

Signs of Mental Health



Benefit Raises Money for Consumers

Volume 9 Number 1&2

May, 2012



IN THIS ISSUE

Darling Named EOQ	2
AAD, ODS Partner to Raise Money for Deaf People with Mental Illness	3
Community Options Expand in the Midst of Changes	4
Federal Court Rules Interpreters Are Not Equal Access	5
Changes in Deaf Services Still in Flux	6
Why State Budget Cuts Hurt Social Services Most	6
ODS Presents Domestic Violence Training	7
From the ODS Case Files	8
On The ODS Bookshelf	9
As I See It	11
Notes and Notables	12
Reece Give Presentation, Meets Author	12
Current Qualified Mental Health Interpreters	12
Employment Opportunities	13
NASMHPD Consensus Planning Conference Successful	14
<i>Signs of Mental Health</i> ADMH, Office of Deaf Services Zelia Baugh, Commissioner Steve Hamerdinger, Director P.O. Box 310410 Montgomery, AL 36130 steve.hamerdinger@mh.alabama.gov	

On The Cover:

On the Cover: Left to Right: Shawn Stinson, ADMH, internationally known Deaf personality John Maucere, Steve Hamerdinger, ODS Director, and Jeff McManus from Columbus, South Carolina share a moment after the Friends of Deaf Services benefit golf outing. See story on page 3.

Mea Culpa.

This issue of *the Signs of Mental Health* is a “double issue”, primarily because we didn’t publish our usual March stanza. We just got busy and **SOMH** fell lower and lower on the priority list. Like all state agencies, ADMH is suffering from too much work, too little money and not enough people to do all that needs to be done.

That said, there is a lot to catch y'all up on, as we say down here.

Two new homes for deaf people opening lead off the stories this month. That more than doubles the ASL-fluent residential options deaf people have in Alabama. That story starts on page 4.

Meanwhile, next door in Georgia, a Federal Court has found that the Department of Behavioral Health and Developmental Disabilities has not served deaf people appropriately. Read the whole story on page 5.

One thing the Editor loves to do is brag on ODS staff. There is a lot to brag about! Another Employee of the Quarter! Several staff-written publications, including a book chapter, have been released since our last edition. More are coming. All that and presentations galore are reported throughout these pages.

Former New York Mayor, Ed Koch, was famous for asking, "How am I doing?" Hope you enjoy this issue and we would love to hear from you about how we are doing. ✍

Employee of the Quarter Is a Darling...

Wendy Darling, Region III Interpreter, is indefatigable. Whatever is needed, wherever it is needed, whenever it is needed, Wendy will volunteer to do it. She does it out of compassion for people that not many others are willing to attend. She is the only person in DMH who holds a national certification to work with people who are both deaf and blind. She did this of her own initiative, not because it was a job expectation.



She will often analyze a problem and come up with a solution before others notice that there is a problem. She sees it and fixes it before it rises to the level of consumer complaints. These fixes are almost always at no cost to the state (she has been known to pay for things out of her own pocket rather than to leave a situation without dealing with it.) Finally, Wendy does both the above because it is her nature. She is a ball of positive energy that simply cannot help but go out of her way to spread cheer. ✍

ODS Region II Interpreter Coordinator Wendy Darling was named Central Office Employee of the Quarter for the third quarter of FY2012. Pictured at left with Commissioner Zelia Baugh (right).

AAD, ODS Partner to Raise Money for Deaf People with Mental Illness



Jeff McManus and Steve Hamerding discuss a putt, or so they claim.

Did you know that AAD has a special project to help deaf people who have mental illness? It's called the Friends of Deaf Services, and they seek raise money to help deaf people with mental illness or substance abuse problems get re-established in the community after treatment. Sometimes, the deaf consumer needs some clothes. Sometimes it's about a haircut. Sometimes it is just as simple a thing as making sure that there is a present on Christmas. Regardless, FODS is trying to make things a little better for some of the Deaf Community's most forgotten members.

When a person has mental illness, they often lose jobs, homes, friends and sometimes even family. After treatment, they face a long

hard road to recovery. FODS exists to help make that trip a little easier. They help with needs that are unusual and can't be funded any other way. FODS also can help arrange recreational activities and fun events to make life a bit more normal.

On Sunday, March 18, AAD promoted the first ever golf benefit for FODS. It was held in conjunction with AAD's Deaf Awareness Week Mini-Conference. The benefit was made possible by Sprint, thanks to Regional Representative Mindy McManus. Her husband Jeff was on hand to participate and remarked that he had "a great time and hope we will do this again." Sprint donated the entire cost of the greens fees and prizes for the 12-player field so that 100% of the fees charged to the player went to the FODS program.

The tournament featured internationally known deaf personality, John Maucere, who graciously joined to support the cause. Altogether, close to \$1,000 was raised by this event.

Tournament Chair, Paul Kulick and ODS Director, Steve Hamerding are already talking about organizing another tournament next year, with a bigger field. *✍*



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

Scott Staubach, 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)



Community Options Expand in the Midst of Mental Health System Changes



Civitan House in Clanton

After a long trip from the BDU to Jackson Place on March 26th, the consumers' faces were brightly lit when they saw their new home. They were so excited to have their own rooms and to meet the staff. They shared that they felt good and were relieved to be out of the hospital. For the past two months, they've been learning how to cook and do chores with assistance from staff. They've enjoyed going shopping, visiting the local park and lake, and even going on a trip to Birmingham to see the JBS Art Show. They are really enjoying this moment in their lives and the staff at Mountain Lakes are honored to be a part of it.

Two new homes for deaf people have opened this spring, doubling the number of community residential beds available to deaf Alabamians with mental illness. The new homes, with three beds in Woodville, and six beds in Clanton, were designed to be deaf-friendly and are staffed entirely with ASL-fluent people.

The Woodville home, called Jackson Place, is operated by Mountain Lakes Behavioral Health Center and is intended for older deaf people. It opened for consumers on March 26, 2012. The home, located about 20 miles from Huntsville, is a three-bedroom, two bath brick house set on a large lot. Three consumers moved there from the Bailey Deaf Unit. The home is run by Mark Moore, who prior to his appointment as home manager, was one of the Deaf Care Workers at BDU. Working with Mark is an all ASL-fluent staff. Mark described the consumers' first day at the home this way:

MLBHC also took the extra step of hiring a special case manager for deaf consumers, Beth Hartman, who was a Vocational Rehabilitation Counselor for deaf people in Tennessee before moving to Alabama. Erica Wasserman, Director of Resident Services at MLBHC told SOMH, "We're getting started with planning some future trips now, including the Space & Rocket Center and Helen Keller's birthplace. The staff are just as excited as the consumers. I include myself in that!"

(Continued on page 11)

A large deck in the back of Jackson Place makes for a great cookout. Alas, the boat was NOT included when MLBHC bought the house!



Jackson Place in Woodville

Federal Court Rules Interpreters Are Not Equal Access

The Georgia Department of Behavioral Health and Developmental Disabilities was recently hit with a summary judgment holding that they discriminate against deaf people.

U.S. District Judge Richard Story, of the Northern District of Georgia, issued the ruling which held that the state has failed to provide appropriate group home care to such individuals, and does not have enough mental health care practitioners who are proficient in American Sign Language. In his ruling he pointed out that, "Deaf consumers, because of their deafness, and as a result of several institutional failures on the part of the state, are denied meaningful access to the mental health care services provided by the state to the general public."

In particular, Judge Story held that, "The 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."

The lawsuit, filed on behalf of all deaf people in Georgia, was initiated by Gale Belton, the mother of one of the plaintiffs. She was joined by the family of Matthew Erickson and the suit was certified as a class action suit.

According to the order, "The two named Plaintiffs are deaf adults who are in need of behavioral health services due to severe mental illness and developmental disabilities. Plaintiff Renita Belton suffers from several mental and developmental disorders, including Major Depression, Obsessive Compulsive Disorder, Mild Mental Retardation, and Mitochondrial Disorder. Belton's most serious and urgent need for behavioral health services stems from her depression; she currently requires 24-hour "awake" care due to the risk of harm she poses to herself and to others. Similarly, Plaintiff Matthew Erickson has been

diagnosed with Bipolar Disorder, Obsessive Compulsive Disorder, Asperger's Syndrome, Oppositional Defiance Disorder, and Pervasive Development Disorder Spectrum. Both Plaintiffs depend on American Sign Language ("ASL") to communicate with others."

Interestingly, the decision cited Georgia DBHDD staff, Dr. Charlie Bliss and Dr. Barry Critchfield testifying that, "Communication between patient and practitioner is central to the provision of mental health care, and that for a deaf consumer to effectively communicate with the practitioner the practitioner must be proficient in ASL. These experts further testified that the State's current reliance on interpreters to act as intermediaries between deaf consumers and hearing practitioners is an inadequate substitute for ASL-fluent practitioners. Most importantly, Dr. Critchfield testified that communication between a deaf patient and hearing practitioner, aided by an interpreter, is not equal to communication between a hearing patient and a hearing practitioner."

The theory is not novel. The same position was held in U.S. District Court in the Southern Division of Florida. In a 1994 decision in the matter of *Tugg v Towey*, Judge Moore, holding that interpreters are not equal access, ordered "The provision of mental health services for the deaf by HRS in District XI serving Dade and Monroe counties shall include, to the extent available in the community, mental health counselors, deaf or hearing, with sign language ability, who possess by training, education, or experience, an understanding of the mental health needs of the deaf community."

Alabama's *Bailey v Sawyer* was based, in part, on the same legal theory behind the *Tugg* decision.

The plaintiffs' attorney, Lee Parks, was quoted in an Atlanta Journal-Constitution article as estimating that the case could affect thousands of deaf people.

"This will change the way deaf and developmentally disabled folks get health care, fundamentally, in

(Continued on page 11)



Changes in Deaf Services Still in Flux

Last January, there was an article about plans the Alabama Department of Mental Health were making to close the Bailey Deaf Unit and shift operations to a more consumer-focused step-down program. The thinking at the time was that ADMH would use vacant buildings on the campus of what used to be Partlow Developmental Center and when residents had psychiatric emergencies they would be able to go to the new psychiatric hospital being built a short distance away to replace Bryce Hospital, taking with them supports from the transition program. This was before it became obvious that a huge reduction in General Fund dollars available for services through state agencies was looming.

While still unsettled – voters have to approve of a \$126 million dollar fund transfer from the Alabama Trust Fund to the General Fund in a special election in September – the state will be operating with about 12% less money than last year. The situation for the Department of Mental Health, in general, and the Division for Mental Health and Substance Abuse is even more dire. (See Sidebar)

ADMH leaders have been debating since mid-February how to make the numbers work. It was decided that closing state hospitals is the only way to take those cuts without more than 10,000 people losing mental health service. True, some state employees would be laid off and about 1,000 people living in the hospitals would have to be transferred to services in the community, but that is better than cutting money to community services. In theory, no person would be without access to hospital services if we close the hospitals since there are many private hospital options. Many people would lose community services if state dollars remained in state-operated hospitals.

An important concern in closing the state-run hospitals is that it removes part of the vital “safety net.” For deaf people, this is especially true. For years the Bailey Deaf Unit has served as a place where deaf people have a safe harbor in ASL. It will close. Hearing people will be able to go to special “crisis units” or acute care programs for hearing people run by the private sector through designated mental health facilities or contracts with private medical hospitals. None of these programs will be designed for deaf people. Since all those programs are run by private companies and not ADMH, they would not be bound by the same strict rules we have for the state-run hospitals. This means communication and treatment from sign-fluent therapists will not exist and access to any interpreters – let alone qualified mental health interpreters – will be at about the same level the deaf community is used to when they go to medical hospitals – somewhere between bad and horrendous. There are valid concerns that deaf people who are hospitalized in those private programs will have little or no communication access and that the stress of being in an inaccessible placement will exacerbate their symptoms and they might even leave in worse shape than they were admitted. Medication becomes a substitute for treatment—in effect a form of chemical restraint.

(Continued on page 15)

Why State Budget Cuts Hurt Social Services Most

Much ink has been spilled in Alabama over just how bad the budget crisis really is. Numbers thrown around in the press and on blogs have quoted everything from around 10% to up to 30% fewer dollars than in years past.

As Mark Twain was quoted to say, "There are lies, damned lies, and statistics." A no less pithy way of saying it would be, "it depends on what the meaning of 'is' is."

A very large chunk of the state budget is tied up in matching funds for Federal dollars, specifically for Medicaid services. A very large percentage of the population in Alabama gets some or all of their medical services through the Federal program, which requires that the state pay a portion of the costs while Washington picks up the lion's share.

When programs that are entirely state-funded, say, the Alabama State Tourism Board, are reduced 20%, it's a reduction of 20% in services. Ditto for many things that are operated entirely with state dollars, like prisons.

But when services that leverage Federal money, like Family Services, or Public Health, and yes, Mental Health, are reduced, the actual loss of services can be many times the dollar amount of the reduction. In the case of mental health services, the loss averages two federal dollars for every one dollar cut by the state. Thus felt loss is three times as big. When the state has to cut \$1.00 from Mental Health services, the consumers get \$3.00 less service.

This pressures the state to cut only programs which are funded by state dollars and protect programs that are funded through match programs. Thus cutting state-operated hospitals, which are 100% state dollars, "hurts" fewer people than cutting community services, which are largely Medicaid funded. 

ODS Presents Domestic Violence Training for Clinicians Working with Deaf People



The Office of Deaf Services hosted a two-day training on Domestic Violence and Deafness February 9-10, 2012 with presenters Angela Kaufman and Amanda Somdal.

Domestic violence is the leading cause of injury to women between the ages of 15 and 44 in the United States and one in four women will experience domestic violence in her lifetime. This is true for individuals who are deaf as well.

While no hard and fast statistics exists for the deaf community, in 2009 there was a combined 31,952 reported domestic violence assaults that occurred in Alabama. By extrapolation, based on a rate of 8.6%, we can estimate that there are approximately 2,478 people with hearing loss included in these statistics. By using prevalence rates from Gallaudet Research Institute (.18%), that number would include approximately 60 individuals who are culturally Deaf in the state of Alabama who are victims of domestic violence.

Kaufman is a certified interpreter and serves as an ADA Compliance Coordinator for the City of Los Angeles Department on Disability in the Disability Access and Services Division. In addition to expertise in ADA compliance and emergency response, Kaufman has presented on violence related issues with persons with disabilities: including child abuse, domestic violence, dating violence, rape, sexual assault, stalking, hate crimes, and elder abuse.

Somdal is a licensed clinical social worker and the director of My Choice Counseling Services. She also works at Five

Acres Deaf Program as a home based therapist. She has worked with sexual assault survivors for over 20 years and with deaf batterers (both men and women) for the past 9 years.

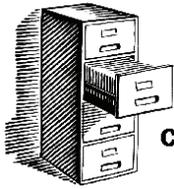
The trainings were held at the Alabama Public Library in Montgomery and both were well received.

The first day, February 9th, focused on domestic violence service provision within the Deaf community for providers who do not specialize in working with deaf people and usually have very little exposure to deaf individuals. The day was spent educating them on types of hearing loss, the unique demands of serving deaf individuals, considerations for language and cultural differences, and requirements under the *Americans with Disabilities Act (ADA)*. Discussion also included the unique dynamics of deaf and hearing relationships and how these play into domestic violence settings.

The second day, February 10th, focused on domestic violence within the Deaf community for providers who are either deaf themselves or who work in the field of deafness. The presentation was taught in American Sign Language. The day was spent on systemic considerations for work within Domestic Violence settings, including awareness of anonymity in order to protect the clients and self awareness.

Both groups participated in a role play based on the game "chutes and ladders" in which all participants played the

(Continued on page 10)



From the ODS Case Files: Challenging Cases, Creative Solutions

An adult Latino male who is Deaf, Mr. Sordos, and uses sign language, gesture and some mouthing to communicate. He is diagnosed with Psychosis NOS with reported history of auditory hallucinations. Assessment was concluded via chart review, direct observation, previous communication assessment, and personal interview.

Language Usage:

Use of expressive and receptive American Sign Language (ASL) is described as basic, atypical and dysfluent. Much of his expressive language is gestural in nature, and he often can make himself understood in this manner. Vocabulary items are sometimes produced with incorrect features (morphemes), such as wrong palm orientation, incorrect handshape, etc.

Mr. Sordos demonstrated the ability to respond appropriately to very basic questions such as "Are you Deaf?" and "What is your name?" He was not able to respond to other questions such as "Where do you live?" or "When did you move to the U.S.?"

His language usage was missing topic and time indicators. Mr. Sordos does understand the use of the sign "past" but it can mean any time in the past. He does not demonstrate understanding of now or future.

He often smiled and nodded his head when asked a yes/no question. For example: he smiled and nodded yes when asked if he grew up in Alabama.

Occasionally Mr. Sordos would use signs that are atypical (not gestural), such as "R on the nose" which seemed to indicate someone who was associated with a hospital. Another example is "X on the chin" which might mean "lie" or "rude." It was unclear if some of the vocabulary items used were of Puerto Rican origin.

It has been observed that incorporating mouthed Spanish words, accompanied by signs, has been somewhat effective, i.e. sign for "school" accompanied by "escuela," "brother/sister" with "hermano/hermana."

Background Information (related to language development)

Etiology is reported as hearing loss as a result of a high fever when he was a young child. (This could include scarlet

fever, meningitis, or various other causes, some of which may have implications for language development/use.)

Mr. Sordos is the sole Deaf member in his family. He lives with his family, consisting of both parents, who speak only Spanish, and do not sign, a brother and a sister, both of which are English/Spanish bilingual, and reported to have some survival sign ability. The mother reports that she or her niece relays most information at appointments. Through observation, their communication strategies included a highly gestural and intimate knowledge based system with mouthing of isolated/common words by the consumer. The conversations were extremely limited and repetitive in nature.

Records indicate that Mr. Sordos attended a school for the Deaf in Puerto Rico, from 3rd grade through age 15. He appears to exhibit severe delays in language, despite having attended a specialized school. The language of instruction is not currently known.

There is recent evidence that the client was the victim of a car accident. Family reports that his attitude/anger control issues changed after this occurrence. It is unclear if language was also affected by this incident, or if language issues have been long standing.

There is report that Mr. Sordos suffers from auditory hallucinations. At the time of this report, deaf clinicians report there was no symptomological evidence to support this claim. One possible reason may be that the consumer uses a sign for "talk" (gestured with one or two hands - open/closed five handshape) that more linguistically sophisticated persons often use it to mean auditory hallucinations. It is extremely unlikely that Mr. Sordos would use this sign that way. It is probable that he uses that sign to represent **anyone** talking. When asked about auditory hallucinations through gesture, he responded with a vehement, "NO! (that's crazy!)"

Discussion on Language:

Language information related to Language Deprivation: (Glickman, 2007)

May possess fund of knowledge deficits, poor vocabulary, sign features formed incorrectly, may be missing topic-comment, clear referents, time indicators or grammar, repeated signs, isolated signs/phrases, use of 3rd person, inappropriate use of visual space.

Language information related to Traumatic Brain Injury (TBI):

(Continued on page 15)



Hot Off the Presses: Important Articles You Must Read

Øhre, B., von Tetzchner, S., Falkum, E. (2011) *Deaf adults and mental health: A review of recent research on the prevalence and distribution of psychiatric symptoms and disorders in the prelingually deaf adult population. International Journal on Mental Health and Deafness. 2011 Volume 1 Issue 1.*

Research on the prevalence and distribution of mental disorders in the prelingually deaf population is scarce. In 1999, an extensive literature review was published, containing prevalence studies published prior to 1994. A systematic search was made for research publications about the prevalence and distribution of psychiatric symptoms and disorders published between 1995 and 2011. Eleven studies were found, five with samples from the general population and six with clinical samples. Since 1999, studies of deaf individuals have improved methodically, especially with regard to assessment procedures and instruments. However, selection bias, lack of representative samples, and unmatched comparison samples still preclude firm conclusions on the prevalence and distribution of psychiatric symptoms and disorders in the prelingually deaf population. This means that in order to gain a better understanding of the impact of prelingual deafness on mental health, studies with more representative samples and better matched samples in comparisons are needed.

Crump, C. & Glickman, N. (2011) *Mental Health Interpreting with Language Dysfluent Deaf Clients. Journal of Interpretation, 21 - 36*

Many deaf persons served in mental health settings show significant language dysfluency in the best language, usually ASL. Sign language dysfluency in deaf people has four major causes: neurological problems associated with the etiology of deafness, language deprivation, aphasias, and psychotic disorders. Each cause can effect language development and usage in a particular way. In this article, numerous examples of sign language dysfluency are offered along with a discussion of their implications for interpreting, especially in mental health settings. The authors draw upon the Demand-Control interpreting approach of Dean and Pollard to illustrate interpreter decision-making when faced with the challenge of dysfluent language. The advantages and disadvantages of collaboration with deaf interpreters are reviewed. Finally, suggestions for best practice in interpreting for language dysfluent deaf persons in mental health settings are reviewed.

Schild, S. & Dalenberg, C.J. (2012): *Psychoform and Somatoform Dissociation and PTSD in Deaf Adults, Journal of Trauma & Dissociation, 13:3, 361-376*

Both deafness and dissociation disconnect people from certain aspects of the external environment. Dissociation among the deaf population has been largely neglected as an area of scientific investigation. The purpose of this study was twofold: first, to examine the psychometrics of 2 dissociation measures—the Dissociation scale of the Trauma Symptom Inventory (TSI) and the Somatoform Dissociation Questionnaire–20 (SDQ-20); and second, to evaluate the relationship between dissociation and posttraumatic stress disorder (PTSD) in deaf adults. A diverse sample of 79 deaf adults was assessed using the Clinician-Administered PTSD Scale, the TSI, and the SDQ-20. Results provided support for the concept of psychoform dissociation, as measured by the TSI Dissociation scale, in deaf adults. However, somatoform dissociation, as measured by the SDQ-20, showed lower internal consistency. The SDQ-5, a shortened version of the SDQ-20, was unreliable in the current sample. Deaf adults were significantly higher on psychoform dissociation than the norm samples of hearing adults. As in hearing samples, dissociation—both psychoform and somatoform—was significantly related to PTSD symptoms. In addition, those with dissociative PTSD displayed significantly more symptoms of depression, anger, impaired self-reference, tension reduction behavior and somatoform dissociation than did the nondissociative PTSD group.

Schild, S. & Dalenberg, C.J. (2012) *Trauma Exposure and Traumatic Symptoms in Deaf Adults. Psychological Trauma: Theory, Research, Practice, and Policy, Vol. 4, No. 1, 117–127*

While existing research suggests vulnerability of the deaf community to trauma, very little data exists on prevalence, symptom manifestation, and/or unique characteristics of the response of deaf adults and children to traumatic events. In this research, 79 deaf adults were interviewed with the Clinician Administered PTSD Scale, the Life Event Checklist, the Trauma Symptom Inventory, the Peritraumatic Distress Scale, and the Somatoform Dissociation Questionnaire. The average number of unique trauma types experienced per participant was high, averaging 6.18 (SD 2.65). Findings supported the dose-response model for trauma. Vulnerability factors included number of traumatic events, race/ ethnicity, sexual orientation, additional disabilities, prior substance abuse, and low social support. Higher levels of trauma exposure were associated with more depression, anger, irritability,

(Continued on page 16)

Domestic Violence Training

(Continued from page 7)

beloved pet who were in a marriage to a hearing male, showing increasing indications of domestic violence. Participants had various resources and were directed through a system from the perspective of a deaf person. This activity helped both sets of providers to understand the challenges that a deaf person faces. Some examples include lack of communication accessibility or inappropriate interpreting, and include the following:

- Police called to a domestic violence setting
- Court hearings
- Social worker visits
- Child Welfare services/DHR
- Shelters
- Family and friends
- Temporary housing, including apartments/hotels
- Emergency rooms
- Therapy
- Drug/alcohol management
- Batter's intervention program

In each of these settings, the potential for utilization of the offending spouse or children for the purpose of communication exists. Sometimes, even in these dire circumstances, deaf individuals are asked to bring their own interpreter and more often to make do with whatever communication options are available. Sometimes the violence is dismissed as a natural consequence of a deaf-hearing marriage.

The ADA, as amended states that the expressed choice of the



It's not easy to make your needs known when you have a "hearing loss" and can't "talk." An icebreaker activity simulates for hearing people how hard it can be to communicate when people around you are not able to understand you. This was one of several activities that reinforced the lessons taught during the training

individual with the disability, who is in the best position to know their needs should be given primary consideration in determining which communication aid to provide.

While technology has been a boon to the deaf community, it can also be used against a deaf person in abusive situations. Technology, including videophones, TTYs, cell phones, etc. can be broken or withheld as punishment. They can also be used to locate, track and harass a victim, to post private information or photos, to spam or flame a person.

Deaf service providers and interpreters also can play a role in the cycle of abuse. Considerations should be given not only to the provider's qualifications, but to the gender of the provider and of the deaf person, how deaf service providers or interpreters are contacted, their training to work in domestic violence settings, and the person's own experiences with domestic violence. Behaviors that may put the deaf victim further at risk include items such as being followed to the location, becoming a barrier, announcing their presence in some settings, etc.

The goal for the training was to increase awareness and competencies in both the hearing and deaf service provider populations who serve victims of domestic violence who are Deaf. Networking between Domestic violence providers, including others who work within this service spectrum and sign fluent providers who work in Deafness, will allow better opportunities and more competent services.

The presenters did an excellent job in helping our state with



Domestic Violence and Deafness with presenters Angela Kaufman (left) and Amanda Somdal discuss why hearing people find it challenging to work with deaf victims.

Community Options Expand

(Continued from page 4)



Like Jackson Place, all members of the direct service staff of the Civitan House are deaf. They are participating in a training and planning meeting. ODS staff interpreter Sereta Campbell (standing) assists.

The Clanton program, called Civitan House, opened for consumers April 23rd. This six-bed program is operated by Chilton Shelby Mental Health Center and is designed for consumers needing more concentrated programming. Like Jackson Place, the staff is entirely ASL-fluent and the home manager, Anita Moore, is an experienced group home director.

These programs add to the options deaf people with mental illness have for services. Jefferson-Blount-St. Clair Mental Health Authority also operates 12 beds and a day program for deaf people in the Birmingham area, while AltaPointe Health Systems operates a three-bed home for Deaf people in Mobile.

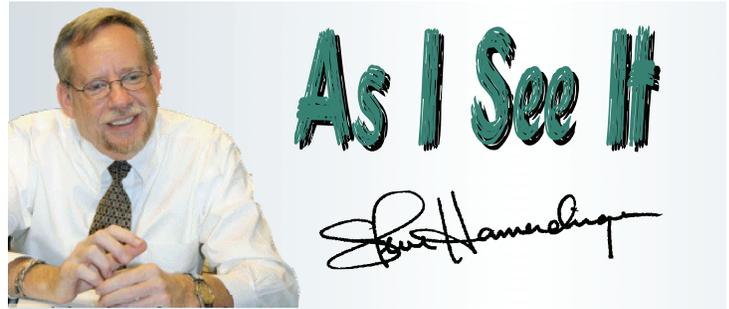
Additionally, there is a six-bed home for deaf people with developmental disabilities, operated by Volunteers of America (VOA) in Montgomery, which is not part of the system of care for people with mental illness, but is part of the services funded by ADMH. ✎

Federal Court Rules Interpreters Are Not Equal Access

(Continued from page 9)

Georgia," said Parks. "They've just been left aside. There's been a giant hole in the public health care system and we're getting it fixed."

Parks said he anticipates the remedy will require the state to set up programs to help prospective caretakers learn American Sign Language, and to make sure group homes are adequately staffed with the right professionals. Dr. Barry Critchfield, a nationally renowned expert on deafness and mental health has been named Director of Deaf and Hard of Hearing Services ✎



Most of the "Deaf Mental Health world" has been buzzing about the Federal Court decision in Georgia holding that the Department of Behavioral Health and Developmental Disabilities discriminated against deaf people by not providing equal access to services. (See story on page 5.) That's nothing new. That has been the outcome of every decision and the implied statement behind every settlement since the *Wilzack* decision back in the 80's.

What was surprising about the decision was the emphasis on how interpreters are not equal access. This, too, is not a new concept, having been first judicially articulated in the 1994 *Tugg* decision. Unlike *Tugg*, which had a "to the extent possible" qualifier, *Belton* was pretty blunt in saying that ASL-fluent clinicians are the only way deaf people can really have equal access and that interpreters do not cut it.

Part of why this is true can be seen in the case study published elsewhere in this issue. Reading through that study will demonstrate one of the primary problems with an overreliance on interpreters. Clinicians just do not have the schema to comprehend the complexities of that type of language deprivation. The multiple and varied diagnoses ranging from intellectual disability to schizophrenia, all trying to explain the same symptom set, demonstrates why the "run of the mill interpreter" is likely to make the problem worse not better. Hearing clinicians lack the training and experience to see the impact of language deprivation (not to mention cross-cultural issues) and think the interpreter is giving a gospel-pure translation of what the deaf person said. Since that "translation" will vary from interpreter to interpreter, clinicians do not factor in interpreter bias and attribute the "contradictions" to either cognitive disability or psychosis. As Maslow famously said, "When your only tool is a hammer, every problem begins looking like a nail."

Judge Story apparently understands it, or at least listened to the experts in mental health services with deaf people. Kudos. That's more than most mental health program administrators around the country do.

(Continued on page 16)

Notes and Notables

Several ODS staff members have given notable presentations. **Charlene Crump** did a two-day training for interpreters on dealing with Dysfluency Kentucky April 20–21. Her training, Sign language Dysfluency in Deaf Persons: Implications for interpreters and clinicians in mental health settings, was attended by more 90 people, It was split into two parts, one for interpreters and one for clinicians. Crump has authored two recently published peer-reviewed articles related to this area of study.

Shannon Reese was invited to present on sexual abuse prevention at the Virginia School for the Deaf and Blind in Staunton, VA on April 27, 2012. (See side bar.) She has extensive experience working in the area of Sex Abuse Prevention with deaf kids and ODS was pleased to be able to partner with VSDB to make this possible.

Brian McKenny was a guest on Keith Wann’s Cultural Bridges Radio show on March 7, 2012. The topic was Mental Health Interpreting” and Brian was able to share his knowledge and experience with a nationwide audience. You can listen to the podcast here: <http://toginet.com/podcasts/thatkeithwannshowculturalbridges/>



Presenting at VA School for the Deaf Gives Reese a Chance to Meet Author

By Shannon Reese

Back in February, I was asked by Rebecca Plesko-DuBois of Virginia School for the Deaf and Blind to give a presentation on sexual abuse prevention. I was honored and thrilled since I’ve been working in this field for a while. Then to discover that my favorite author would be presenting after me was even more exciting for me. As I prepared for the trip, I talked with Rebecca and she shared with me about her grant she was able to get from ICAP (International Child Abuse Prevention) to set up activities for April since April is Child Abuse Prevention month. She explained to me that ICAP had given her permission to tweak the curriculum so deaf and hard of hearing children could understand in American Sign Language.

In addition to my presentation, I was able to meet a great group of volunteers who shared their time in practicing the skit for several age groups. They did a great job of involving the kids and stressed three words-STRONG, SAFE, FREE. These three words are encouraged to build self-esteem and emphasize the importance of telling an adult if they have been touched inappropriately. After my presentation, I met with representative s from various agencies who told me they had no idea the statistics were that high and especially VA’s policy on what abuse means in the community.

One of the highlights of the trip was that I was also able to meet with Joyce Allan. She wrote the book, “P.S. Because I Love You” about her deaf father, who was a perpetrator. I encourage you to read the book if you haven’t already done so. ✍

Left: Shannon Reese presents at VSDB on April 27th.

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*)

Charlene Crump, *Montgomery*
Denise Zander, *Wisconsin*
Nancy Hayes, *Remlap*
Brian McKenny, *Montgomery*
Dee Johnston, *Talladega*
Debra Walker, *Georgia*
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 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*
Bridget Bange, *Missouri*
Julayne Feilbach, *Wisconsin*
Sue Gudenkauf, *Wisconsin*

Positions Available In Deaf Services

Office of Deaf Services

DEAF CARE WORKER (Tuscaloosa)

SALARY RANGE: 50 (\$21,722.40 - \$30,724.80)

Works primarily in a specialized psychiatric unit providing care, habilitation, and rehabilitation of deaf and hard of hearing (D/HH) patients with co-occurring disorders of mental illness and chemical dependency in a state mental health hospital. Performs basic nursing care and assist patients with personal hygiene and activities of daily living. Observes patients closely and documents patients' physical and mental condition. Maintains the security of patients. Accompanies patients off unit to hospital activities, functions, and off hospital grounds to medical appointments and field trips. Communicates with D/HH patients in sign language. Performs assigned work under supervision of professional nurses and LPNs with instructions from physicians. Performs related work as required.

NECESSARY SPECIAL REQUIREMENTS: Must be 18 years of age. Graduation from a standard high school or GED equivalent. Possession of a valid Alabama Driver's License. Proficiency in American Sign Language (ASL) at "native" or near "native fluency" level of signing skills as measured by a recognized screening process, such as SLPI/SCPI at the "Advanced" level or higher.

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)

Deaf Services Group Homes

MENTAL HEALTH TECHNICIANS (Birmingham area)
(\$8.00/hr Part-Time \$7.50/hr Relief)

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 Galliher, MACN

Director of Deaf Services

JBS Mental Health Authority

956 Montclair Road, Suite 108

Birmingham, AL 35213

205-380-4367(Voice)

205-623-0361(TTY)

mcates@jbsmha.com

Importance of Incidental Learning

By Doug Dittfurth

Intrigued by the challenge in defining how incidental learning plays a role in our lives and why professionals working with people with various hearing losses need to keep this in the forefront when advocating for services for this population, I wanted to find a way to get this message across. This is of special importance to me, as an advocate, to apply the concept of "incidental learning" to mental health counseling to emphasize that verbal knowledge is not connected to intelligence. One technique that has proven popular and successful is the sharing of the results of my "Airforce One" survey.

I surveyed 40 people whose hearing status were thought to me to "normal" and 40 people whose hearing loss/deafness was known to me as being severe-to-profound from an early age. Both groups had an even mix of master/bachelor and/or high school degrees. Each subject (n =80) was shown an 8.5 x 11 piece of paper onto which the words AIRFORCE ONE had been printed. While reading the words AIRFORCE ONE, they were to spontaneously express the thoughts that came to their minds.

Of the 40 who were "hearing," 100% relayed in one way or another it was the plane in which the President flew. Only one could remember how or when he actually learned this information.

Of the 40 who were "deaf/had severe hearing loss," 15 percent more or less replied that it was the plane in which the President flew. Eighty-five percent of the subjects replied with "military", "first military", "something to do with military", and the like.

Of the six individuals (congenital/early onset deaf/severe hearing loss) who knew, all readily told me the reason they had learned Airforce One was the "President's plane." One stated he was an air force military brat; one learned of it when Airforce One landed in his hometown and his father took him to see it as a middle school aged child. Another learned it as an adult when they viewed a captioned version of the movie, "Airforce One"; one stated he was a social studies teacher and learned it himself as an adult; one replied, "I read everything I can;" and another replied that her mother had told her sometime prior to entering high school.

As proven above, incidental learning plays a big role in the information we possess. Yet I, as a hearing individual, can learn several things daily on my short commute from my gym to my office by just listening to my car radio. Multiply that by a decade and you have not even begun to uncover the amount of incidental learning a deaf/severely hard of hearing person must make up to have the knowledge base and fund of information to be as competitive and as responsive as those who can hear. 

Reprinted from The ADARA Update

NASMHPD Deaf Mental Health Research Priority Consensus-Planning Conference Concludes Successfully

(Editor's Note: ODS Director Steve Hamerdinger was one of the 22 people who took part of Consensus-Planning Conference. The following is a conference summary prepared by NASMHPD.)

A gathering of 22 individuals, including a diverse array of experts in the deaf mental health field, concluded a five-day meeting on January 29, 2012, having reached consensus on 34 research priorities in this neglected topic area.

Sponsored by NASMHPD and supported by SAMHSA funding, the conference was the first of its kind. The impetus for the historic meeting was the research knowledge gap impeding the development and implementation of linguistic and socioculturally appropriate mental health services for deaf individuals throughout the U.S. public mental health system.

Conference organizer Robert Pollard, Ph.D., director of the Deaf Wellness Center at the University of Rochester School of Medicine, explained that research in this area lags far behind because few are qualified to conduct quality research studies involving the Deaf community and because most research in this area over the past four decades has been focused on disproving erroneous perceptions regarding deaf people established in the professional literature prior to the 1970s, before American Sign Language (ASL) was finally recognized as a complex and fully-developed language quite unlike English.

The conference delegates consisted of prominent researchers in the field, several state-level directors of public mental health services for deaf persons, clinicians, consumers, and representatives from research funding agencies. One-third of the delegates were themselves deaf users of ASL, including the consumer representatives.

Each day, the conference focused on research priorities in a different thematic area: disease burden, treatment, and research infrastructure. Plenary presentations were interspersed, offering cutting-edge information relevant to the proceedings.

The consensus deliberation plan was rigorously structured. Three breakout groups, balanced in relation to the backgrounds of the individuals involved and the deaf-hearing participant mix in each group, first met to brainstorm research priorities relevant to the day's theme. In a subse-

quent plenary meeting, a spokesperson from each group explained the reasoning behind that group's priority list. Returning to their small groups, with the complete list of ideas from all three groups, delegates then winnowed the complete list down to their "top 10" priorities. The final priority list consisted of those ideas ranked in the "top 10" by two or all three of the small groups. Repeated for each of three days, this process yielded a total of 34 research priorities over the three thematic areas. Membership of the small groups was reconfigured each day, to promote the sharing of multiple perspectives and expertise, yet remained balanced each day as noted above.

While the list of 34 priorities was itself a valuable and historic outcome, the conference continued with another consensus-building step, aimed at turning the priority list into a blueprint for action. Each of the research priorities was subsequently rated on a two-dimensional "impact-feasibility" scale. Three small groups deliberated the "impact" each research idea would have on the public mental health system and the deaf mental health field if it were successfully accomplished. Then, each group debated the "feasibility" of each idea, that is, the degree to which cost, time, complexity, and other factors would affect the successful pursuit of that particular research priority. These impact-feasibility deliberations comprised the longest segment of the conference agenda, as it was considered imperative for the groups' conversations to yield a consensus-built opinion on the impact and feasibility of each idea. The plan succeeded; each of the three groups indeed reached impact-feasibility consensus on all 34 ideas.

In addition to noting the impact ranking of a given idea, the distribution of these research priorities across the feasibility range leads to important guidance regarding subsequent activities in this area. Specifically, priorities ranked highest in impact and feasibility are "low hanging fruit," likely to be pursued most quickly, perhaps by individuals or collaborators who may or may not be career researchers. Yet Pollard emphasized to the delegates that ideas high in impact but low in feasibility may be very much worth pursuing. Lower feasibility priorities may simply require more time, funding, or expertise to accomplish.

(Continued on page 16)

From the ODS Case Files

(Continued from page 8)

Deficits that can follow TBI include impaired attention; disrupted insight, judgment, and thought; reduced processing speed; distractibility; and deficits in executive functions such as abstract reasoning, planning, problem-solving, and multitasking. People who have suffered TBI may also have difficulty with understanding or producing language, or with more subtle aspects of communication such as body language.

Language strengths (ASL):

Strong gestural ability, affective facial expressions, understanding of and expression of “past” as a time marker in a general sense, knows some basic signs such as name, mom, dad, boy, girl, where, hospital, etc., willingness to participate in conversations and to ask questions.

Language weaknesses (ASL):

Grammatical facial expressions are not present, limited depth of responses or language use, does not use/understand time markers, except for “past” – limitedly, does not use pronouns or possessive pronouns appropriately, some sign misproductions or signs with incorrect morphemes, use of atypical/non-standard ASL signs, possible use of Puerto Rican sign language or culture-specific gestures, may utilize behaviors which are typically considered unacceptable/inappropriate as a substitute for communication, pretends to understand information.

Communication Strategies (for signing therapists and interpreters)

Individuals communicating with the consumer should avoid the use of questions which illicit a yes/no response, since this may give an illusion of understanding that is not present. Ensure understanding of material through the use of reframed questions, preferably in a wh-format. Prompting for response may be required. Having the consumer demonstrate application of the information is recommended.

For interpreters, strong gestural expressive interpreting supported by incorporation of basic sign vocabulary and mouthing of some basic spoken Spanish vocabulary with signs. Voiced interpretations in this setting may necessitate the use of 3rd person narrative and descriptive techniques weaved throughout the interpretation to deal with language

that is not readily understandable.

The therapist and interpreter will need to work together to ensure that understanding is happening. Information dependent on higher language levels may not be possible to secure without time intensive efforts.

Communication strategies precipitate the need for visual demonstrations of the environment, such as pictures of family, friends, staff and locations. Written schedules and announcements would benefit from iconic representations as well as incorporation of Spanish words to clue the consumer into the event (Example: pictures of food for meal times). Abstract concepts (including applicable rules) should be represented visually through emotion charts, drawings, pictures, color scales and role play, etc.

Utilize Certified Deaf Interpreter or Visual Gestural Communication Specialist when possible, or perhaps a tri-lingual (English-Spanish-ASL) interpreter

Changes in Deaf Services Still in Flux

(Continued from page 6)

None of this is happening in a vacuum. As the seriousness of the situation becomes more apparent to the general population, some effort has been directed at preserving some of the safety net for hearing people. As of press time, it appears that the new psychiatric hospital in Tuscaloosa will move forward, after being put on hold. Deaf consumers needing hospital options will go there. One important development is that ADMH has received permission to post five Deaf Care Worker positions in Tuscaloosa to meet this potential demand. (See column at left for more information.)

It also appears that North Alabama Regional Hospital will remain open as well. Searcy and Greil are still slated to close. (Taylor Hardin Secure Medical and Mary Starke Harper Geriatric facilities were not considered for closing under any of the previous scenarios.) . It also means that, in the long-term, some version of the plan that was outlined earlier this year is still on the table.

Given the magnitude of budget cuts for the coming year, it may be difficult to move it forward with Deaf Services until some time in the future. The leadership at ADMH is very aware and sensitive to this and several short-term remedies are being studied in an effort to create a safety net option that is linguistically appropriate for deaf people, taking advantage of the state programs that will remain open. The number of community beds opened since April is nearly equal to the number of beds that are lost due to the closing for the Bailey Deaf Unit. (See article on page 4.) ✂

NASMHP Conference Concludes Successfully

(Continued from page 14)

For a complete listing of the 34 research priorities, please visit www.nasmhpd.org. Correspondence regarding the NASMHPD Deaf Mental Health Research Priority Consensus-Planning Conference should be directed to Dr. Pollard at Robert_Pollard@urmc.rochester.edu or Meighan Haupt, NASMHPD Associate to the Executive Director, at meighan.haupt@nasmhpd.org. ✂

As I See It

(Continued from page 11)

So does that mean dancing in the streets for advocates of culturally and linguistically appropriate mental health services for deaf people? Not exactly. If anything, it brings to mind the old adage that we should, "be careful what we ask for, we might get it."

In the years immediately surrounding the beginning for the 21st century, there were numerous clinical training programs focused on producing ASL-fluent clinicians. Alas, those programs have all gone away except one or two exceptions. At the precise time that more and more courts are recognizing the need to deaf clinicians, opportunities for getting training have practically dried up. The deaf-specific programs across the country have dwindled to just Gallaudet University in DC.

There are a very small handful of well-trained people competing for an expanding number of clinical jobs. To an administrator of a deaf program in a southern rural state, this is the stuff of nightmares. To add monsters under the bed, the economic condition the country faces does not bode well for the possibility of federally-funded clinical training programs for deaf people coming back any time soon.

The administrators of the Alabama Department of Mental Health are trying to keep Deaf Services going in the face of incredible financial difficulty and that is a powerful commitment. Adding training programs for deaf clinicians is not something that is on the table. Yet we will need those programs if we are to hope to meet the standards set by *Belton*.

Deaf People in Georgia have won a magnificent victory. It will reverberate through mental health services for decades. **As I See It**, unfortunately for the rest of us, finding the clinicians without a "grow our own" plan is going to be tough hoeing. ✂

On The ODS Book Shelf

(Continued from page 9)

sexual concerns, tension reduction behaviors, and substance abuse problems. The unique trauma symptoms of deaf trauma survivors, including higher levels of dissociation, are discussed. A concept relevant to the deaf trauma community—information deprivation trauma—is introduced.

Fellinger, J., Holzinger, D., Pollard, R (2012) Mental health of deaf people. Lancet 2012; 379: 1037–44.

Deafness is a heterogeneous condition with far-reaching effects on social, emotional, and cognitive development. Onset before language has been established happens in about seven per 10 000 people. Increased rates of mental health problems are reported in deaf people. Many regard themselves as members of a cultural minority who use sign language. In this Review, we describe discrepancies between a high burden of common mental health disorders and barriers to health care. About a quarter of deaf individuals have additional disabilities and a high probability of complex mental health needs. Research into factors affecting mental health of deaf children shows that early access to effective communication with family members and peers is desirable. Improved access to health and mental health care can be achieved by provision of specialist services with professionals trained to directly communicate with deaf people and with sign-language interpreters. ✂

National Survey on Abuse of People with Disabilities (including the Deaf Community)

Please help get the word out to the deaf community and family members, interpreters, deaf or interpreter list serves, etc. so that we can ensure the deaf community experience is captured. This study has been in the works for many years. It is only now with current technology that we can attempt to capture the disability and deaf abuse experience with a very large sample.

Those leading the study are national experts in the areas of child abuse and violence against children and adults with a disability. I cannot speak more highly of those involved and know that the results will be used to help shed real data on the prevalence and experiences of children and adults with disabilities and will help to shape public policy and education requirements for those responding to victims/survivors of abuse.

Please help spread the word for the deaf community. Click on: www.surveymonkey.com/s/disabilityandabuse

2011 Mental Health Interpreter Institute August 6 - 10, 2012 Montgomery, Alabama



A collaborative effort between the
Alabama 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://mhit.org/2012institute.html>

**Class is Full
Applications for Wait List Now Being Accepted**

	March 31	April 1 May 31	June 1 July 30	after July 30	Day Rate
Participants	\$275	\$325	\$375	\$400	\$90
Alumni/Students	\$150	\$200	\$250	\$300	\$70

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

