A woman with glasses and a blue button-down shirt over a white top is shown from the waist up, signing. Her hands are positioned near her face, with fingers spread and palms facing each other. The background is a plain, light-colored wall.

Signs of Mental Health

Training Deaf and Hearing Interpreters To Work Together

Volume 6 Number 3

September, 2009

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

Editor's Notes:



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Alabama's Department of Mental Health officially dropped the "R" word beginning the first of August. Like most people, we think, "PAH!" It's long over due. The name change means many of the logos, seals, and trademarks need to be changed. We have a few such relics floating around in the *Signs of Mental Health*. We will get them all out sooner or later!

Now if we can just get people to stop writing "deaf - mute."

The change gives us a chance to freshen our look a little more, continuing our efforts of the past few issues. Nothing major, just a little touching up here and there... Let us know what you think.

The overall theme this issue is can be summed up as "language access for deaf people." There have been some important discussions around the country on how deaf people should be served by the mental health system. You will want to check out the stories for yourself.

We are pleased to help promote Breakout. Your editor was deeply involved in this conference series in the 90s and was the chair of the conference in 2000. It kind of faded away for a while and we are glad it's back. The call for papers is on page 10. 

New MHIT Website Launched

The Mental Health Interpreter Training Project launched its own website last summer in response to the need to keep participants and stakeholders informed on what is happening. The website, which is a volunteer project of the MHIT staff, is not affiliated with the official DMH website.

Information about training and practica can be found there as well as other information regarding the MHIT project.



You can access the website at www.mhit.org. 

Corrections:

One page 11 of the previous issue of the Signs of Mental Health, one of the staff members of the Princess Helen group home was misidentified as Jonathan Hollins. The name should have read Joseph Hollins. We regret the error.

On The Cover:

Carole Lazorisak leads an all day training for deaf and hearing interpreters on teamwork.

ADMH Drops “R” Word in Name Change

Over time, some words and terminology transform into slang or gain negative contexts that are offensive. The phrase mental retardation is a prime example of negative word evolution. Use of the “R word” is being dropped across the nation, on the state level and by advocacy groups; it is most commonly replaced with the term intellectual disability. Under the purview of the Commissioner, the department not only can, but did rename its Division of

Health. Commissioner John Houston said, “The department is thrilled to see the Alabama Legislature and the Governor take another major step in supporting the use of appropriate language for people with an intellectual disability. We hope this raises awareness in the general public about the use of people first language in their everyday lives.” People first language is the simple notion that one should always place the person before the disability. Self-advocates from People First



Mental Retardation Services to the Division of Intellectual Disability Services last year. However, in order to change the name of the department, legislation had to be passed.

Recently, Representatives Randy Davis and Joe Faust, and Senator Vivian Figures co-sponsored a bill to eliminate the “r word” from the department’s name, which has had unanimous legislative support. This bill passed on May 14, 2009. Once the Governor signs it, the department will legally become The Alabama Department of Mental

of Alabama and other groups led the way through the series of events to produce the name changing bill.

Last year Jeff Ridgeway, President of ADAC (Alabama Disability Action Coalition) and former President of People First of Alabama, led the fight to have the People First Language Bill passed. That bill required changes in the Code of Alabama regarding the use of derogatory language referencing people with a disability. Around that same time, People First of Alabama representatives met with Com-

(Continued on page 10)

DEAF SERVICES REGIONAL OFFICES

Region 1

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

Region 2

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

Region 4

Lee Stoutamire, Interpreter
AltaPointe Health Systems
2400 Gordon Smith Drive
Mobile, AL 36617
(251) 450-4353 (Voice)
(251) 450-4371 (TTY)





Training Deaf and Hearing Interpreters To Work Together

Carole Lazorisak returned to Alabama, Saturday September 12, to conduct Alabama's first ever training on how deaf and hearing interpreters can work together.

Nearly 50 participants attended the training, which was held at the Janice Capilouto Center for the Deaf. JCCD, along with the Gallaudet University Regional Center joined Office of Deaf Services as co-sponsors of the event.



Eugenia Truman (back) makes a point as Angela Thompson (right) and Ben Hollingsworth (front) look on.

This was the third training Lazorisak has conducted in Alabama. She was here in November of 2004 and May of 2008. In previous sessions she focused exclusively on Deaf Interpreters, which have a unique role that is different from what most people think when they hear the term. A deaf interpreter (DI) is person who is deaf and usually is a native user of American Sign Language. The DI is specially trained to work with

people who have deprived/dysfluent language and are very important in situations where there is possibility of harm to a consumer due to misunderstanding.

According to the Registry of Interpreters for the Deaf, *A Certified Deaf Interpreter may be needed when the communication mode of a deaf consumer is so unique that it cannot be adequately accessed by interpreters who are hearing. Some such situations may involve individuals who:*

- use idiosyncratic non-standard signs or gestures such as those commonly referred to as "home signs" which are unique to a family
- use a foreign sign language
- have minimal or limited communication skills
- are deaf-blind or deaf with limited vision
- use signs particular to a given region, ethnic or age group
- have characteristics reflective of Deaf Culture not familiar to hearing interpreters.

<http://www.rid.org/UserFiles/File/pdfs/Standard Practice Papers/CDISPP.pdf>

ODS uses deaf interpreters regularly with dysfluent consumers. (See sidebar on page 7.)

The primary focus of the training was on learning how to build effective partnerships within a team interpreting situation. Deaf interpreters usually do not work solo and there is heavy emphasis on collaboration. The content of the day's training reflected that.

(Continued on page 7)

Alabama Has Strong Voice In National Policy Experts Group

The National Coalition on Mental Health and Deaf Individuals (NCMHDI), an affiliate of the National Association of State Mental Health Program Directors, convened an Experts' meeting focusing on mental health and deaf people. The meeting was held in Washington, DC, August 6 - 8. Three of the attendees were from Alabama.

Leaders of four state programs, a state mental health commissioner, and officials from several federal agencies spent the better part of two and a half days at the Kellogg Conference Center at Gallaudet University discussing how to better serve the deaf population.

John Houston, the Commissioner of the Alabama Department of Mental Health, was there representing the viewpoint of state policy members. He was joined by Steve Hamerdinger, Director of ADMH Office of Deaf Services and Charlene Crump, the state mental health interpreter coordinator.

The meeting was chaired by Dr. Candice Tate, who is the president of NCMHDI.

Among the issues addressed were the lack of clinical training programs with a focus on deaf mental illness,

clinical research priorities and concerns over whether general research conducted related to "Best Practices" address the appropriateness of those practices for deaf people. Another major topic was how to encourage state mental health authorities to address some of the deficits in services to deaf people, even in the current down economy.

Several federal programs were examined for possible ways to leverage their activities into expanded options for deaf people. Telepsychiatry is viewed as an important option and the group recommended that Medicaid/Medicare billing options be modified to make it financially viable for deaf clinicians to utilize this technology. In addition, the group talked about licensure issues that are barriers to using clinicians across state lines.

The panel expressed concern about the dwindling number of training programs that produce clinicians who specialize in working with deaf people. Over the past five years several specialty programs have shuttered creating a severe shortage in available clinicians to staff programs. Options for encouraging people to become clinicians were reviewed, including the loan forgiveness programs under the Health Resources and Services Administration.

(Continued on page 12)



NASMHPD Initiative to Address Treatment, Service Needs Of Deaf Population With MI

The following article is excerpted with permission from the August 17, 2009 issue of the Mental Health Weekly, a publication of NASMHPD.

With an eye toward advancing mental health treatment and access to services for the deaf population with mental illness, the National Association of State Mental Health Program Directors (NASMHPD) and the National Coalition on Mental Health and Deaf Individuals (NCMHDI) have embarked on an effort to address the needs of a population they say has traditionally been underserved and underrepresented.

NASMHPD and NCMHDI will work toward identifying and promoting research priorities, training and developing a workforce to understand and work with this population, and making use of technological resources. Both groups convened August 7-8 to identify incremental action steps that are doable, could impact the system and be done over the next six to 12 months.

“Many people don’t understand how isolated the community is,” Robert W. Glover, Ph.D., executive director of NASMHPD, told *MHW*. “We need to be much more culturally sensitive if we’re going to be supportive of their needs.” This population has traditionally not been well served in the public mental health system, said Glover.

The effort will be funded in part by the Substance Abuse and Mental Health Services Administration (SAMHSA), added Glover. NCMHDI, a non-profit organization, was established in 2008 to provide leadership and support in the areas of public mental health and deaf and hard of hearing populations in the U.S. The Coalition is an affiliate of NASMHPD.

In advancing the importance of treating the deaf population with mental illness it is important to bring to the table both state- and federal level administrators so that they will be informed and can work for positive change in a way that had not been done before, said Candice M. Tate, Ph.D., president and chief executive of NCMHDI.

Tate, who is a licensed clinical psychologist, was 2 1/2 years old when her family noticed she had a hearing impairment. Tate noted that 35 years ago it was unprecedented to identify hearing loss that early in a child.

“NASMHPD’s strong interest in working with this population stemmed from its work in reducing seclusion and restraint,” said Meighan Haupt, associate to the executive director of NASMHPD, told *MHW*. The seclusion and restraint meeting last year hosted by NASMHPD included medical directors, deaf consumers, and those who direct mental health services for people who are deaf, and SAMHSA.

“The idea is that the deaf population has a unique culture, which has significant clinical implications, including over-and under-diagnosis based on differing manifestations of symptoms,” said Tate. “It’s important to show that there is a disparity in this group [in order] to initiate crucial research on how clinical symptomatology differs in deaf populations and develop evidence based practices and treatment specifically for this population.”

(Continued on page 12)



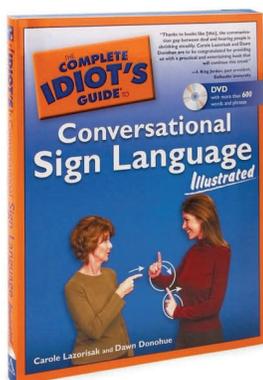
Robert Glover and Robert Pollard discuss research concerns. The lack of hard data was cited as one reason for insufficient funding of specialized deaf services. NCMHDI has made such research one of its priorities

Training Deaf and Hearing Interpreters To Work Together

(Continued from page 4)

Workshop attendees were generally experienced interpreters and little time was spent on interpreting mechanics. Instead, time was used to set up a framework for how responsibilities should be divided. Rather than being prescriptive, the process should be open-ended and allow for adjustments “on the fly.”

Both hearing and deaf interpreters were surprised at the complexity of the other’s tasks. Jaime McPoland, a DI, said, “I have gained more knowledge about the difficulty that the ‘hearing’ interpreters have while interpreting.”



Lazarisak is uniquely qualified to teach this workshop. She holds Certified Deaf Interpreter and Reverse Skills certification from RID, and has several degrees. She's worked as a teacher, consultant, interpreter, and interpreter trainer, in the areas of communication, language and cultural studies, interpreting, language and interpreter assessment, human relations, and professional and teacher training; she also advises Deaf Studies students at LaGuardia Community College. She co-authored, with her daughter, Dawn Donahue, “The Complete Idiot’s Guide to Conversational Sign Language.”



First Person Experience: Using DI to Make a Break Through



By Lee Stoutamire, CI/CT, QMHI

As most of us know working with an individual with mental illness presents challenges. Add deafness to the mix and the fun really begins. To really

make it interesting let’s add the aspect of the absence of language fluency, a hearing therapist, and a hearing interpreter. Where to go from there?

For many years the therapist working in one of my counties struggled with trying to make progress with one of the consumers. The thinking was, “I have an interpreter so I should be fine.” Progress was very slow if any. Dynamics had the “us against them” appearance. These situations led to more barriers and communication being minimal at best.

A DI, Deaf Interpreter, is introduced into the equation. Voila!!! Things began to take shape and move in the right direction. The therapist was pleasantly surprised at the progress that was being made once the DI was involved. They felt able to bridge the gaps that were present and really move forward with treating the consumer.

The therapist stated the only issue they had with the situation is the time involved to work with so many people in the room. They felt one interpreter was plenty but they were more than willing to do what is necessary to have an effective session with the consumer.



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, Hayden
Brian McKenny, Montgomery
Dee Johnston, Oxford
Debra Walker, Montgomery
Lisa Gould, Mobile
Gail Schenfisch, Wyoming
Dawn Marren, Huntsville
Wendy Darling, Prattville

Pat Smartt, Sterrett
Lee Stoutamire, Mobile
Frances Smallwood, Huntsville
Cindy Camp, Jacksonville
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
Gail Schenfisch, Wyoming
Stephanie Kerkvliet, Wisconsin



As I See It

Steve Hambrick

This is going to be a hard column to write. It will go against the grain of the past 16- plus years of my professional life, but I think it needs to be said.

Ever since I took my first state-level job way back in 1993, I have bought into the “gospel” that Deaf* and hard of hearing people “need to stand together” in advocacy for services. Our “needs are the same” we were told over and over.

Of course, this was back at the dawn of the new post – Americans with Disabilities Act “future”, where all discrimination would cease and there would be universal access for everyone. No longer would Deaf people be second–class citizens. We would take our place at the table. We would attend the theatre, see movies with captions, get good jobs, and be treated with respect and dignity.

It was a nice dream. For many Deaf people, it is still but a dream. If you are Deaf and use American Sign Language, you still live a second-class life, more so than if you are hard of hearing or blind. Even drive-through ATMs have Braille, but see if you can find ASL instructions anywhere in the public. Those who use wheelchairs can generally count on ramps being available, though not always in convenient locations. Once in, assuming they know English, communication is not a problem. Enjoying the interpretive videos at some historic site depends only on being able to get into the site if you use a wheelchair. If you are Deaf and not bi-lingual, good luck *(Continued on page13)*

*Style convention for the Signs of Mental Health does not capitalize Deaf except in situations where the reference is made as a proper noun, i.e. “The Deaf Community” of “Deaf Culture.” Other publications will use “D”eaf when referring to a person who identifies with Deaf Culture, much like Black is used for people who are African American. This article follows the latter convention.

VSA arts of Alabama
cordially invites you to

“Hands That Speak” Art Exhibit and Closing Reception

To celebrate the work created by the artists of our Jefferson-Blount-St. Clair Mental Health / Mental Retardation Authority Deaf Services visual arts program under VSA Teaching Artist Sally Smith

~~~~

**Tuesday, September 22, 2009**  
5:30—7:30 pm  
**FREE AND OPEN TO THE PUBLIC**

VSA arts of Alabama Gallery  
1915 4th Ave S  
Birmingham, AL 35233

*Refreshments will be provided  
(catering by Mary Susan Lewis)*

**Artwork is on display and available for  
purchase  
September 21—October 23, 2009**

*This program was made possible, in part, by the  
Alabama State Council on the Arts and the National  
Endowment for the Arts.*



## Hot Off the Presses : Important Articles You Must Read

Steinberg, A, Sullivan, V., Loew, R. (1998). Cultural and Linguistic Barriers to Mental Health Service Access: The Deaf Consumer's Perspective. *American Journal of Psychiatry* 1998; 155:982-984.

*Objective: The authors investigated knowledge, attitudes, and beliefs about mental illness and providers held by a group of deaf adults. Method: The American Sign Language interviews of 54 deaf adults were analyzed. Results: Recurrent themes included mistrust of providers, communication difficulty as a primary cause of mental health problems, profound concern with communication in therapy, and widespread ignorance about how to obtain services. Conclusions: Deaf consumers' views need due consideration in service delivery planning. Outreach regarding existing programs is essential.*

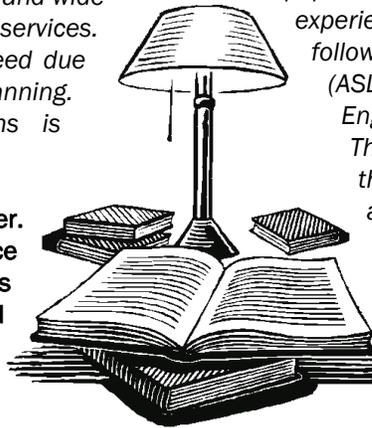
Cooper, Alexandra. & Rose, John. & Mason, Oliver. (2004). Measuring the attitudes of human service professionals toward deafness. *American Annals of the Deaf* 148(5), 385-389. Retrieved September 16, 2009, from Project MUSE database.

*The Attitudes to Deafness Scale is a 22-item measure of attitudes toward people who are deaf designed for use with human service professionals. Attitude statements were generated from personal accounts by deaf people in the literature and from a focus group in which deaf people discussed their experience of hearing people's attitudes toward them. A 60-item scale was administered to a group of 121 clinical and forensic psychologists during their training. Item analysis was conducted to select items that effectively distinguished participants with a positive attitude from those with a negative attitude toward deaf people. The scale may be used in any context where a professional group comes into contact with people who are deaf.*

Pollard Jr., R., Dean, R., O'Hearn, A., Haynes, S. (2009). Adapting health education material for deaf audiences. *Rehabilitation Psychology*. Vol 54(2), May 2009, 232-238.

*Problem: The deaf population is an often-overlooked limited English proficiency (LEP) group at risk for health disparities associated with low health literacy.*

*Lack of access to health information conveyed via radio, television, or ambient auditory sources such as public conversation further aggravates this population's low health literacy. Methods of adapting health education material for hearing LEP populations do not reach deaf audiences with equal effectiveness. Method: We adapt health education material for deaf audiences by first determining the "learning points" contained in vetted source material. A dialog-based film script covering those learning points is created. Supplemental content addressing common deaf population knowledge gaps and sociocultural experiences is added. Deaf actors are filmed following the adapted American Sign Language (ASL) script. Their ASL is back-translated into English to yield vocal track and subtitle scripts. The source material author(s) are consulted throughout the process to assure the film's adherence to the learning point list. Results: Users report that the adapted product is more relevant, engaging, and effective for deaf audiences. Conclusion: This adaptation approach may aid in reducing deaf population health disparities.*



Mejstad, L., Heiling, K. & Svedin, C. (2009). Mental Health and Self-Image Among Deaf and Hard of Hearing Children *American Annals of the Deaf - Volume 153, Number 5, Winter 2009, pp. 504-515.*

*Mental health and self-image among deaf and hard of hearing children (ages 11-18 years) in southern Sweden was investigated. The children (N = 111) attended special schools for the deaf (n = 28), special schools for the hard of hearing (n = 23), and regular schools where hard of hearing children were mainstreamed (n = 60). The Strengths and Difficulties Questionnaire (Goodman, 1997) was used to screen mental health and the "I Think I Am" questionnaire Ouvinen-Birgerstam (1982, 1984) to measure self-esteem. The study shows that hard of hearing children seem to do as well, as a group, as other children in Swedish society. Mean SDQ and ITIA scores indicated that the mainstreamed students and the students in special schools for the hard of hearing had higher levels of rated mental health and self-image than the students in schools for the deaf.*



## ADMH Drops “R” Word

*(Continued from page 3)*

missioner John Houston and expressed their desire to drop the “r word” from the name of the department and the Division of Mental Retardation Services. Commissioner Houston reflected, “When the people most directly affected by the terminology asked for the change, I respected their feelings and their wishes. At that moment, I knew that we would join them in asking for the name change. When you get right down to it, this is really an issue of stigma. The negative connotations associated with terms that we use when we refer to individuals or groups carry the weight of that stigma. Stigma is the greatest obstacle that we and the individuals that we serve face as we strive to create a life in the community for everyone.”

George Neal, a self-advocate and director of the Office of Consumer Empowerment for the department said, “Dropping the “r word” from the department’s name makes a loud and clear statement about the impact of good or bad words. Most people in life don’t feel the shame from name calling. When it happened to me in the past...I knew I was an OK guy, but it still hurt.” Neal went

on to say, “I am so proud that Alabama has done the right thing.” Jeff Ridgeway echoed Neal’s sentiments and said, “This is much, much better! To promote consumer dignity on the one hand and have a bad word in your department name on the other hand, seemed downright hypocritical to me. With the new name, both the department and the people it serves can hold their heads high.”

The department acknowledges that it will take time to replace stationary, other documents, and signage that contain the old name. It is not financially prudent to immediately destroy and reprint thousands of forms. However, every effort will be made to replace those items as quickly as possible, in consideration of the positive outcome for consumers and the public. ✂

## NOTES AND NOTABLES

**Amy Peterson**, BDU communication specialist, was recently awarded her Deaf Interpreter certification from the Registry of Interpreters for the Deaf. She is the first Deaf Services staff person to earn CDI, and the second CDI in the state. Congratulations!

### **Call for Presentations** **Breakout Conference:** **Effective Mental Health Services** **for Deaf and Hard of Hearing Persons**

**June 17-19, 2010**

Westin Atlanta North Hotel at Perimeter  
Seven Concourse Parkway  
Atlanta, GA

#### **Goal of the Conference**

The *American Deafness and Rehabilitation Association (ADARA)* is pleased to revive the **Breakout Conference** in cooperation with the *Gallaudet University Regional Center at Flagler College*. The goal of this conference is to provide training and networking opportunities for mental health professionals serving deaf, deafened, and hard of hearing adults and/or children who have severe mental illness or emotional disorders. Presentations will provide information that attendees will be able to implement and utilize in the workplace with their clientele.

#### **Presentation Proposals**

Presentation proposals should address current effective practices used in working with deaf and hard of hearing individuals with severe mental illness or emotional disorders. Proposals should be for 90 or 180 minute sessions. The Call For Presentations can be found at <http://tinyurl.com/mlyawp>. Submitted proposals should include learning objectives and references that will assist in applying for professional continuing education units for conference attendees. ***The deadline for submitting proposals is January 31, 2010.***

## Students Tour BDU

Three high school seniors toured the Bailey Deaf Unit as their studies on effective state government. They were accompanied by Liz Barton, an analyst from Governor Riley's office.

BDU Director, Scott Staubach led the tour with Steve Hamerdinger providing commentary about how BDU fits into the larger Deaf Service continuum. John Zeigler, Director of the Office of Public Information & Community Relations provided the overall departmental picture and how deaf services fit into it.

The tour was part of the Office of Deaf Services community outreach efforts. 



*Left to right: Rebekah Seay, Ashley Adams, Liz Barton, and Jessica Weller. Brian McKenny (far right) interprets as Scott Staubach explains the program.*



*Scott Staubach shows group how the patients live on the ward.*

## Positions Available In Deaf Services

### Deaf Services Group Homes Birmingham

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

QUALIFICATIONS: Must have near 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](mailto:mcates@jbsmha.com)

### Deaf Group Homes (Intellectual Disabilities) Montgomery

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 and full-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

## Alabama Has Strong Voice In National Policy Experts Group

(Continued from page 5)

Among the people also in attendance were Barry Critchfield Director of the Missouri Commission for the Deaf and Hard of Hearing, Brad Trotter, Program Manager for Deaf and Hard of Hearing Services at North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services, Roger Williams, who heads the Services to Deaf and Hard of Hearing People within the South Carolina Department of Mental Health and Bob Pollard, who is a professor of Psychiatry at the University of Rochester and the Director of the Deaf Wellness Center.



*Alabama Department of Mental Health Commissioner John Houston and NASMHPD Director Robert Glover discuss services for people who are deaf and have mental illness*

Federal Level policy makers in attendance were Beth Bowers of the National Institute on Mental Health and Stacey Lesko of the Center for Mental Health Services of Substance Abuse and Mental Health Services Administration. NASMHPD Director, Bob Glover, and Meighan Haupt, who is the NASMHPD liaison with NCMHDI rounded out the roster of attendees.

The significant Alabama involvement in this activity underscores how important ADMH views services and how much influence the program has on policy related to deaf and hard of hearing people.

Learn more: You can find information about NCMHDI at <http://www.nasmhpd.org/NCMHDI.cfm>. 

## NASMHPD Initiative to Address Treatment, Service Needs

(Continued from page 6)

Regarding the deaf population as a whole, untrained hearing clinicians were likely to minimize the language differences of their clients, believing that an interpreter would be automatically capable of providing a 100 percent accurate translation, enough to provide an accurate diagnosis and treatment, she said.

Using professionals who are fluent in American Sign Language (ASL) is generally the most appropriate option in working with deaf consumers with mental illness, said Tate.

“Oftentimes deaf people were inadvertently committed to a psychiatric hospital when they did not have a diagnosis of severe mental illness at all,” Tate said. This created a fear and mistrust by the deaf population of the mental health field that still exists today, she added.

“Challenges from a system perspective are knowing that we do not have census data or survey results to determine how many are deaf and hard of hearing in the U.S.,” she noted. “Funding in the state system is typically based on population and numbers.”

Tate added, “It’s difficult to convey to administrators that funding is needed when you can’t define the population or show service disparities between hearing and deaf populations.” 

**“Many people don’t understand how isolated the community is,”**  
**Robert W. Glover, Ph.D.,**  
**executive director of**  
**NASMHPD, told MHW.**

## As I See It

(Continued from page 8)

The occasional video that is captioned won't do you much good if your English skills are poor. Deaf people can't count on having ASL interpreters without tedious and stressful haggling days before a visit.

For my entire professional career I have been told - and in turn have taught - that Deaf and hard of hearing people are more alike than different. That we needed to stand together for numbers and political strength. So we did. What has it gotten us?

More Interpreter access? Barely. Only when interpreters are paid with "OPM" (Other People's Money. I am still asked, "Will you bring your interpreter?" As if a flesh and blood human was mine to carry about like some sort of walking hearing aid that I alone was responsible for providing. When I tell people that the service provider must make their service accessible, they look at me as if I had grown horns and a tail.

Interpreters are fine for some things, but they have limitations. They cannot transliterate well that which they do not know. If I want to attend a reading of Shakespeare in the original the interpreter might have trouble unless the interpreter is a theater buff or an English major. Bi-lingual Deaf people, who are in the best position to make use of interpreters often find themselves somewhere between bemused and bewildered when something "gets lost in the translation."

Deaf people who are effectively monolingual ASL users do even worse when they have to try puzzle out what is "signed." Bi-linguals understand that it is easier to formulate your own thoughts in one language or the other than it is to translate another person's thoughts and keep all the subtle nuances. We also understand that when interpreting happens the "product" is not what the first person said. Rather, it is what the interpreter thought the speaker said. The bi-lingual consumer has to make judgments as to the accuracy of the interpretation and the intent of the speaker. (I can just see all the hate mail piling up.

Trust me; I am not bashing interpreters here. I'm just pointing out what any sentient person should be able to figure out.)

If the Deaf consumer (or any consumer with limited English proficiency for that matter) is not reasonably bilingual, this process quickly runs into trouble. Information received from the interpreter is processed in accordance to ASL language rules and Deaf Community Culture norms. If judgments, behaviors, thoughts, and actions do not conform to those rules and norms, communication is, at best, constricted. It frequently breaks down.

Into this morass we lead the mentally ill, language-deprived Deaf person. Without the language skills to use an interpreter, communication only appears to be happening. Without the fund of information to help frame what is happening, psychobabble becomes as comprehensible as Quantum Physics would be to Jivaro Indians in South America. Neil Glickman calls this the "Illusion of Inclusion." It doesn't work.

We have known for decades it doesn't work. The courts recognized that it doesn't work in the *Tugg* decision in 1994. We have known it since at least 1965, when William Stokoe started publishing his research into ASL as a distinct language.

But for the sake of political advantage, unity, Kumbaya, and, thanks to our own learned passivity, we bought into the fiction that English-speaking hard of hearing people and ASL using Deaf people "have the same needs."

We don't. Not entirely, anyway. Oh sure, some the environmental accommodations are the same. But not the language. Not the world view. Hearing people cannot understand Deaf people. Deaf people don't understand hearing people. Fish swim. Dogs bark. Deaf and hearing people miscommunicate. It's inevitable. And universally ignored.

One of the most profound—and pleasing—surprises at the National Experts meeting in Washington last month was, for the first time in my professional career, was to hear true experts say, "Deaf is Different." And we are. Just "providing an interpreter" is not equal to giving us access to services by clinicians fluent in our language.

**As I See It**, we need to stop pretending it is.



September  
National Alcohol  
& Drug Addiction  
*Recovery Month* 2009

C E L E B R A T I N G  
2 0 Y E A R S

JOIN THE  
VOICES FOR

# RECOVERY

TOGETHER WE **LEARN**, TOGETHER WE **HEAL**

In its 20<sup>th</sup> year of celebrating people in recovery and those who serve them, *National Alcohol and Drug Addiction Recovery Month (Recovery Month)* will expand its reach by educating more people about addiction, treatment, and recovery through community and online channels.

In 2009, through its theme, "*Join the Voices for Recovery: Together We Learn, Together We Heal*," *Recovery Month* and communities nationwide will:

- Celebrate the endeavors of people in recovery, those close to them, and the treatment providers that help them
- Emphasize the need to use all resources on the Internet and in communities to better help those affected by addiction and educate people about the disease
- Educate the public and community leaders about the realities of addiction, the benefits of treatment, and true possibility of recovery through community- and Web-based media

## The 20<sup>th</sup> annual *National Alcohol and Drug Addiction Recovery Month (Recovery Month)* celebration in September 2009 will include:

- A national *Recovery Month* kick-off media event in Washington, D.C., and local events held throughout the country and online, celebrating people in recovery from addiction – and those close to them
- A planning toolkit that includes abbreviated printed materials and more extensive, detailed versions available at [www.recoverymonth.gov](http://www.recoverymonth.gov) to support organizers in their event planning and outreach
- Media tips and tools available exclusively online that offer guidance for garnering coverage, feature adaptable templates, and include tips on how to write and distribute media materials
- Television and radio public service announcements (PSAs) and the *Road to Recovery* television and radio programming series
- An interactive *Recovery Month* Web site and Webcasts
- A commemorative poster and brochure



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Substance Abuse and Mental Health Services Administration  
Center for Substance Abuse Treatment  
[www.samhsa.gov](http://www.samhsa.gov)

(SMA) 09-4420

Materials are available starting spring 2009 through the Substance Abuse and Mental Health Services Administration's (SAMHSA's) *Recovery Month* Web site at [www.recoverymonth.gov](http://www.recoverymonth.gov).

Please contact SAMHSA at 240-276-2750 for more details.