) tracks: Rehabilitation, Mental Health/Chemical Dependency and Transition/Independent Living. Proposals clearly focusing on these tracks will be given priority.

Conference Hotel: **Marriot San Diego – Mission Valley**

GROUP RATES*:	Single/Double:	\$135.00
	Triple:	\$145.00
	Quad:	\$155.00

*This special group rate will be extended to attendees 3 days prior to and after the conference. Reservations must be called in to take advantage of the extended rates.

*A special rate for ADARA of \$8.00 is being offered for self parking with In-and-Out privileges.

[CLICK HERE TO MAKE RESERVATIONS ONLINE](#)

& then click on [check availability](#) to get to ADARA Conference registration page

Or

Call Toll Free:

1-800-228-9290 (use relay option of your choice, if needed)

Group Code (For Call-In Reservations Only): ADARA

RESERVATIONS MUST BE MADE BY MARCH 22, 2011

Did you know

Certain forms of mental illness (e.g., schizophrenia, mania, dementia) cause specific language dysfluency symptoms in hearing and deaf people. The nature of these symptoms, at times, is quite different from the language "symptoms" (patterns) associated with deprivation-caused dysfluency. Distinguishing between deprivation-caused dysfluency and mental illness-caused dysfluency is one of the most interesting and challenging aspects of mental health work with the deaf population because hearing people virtually never have deprivation-caused dysfluency. For this reason, few mental health clinicians outside the field of deaf services have any knowledge of this issue or ability to make such differential diagnosis. - Robert Pollard, Ph.D. Director, Deaf Wellness Center at the University of Rochester School of Medicine

**Alabama Department of Mental Health
OFFICE OF DEAF SERVICES**

Presents:

Important Note: Limited to 25 participants. First come, first served.

**Congenital Rubella Syndrome
Late Manifestations:
New Challenges for Rehabilitation and
Mental Health Providers**

DECEMBER 17, 2010

8:00 a.m. – 12:00 p.m.

Location: DMH Central Offices, Montgomery, AL

AUDIENCE:

Clinicians and case managers working with Deaf people, mental health interpreters, community interpreters, substance abuse counselors, other mental health professionals

Presenters:

Laura Burg and Janis Friend

Laura Burg is the Clinical Specialist for Deaf and hard of hearing adults for central Kentucky. Her primary responsibilities include individual, couple and family therapy with persons who are Deaf/hard of hearing. Other responsibilities include education for mental health professionals and the general hearing population regarding Deaf/hard of hearing issues, as well as education for the Deaf/hard of hearing community regarding mental health issues. She has been working in this capacity for more than 10 years. Prior to her current position, she worked with people who have developmental disabilities and/or people with chronic mental illness. She has also worked with the Deaf/hard of hearing population as an interpreter and dorm supervisor. After noticing a trend in some of her current clients, she began to do research on CRS and now is trying to spread the word about CRS to increase awareness.

Janis Friend is the branch manager for deaf and hard of hearing services within the Kentucky Office of Vocational Rehabilitation (OVR), a position she assumed 3 years ago. Prior to that, she was the Helen Keller National Center affiliate and coordinator of deaf-blind and deaf at risk services for OVR for 17 years, and a counselor for the deaf for 3 years. She earned a B.A. in Art and Secondary Education from Lipscomb University in Nashville and completed a graduate program in Deaf Education from Eastern Kentucky University and completed a graduate program in Deaf Education from Eastern Kentucky University. She also completed certificate programs in Deaf Blindness from Northern Illinois University and Rehabilitation Administration from San Diego State University.

PURPOSE:

It is estimated that 12.5 million individuals were infected with the Rubella virus during an epidemic in the mid-1960s. As a result, approximately 20,000 babies were born either deaf, blind, or deaf blind, many with additional disabilities. These children were classified as having Congenital Rubella Syndrome (CRS). A vaccine was developed in the late 60s, and Rubella was declared "eliminated" in the United States in March 2005. However, recent reports have emerged showing that many individuals born with CRS are exhibiting late manifestations of the virus ranging from diabetes and thyroid conditions to significant psychological problems. This has significant implications for clinicians working with deaf people who have substance abuse problems or mental illness. This presentation will focus on some of these symptoms and their effect on the individual as well as some of the research being conducted into this devastating development.



CONTINUING EDUCATION CREDIT:

The Alabama Department of Mental Health is an Approved Registry of Interpreters for the Deaf (RID) CMP Sponsor for Continuing Education Activities. This professional studies program is offered for a total of .4 CEUS at the "some" content knowledge level for CMP and ACET Participants. Activity Numbers: TBA

3.5 Continuing Education Units are offered by the Alabama Alcohol and Drug Association

- Alabama Alcohol and Drug Abuse Association (AADAA)
- Alabama Alcoholism and Drug Counselor Certification Board
- Alabama State Board of Social Work Examiners
- National Board of Certified Counselors (Provider #5581)
- Marriage and Family Therapists
- Alabama Board of Nursing – nurses must sign in at the beginning and the end of the training and provide their licensee number.

See below for more information or to request special accommodations

Mail registration to:

Office of Deaf Services

PO Box 301410, Montgomery, AL 36130

334.353.4703 Voice or 334.239.3558 VP

shannon.reese@mh.alabama.gov

Detach here, fill out and fax, mail or email back the application below

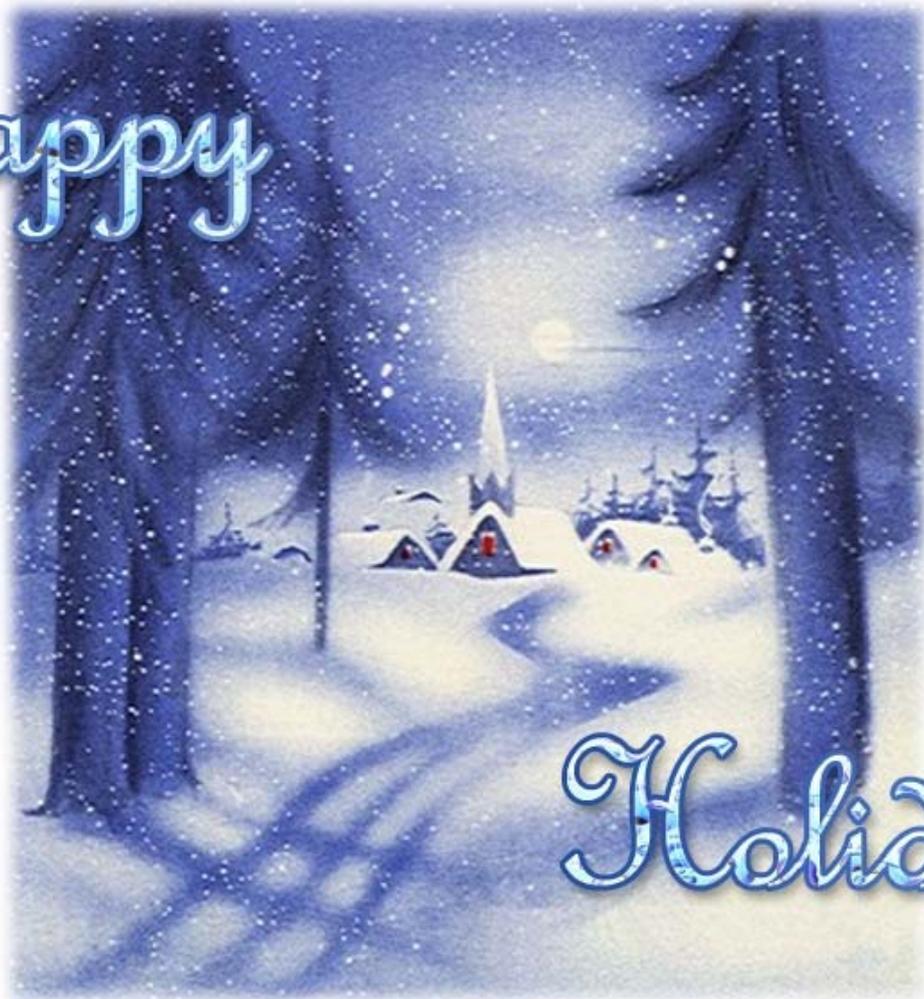
Important Note: Limited to 25 participants. First come, first served.

Congenital Rubella Syndrome Late Manifestations

Deaf Services Training Series

Name	Deaf	Hearing	H/H
Address			
City	State	Zip	
Telephone Voice VP TTY ()	Fax ()		
Pager ()	Mobile Phone ()		
Email	Additional Info		
Type of CE credit requested: AADAA <input type="checkbox"/> , AADCC <input type="checkbox"/> , ASBSW <input type="checkbox"/> , NBCC <input type="checkbox"/> , MFT <input type="checkbox"/> , ABN <input type="checkbox"/> , RID CMP <input type="checkbox"/>			

Happy



Holidays

From all of us at the
Office of Deaf Services

Joyce Corvann

Shannon E Reese

B. Cruz

LeAnn Stoumire Jr.

Ben Hambrick

Chad Fry

Ben Holt

Sereta Campbell

Donna M

Heidi Dancy

Jim Peterson

Dan M

Louise Rasmussen