Signs of Mental Health

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Farewell to a Friend — Diane Baugher

Associate Commissioner Diane Baugher was feted at a retirement celebration December 5, 2019. She has worked in mental health for more than 25 years, three of which were as the chief of the Division for Mental Health and Substance Abuse Services. Prior to that, she served as the Executive Director of South Central Alabama Mental Health Center, a position she held from September 2009 to September 2016. About 100 people showed up at the event, led by incoming Associate Commissioner Tammie McCurry.

Baugher was charged with bringing the former Divisions of Mental Illness and Substance Abuse into a single operating entity, a task begun by her predecessor Dr. Beverly Bell-Shambley. Her vision for melding the two separate units had a big impact on how services would be delivered to deaf people. Most notably, she expected that ODS would have a stronger role in addiction treatment as well as expanding residential options to get people out of restrictive environments. Projects she charged ODS with developing will continue to move forward under her successor.

At the reception, ODS Director Steve Hamerdinger presented Baugher with an award thanking her for her support for not just ODS but for all deaf people with mental illness, substance use disorder and intellectual disabilities. Some of the initiatives she encouraged that are being developed include stronger program standards that better protect deaf consumers in addiction programs, a residential program for deaf people with developmental disabilities, and expanding supported living options.

The entire ODS family wishes Diane Baugher a long and happy retirement.

Editor’s Notes

Another packed issue! In fact, one of the biggest we have ever published. New faces, some departing friends. An Important position announcement is here on page 30. There’s a lot to see in this issue so we hope you will take time to read through it. It’s also the time for Operation Deaf Santa, and ODS elves will be busy bearing gifts across the land. What’s not to like?
Dr. Tammie McCurry Named New Associate Commissioner of Mental Health and Substance Abuse Services

Dr. Tammie McCurry, D.Min, HS-BCP, who has headed up the Office of Quality Improvement and Risk Management the past two years, was recently promoted to Associate Commissioner for Mental Health and Substance Abuse Services upon the retirement of Diane Baugher.

Dr. McCurry is a graduate of Jacksonville Theological Seminary where she received the Doctor of Ministry in Christian Counseling. She also holds an Associate’s Degree in Criminal Justice, a Bachelor’s Degree in Social Science, and a Master’s Degree in Marriage and Family Therapy.

She is certified by The Professional Woman Network as a Diversity Trainer. She is also certified by Life Innovations as a Marriage Enrichment Facilitator. Her knowledge of business and professionalism is supported by over 25 years of real world and leadership experience acquired by serving in the military and working with corporations, behavioral healthcare systems, local government offices, and charitable/non-profit organizations.

Dr. McCurry has a passion for writing. She has authored two books entitled Building The Unbreakable Bond and Under The Shadow: Our Journey With Polycystic Kidney Disease. She has also co-authored two books, Silence and Bruised But Not Broken.

Dr. Tammie Ross McCurry has been married to her husband and best friend Elder Michael McCurry for over thirty-one years. She is the proud mother of six daughters and a grandmother of five.

Dr. McCurry told SOMH, “As Associate Commissioner of the Division of Mental Health and Substance Abuse Services, I am committed to serving, empowering, and supporting Alabamians with mental illness and substance use disorders. It is my hope that as we continue to provide services and support for the citizens of this great state, we are able to expand our footprint by identifying need and engaging more citizens. I recognize this can only be done with the support of amazing people working alongside you. I am grateful to have these types of staff members within this division. I look forward to serving the Department of Mental Health as the Associate Commissioner.”

Brian A. Moss Joins ODS as New Visual Gestural Specialist

A proud Alabama native and a recent Social Work graduate from Jacksonville State University, Brian “BAM” Moss, was raised in Montgomery and became deaf due to bacterial meningitis at 18 months.

Moss is a former Deaf Care Worker employed by the now closed Bailey Deaf Unit at Greil Psychiatric Hospital in Montgomery and at Bryce Psychiatric Hospital in Tuscaloosa. The experiences he gained while there and his interactions with the Alabama Department of Mental Health’s Office of Deaf Services, inspired him to return to college to become a social worker to better the lives of deaf patients. In addition, he was also inspired to make another professional goal of upward mobility and one day becoming employed by ODS.

Moss feels that the experiences he gained while interning at the Alabama Institute for Deaf and Blind, Birmingham Regional Center, and his past experiences as a Deaf Care Worker has greatly prepared him to dig into the work as a Visual Gestural Specialist. He is genuinely excited and grateful to have the opportunity to work with ODS and looks forward to learning more throughout his years with the Department. He is also planning on starting graduate school for a master’s degree and starting the process of obtaining his Certified Deaf Interpreter credential.

Last but not least, Moss is the very proud father of three beautiful daughters, who are his entire world.
An Open Letter to Fairview Health Services Concerning their Decision to Close the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals

December 10, 2019

To Whom It May Concern,

As the founding Director of the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals (Minnesota Program), I am writing to ask your assistance with a dire situation which impacts the Minnesota Program. This Program, which began in 1989, has benefited over 1650 clients. On December 6, 2019, the Program staff was informed that the program will close in February 2020, due to budget cuts. We are reaching out to our colleagues, former clients, local, state and national leaders to help us contact Health-Fairview’s and express our alarm about the decision to close the Minnesota Program after 30 years of service. The goal of this ‘call-to-action’ is to work with the administration in order to reverse their closure decision.

Why is this “call-to-action” necessary?

- The Minnesota Program is one of the only specialized residential treatment programs serving clients nationally that is linguistically and culturally appropriate to meet the needs of Deaf, Hard of Hearing and DeafBlind individuals.

- These individuals must often seek services outside of their state of residence to receive appropriate substance use disorder (SUD) treatment.

- Individuals who are on public funding, such as state-managed Medicaid programs, are often not covered for out of state service and those with Medicare are required to make a co-payment that can be as high as $11,000. Until a few years ago, Fairview University Medical Center’s charity care program covered that cost. Since Fairview no longer provides that assistance, many clients are unable to afford the treatment program.

- The Minnesota Program staff has been trying to work on a solution to the Medicaid and Medicare funding problem, without much success. Resolving this issue would result in a clinically beneficial and cost-effective specialized treatment program with clinically trained staff, fluent in American Sign Language.

- Because of these funding obstacles over the past two years, the Minnesota Program has maintained a low census; which often has meant that approximately 25 Deaf, Hard of Hearing and DeafBlind people seeking help have not been able to afford the out of pocket expenses and have not been able to receive treatment services. These individuals have been wait-listed, while trying for admission into the program.

What has been done so far to address these concerns?

- In 2018, the Minnesota Program staff was working with the former Executive Director of the Minnesota Commission of the Deaf, DeafBlind and Hard of Hearing, preparing to go to the Legislature to request emergency funds to continue the Program. The Fairview University Medical Center administration put a stop to that process because they wanted to handle the situation internally, indicating that they were committed to keeping the Deaf and Hard of Hearing program open. The administration requested that no meetings with any legislators occur.

- On May 23, 2018, a Fairview University Medical Center administrator responded to concerns about the reimbursement issue, which had a negative impact on the program census. A note from a key administrator for the Behavioral Health Program was forwarded to the former Minnesota Commission Executive Director, stating the following:

  “……. I have learned that there have been some reimbursement issues; however, I want you to know that we have no intention to close this program. We are working with internal channels to support individuals to get the services they need despite their insurance or payer status. We are dedicated to serving our deaf and hard of hearing patients and families.”

- On repeated occasions, the Fairview University Hospital administration assured the community and program staff that they would continue to support the program, as well as work on the reimbursement issues.

- In January 2019, the Substance Abuse and Mental Health Services Administration (SAMHSA) published a request for proposals to develop and implement targeted strategies for substance use disorder treatment provision, addressing a specific population or area of (Continued on page 5)
focus identified by the community. Program staff pursued this possibility with the hope that funding the program’s treatment services would open opportunities to assist. Upon further inquiry, it was determined that recipients of these funds could use them to help DHH people with their out-of-pocket costs. SAMHSA also indicated that the Minnesota Program had a compelling case as a National community with an excellent targeted population to serve. However, the Fairview University Medical Center Administration decided not to apply for the grant, citing that the monies would not be able to be distributed directly to patients in need of co-insurance support. The Administration indicated that they would continue to be supportive of the program.

Although other programs in the Fairview University Medical Center are also scheduled for downsizing or closure due to financial concerns, the small Minnesota Program fills a gap for a much-needed service. The small cost benefit that Health Fairview may gain [by closing the program] will result in an enormous loss at the local, state, and national level for the community served by the program. In light of the administration’s false assurances of support, it is tragic that the administration did not allow staff to pursue external funding or assistance from the state legislature to continue this much-needed resource.

The closing of this programs means that many Deaf/Hard of Hearing and DeafBlind individuals suffering from addiction throughout the United States will now be unable to get the services they need. Since most states do not have culturally and linguistically appropriate chemical dependency treatment programs available, these individuals have the right to receive accessible services, even if it means going out of state. Although we should be seeing more treatment options for this population on a national basis, the fact is that over the past five years, we have witnessed the closure of several specialized treatment programs. The Minnesota Program is unique with its highly qualified, licensed staff offering targeted services in a culturally and linguistically appropriate setting, and its services are desperately needed.

Please help us communicate to the media and elsewhere, letting people know about this alarming situation. Additionally, please reach out to the Administration at Fairview University Medical Center with your impassioned plea that they reverse their ill-informed decision. Help us keep the Minnesota Substance Use Disorder Program or Deaf and Hard of Hearing Individuals open.

Please address your letters of concern to:
James Hereford, President/CEO
Fairview Health Services
2450 Riverside Avenue
Minneapolis, MN 55454

If you have additional questions, or need more information, I can be reached at dguthmann@aol.com or on my cell phone or by text at 925-788-2852

Sincerely,
Debra Guthmann, Ed.D
Founding Director, Minnesota Chemical

Note From ODS Director Steve Hamerding

The Minnesota Program, which has been in continuous operation since 1989, has saved hundreds of deaf lives over the 30 years it has been open. The work they have done there has influenced SUD treatment throughout the world. The Alabama Department of Mental Health has been able to refer a number of deaf people to the Minnesota Program and we have always been impressed with the results.

There, addicts have been able to get treatment from clinicians who are fluent in American Sign Language. They do not have to rely on interpreters to get necessary information. They are supported in a Deaf Environment, without having to compromise cultural principles.

It was with great sorrow and no small measure of anger I received the above letter from our good friend Dr. Guthmann. I promised her I would do my bit to get the word out.

As it is so often the case, hearing administrators, concerned only with their bottom-line, see deaf people as expendable, deaf programs as unnecessary. The hundreds of recovering deaf addicts around the country—indeed around the world—will testify to the life changing, life saving value of this vital program.

I urge SOMH readers to contact Mr. Hereford and share with him your concerns.
In our previous, part one article in this two-part series, we holistically approached communication, culture, and deception. In this second article, we will build on our discussion of communication in general and focus deeper on what we know about lying and deception in particular. We extend our knowledge to the Deaf community for purposes of a thought-provoking exercise. There is very limited research on how deception functions among the Deaf community, but we ask here how Deaf cultural experiences might help us better understand what we know about deception, biculturality, and bilingualism in this context. We will also discuss how interpretation between one’s languages and language deprivation function to share less than clear messages. In relation to the Deaf community, we will highlight how deception and deception detection may function. We aim to share with you, the reader, the concepts of cultural schemas and code-switching, and how these relate to the intercultural interactions Deaf people experience with those who are hearing. We end this article on how the act of code-switching and how intercultural exchanges may hold implications for mental health in the Deaf community.

To begin, let’s rely on an analogy. Picture a lock and a key. In this illustration, there are millions of keys each unique in their specific shape, cut, and dimensions. As one of those keys enters a lock, the lock may either accept or reject the key outright. The key will insert into and open the lock only if it matches that lock. That, essentially, represents the process of exchanging messages during interpersonal communication. For the purposes of this analogy, the message is the key and the recipient of the message is the lock. We must often accept or reject a variety of messages based on how we perceive their level of authenticity. We accept those messages that align with our preconceived notions of truth in a way that parallels how a lock permits entry by the correct key. This metaphorical example works particularly well because locks often accept more than one exact key. That is, there are master keys or several keys that may allow multiple people entry into a door. Our psychological heuristics for what we believe is true (i.e., veracity) serves as the lock-mechanisms that filter messages based on their accuracy or truthfulness. Lastly, a lock can be forced open by picking of the lock. This signifies the act of human deceptions, lies, or misinterpreted information by which people are sometimes deceived. Deceptions can bypass our truth filters and force erroneous information into our consciousness. Messages (whether truth or lies) are complicated and, like a key, can take many shapes.

Overall, there are four major components to how messages function in communication: 1) the factual information level of the message; 2) information about the sender of the message; 3) revelations about the relationship of the interactants; and 4) each message contains some level of appeal—the persuasive goal of the message. Again, factual information is the truthfulness of a message itself, self-revelation is the part of the message that reveals personal information about the messenger, there is the relational information packaged in the message, and appeal is the measure of the persuasiveness of the message (in other words, what does the message want the sender to do?). The easiest way to understand these four functions is to think of them as the “subtext” of the message. While the literal meaning of a message may contain the facts of some proclamation, the context of the environment and relationship of the messenger and the receiver contain a great deal of information that further indicates what is happening in an exchange. Yes, this is rather deep. Every message goes far beyond the literal meaning taken from the words ascribed to it.

If you are still reading after our metaphor and theoretical visit to the four sides model (Schulz von Thun, 1981), then you may be interested in what we have to say about lying and deception. As touched on briefly in our prior article,
some cultures do not view specific modes of communication (e.g., omission of shared information) as intentional acts of lying per se. Unfortunately, researchers have not explored deception very much in the Deaf community. Largely, there are many interesting questions that can be asked in this communication group.

For example, it would be worth asking: How does the Deaf community think of deception, and what specific types of messages and exchanges might they consider as lying? How do various situations, contexts, or behaviors lend themselves to deception or lies? How are lies thought of from an ethical perspective and how do various contexts play a role in these types of judgments? Take the act of code-switching, for example, whereby a person switches between their cultural schemas or norms when communicating with others. In a room full of hearing people, a Deaf person may communicate quite differently than they would with a group of their Deaf friends or colleagues. Is it possible to think of this change in language, nonverbal behavior, and thinking as a form of deception? Or might this situation serve as a form of self-deception? Though there is not much research on how lying functions and is viewed in Deaf communities, we want to visit modern views on lying and deception in the literature at large. We challenge you, the reader, to think about how these models and theories may or may not fit the communication norms of the Deaf community.

Deception Detection

Let’s take a closer look at deception detection. There are many ways, some more effective than others, of detecting lies. Many people believe that liars generally seem nervous. They think that a liar may shake their feet or legs, fidget in their chair, sit up too straight, or avoid eye contact when lying. These nonverbal behaviors are the basis of “cue theories” that have dominated the literature on deception for over 50 years. Though popular culture portrayals (e.g., TV shows and movies) love to support beliefs in these Pinocchio cues that betray a liar, meta-analytic research (examining larger trends across studies) have revealed that cues are poor indicators of deception. There are no large and reliable trends in liar nonverbal behavior that may betray when someone is lying (Levine, 2010). More recently, deception scientists have relied on what people say, their verbal behaviors, to determine whether someone is lying. Accordingly, modern deception scientists are creating theories that support the notion that liars communicate verbally in ways that differ from truthtellers.

We invite interested readers to take a journey into the work of Timothy Levine, Department Chair of Communication Studies at The University of Alabama-Birmingham. Levine has spent the last 25 years of his career investigating deception and recently published the culmination of findings from his 55 studies in his new book about Truth Default Theory. His book, Duped (2019), published by The University of Alabama Press, takes a scientific approach to understanding why past research has found, time and time again, that people are only slightly better than chance at deception detection (54% accuracy). This new theory helps us to better understand people’s motivations for lying, how to better detect lies, and how we all tend to operate on a powerful heuristic he calls the “truth bias”.

Simply put, Levine believes that we operate on the notion that people are telling us the truth most of the time, and so therefore we require a trigger to activate our suspicion that the information we are receiving may not be truthful. Further, we must be triggered again to decide if a person is deceiving us (to deem them as a liar). We will very often default back to truth and find reasons why someone is not a liar because, after all, we benefit more when we use a truth default state to interpret our social world. This truth default
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heuristic, combined with the statistical probabilities of past studies, has led to the 54% accuracy statistic that is often found in meta-analytic results. But, most importantly, Levine shows us that liars do not behave nonverbally in ways that betray their messages. He tells us that we must also regard the content of what someone is saying in context to determine more accurately whether they are being dishonest. His research, in which professional interrogators are given foundational information surrounding the events where a lie takes place, and are allowed to ask unscripted questions of would-be liars, yield very high accuracy rates (90-100%). Levine’s work has created a paradigm shift in deception science and offers a fascinating and refreshing new look at an old puzzle. Malcom Gladwell recently released a new book entitled, *Talking to Strangers* (2019) that is essentially based on Truth Default Theory. He also uses many well-known examples and illustrations in accessible and captivating ways. Bottom line, this stuff is unlocking the mysteries and solving the puzzles that have been plaguing deception detection research for a very long time. It is an exciting time to engage with deception research.

Quite literally, language is helping us to understand deception. The content of what someone says can show us whether we should abandon our truth default state. The concept of content-in-context has proven to be very useful in deception detection research. This is simply unpacking what the literal words of a message mean against the backdrop of the situation at hand. It considers the environment, as well as the past and potential future implications of an exchange or situation (Levine, 2013). Take, for example, that I tell both my family and my soccer teammates that “I ran a mile today.” The message is exactly the same (content), but the relationships to the receivers obviously differ (relational context). Say that, in telling them that I ran a mile, I was communicating a lie. One group may be more likely to detect that I am doing so—particularly the ones with more experience in running (my teammates) or with familiarity with my everyday behaviors and whereabouts (my family). Someone who might have knowledge about my motives for lying would also be inherently more likely to detect when I am lying about running.

Briefly, the idea of active questioning is also vital for deception detection. While neither of these groups may care if I ran a mile, that might be the end to the matter. But, if, for some reason, they doubt my comments about running because they care about my past behavior or whereabouts, they then may question me further by using other facts they know to compartmentalize my statement in the context of other content. However, in general terms, some contextual details may lead the receiver or receivers to more likely believe the lies told to them. If I lied to my coach that I ran a mile and he explicitly instructed the team to avoid running outside of practice, this would change things. This context, that I had disobeyed his instruction, might result in a very different exchange than one with my friends or family. The coach may care more than they would, and may react in ways that change the deception detection game.

Intercultural Schemas

Schemas are intellectual structures, essentially, categories, through which we process our world (see Griffin & Frank, 2018). We categorize things relating to “attention, memory, and inferences,” including people, jobs, and relationships (Hegtvedt, 2006, p. 56). The famous child psychologist, Jean Piaget, held that schemas are both the processes through which we categorize things and the categorizations themselves. In his seminal work, *The Moral Judgment of the Child*, he examines how we form our various schema like mental building blocks—one helping to develop the other. His famous example concerns a child learning about a horse. In his illustration, the little girl learns that the name for this animal with four legs and a tail is a horse. She then applies the concept “horse” to all animals with four legs and a tail until she can further develop her schema to interpret and categorize other animals (Piaget, 1948). Such is the progression for all schemas. We start with a rudimentary categorization of something that we further develop and refine as we become more aware of the categorization’s nuances.

We thus employ cultural schemas in our everyday lives. An example of such a schema consists in categorizing a culture into collectivist or individualist cultures. As we discussed in our Part 1 article, a collectivist culture values the group, or the
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whole, over the individual. In an individualist culture, the inverse is true (Triandis, 1993). The more categorizations we apply to cultures, that is, the more thoroughly we become acquainted with cultures, the better we may assess those cultures. As one progressively experiences and learns about a specific culture or context, the more likely they are to be able to accurately categorize concepts within that culture. A schema for any given culture, its norms, and behaviors serves as a mental database through which a person can reference pertinent information in determining if someone is using deception. Cross-cultural deception-detection, rather than deception-detection within a culture, is an inherently complex process that allows us to better understand how communicators are faced with in-group and out-group decision making.

In one cross-cultural study, participants judged whether two groups of messengers were truthful or deceptive. One group primarily spoke the same language of participants, and the other was a group of non-native bilingual speakers. Interestingly, the participants were more accurate in detecting deception among native speakers than non-native speakers (Silva et al., 2013). This may be due to how the native speakers shared a more developed cultural schema than they did with non-native speakers. The observers thus possessed more of a context with which they could judge the veracity of the native speakers’ statements. They possessed less of a context with the less familiar language group, and as such could not make accurate judgments of their messages. This crude postulation may only begin to explain the complex machinations involved in cross-cultural deception-detection. Our own research (Griffin & Frank, 2018) revealed that Deaf persons could enact two different schemas when asked to judge the veracity of hearing or Deaf suspects being interviewed about a theft. Monocultural hearing participants, who lacked any knowledge of Deaf culture or ASL, were only able to apply and use one schema for the Deaf and hearing suspects they judged. These findings support the notion that bilingual-bicultural persons not only enact different ways of communicating their own messages, but that they enact different perceptual lenses (schemas) when receiving information from others and judging veracity.

Code-Switching

The concept of code-switching comes from the act of alternating between two languages (Gardner-Chloris, 2009). Code-switching can be broken down into three parts: discourse, speech act, and code. Discourse is the form a verbal or non-verbal language takes; speech act is an “utterance” that can range from a single sound to several sentences; and a code is the system (be it verbal, technological, or otherwise) in which communication occurs between two or more individuals (Shay, 2015). The code ranges from verbiage to technology to nonverbal gestures. When one code-switches, they alter the literal form of their language and employ a host of different attitudes and accompanying gestures—what we coined as “nonverbal bilingualism” (Griffin, 2014). That is, in the same way one may switch verbally between their two languages, they must also take on the nonverbal actions and norms associated with those linguistic cultures to appropriately communicate in that language.

Code-switching occurs in bilingual or multilingual communication, and, as the world progressively becomes more multilingual, the use of code-switching subsequently occurs more frequently. Though research on the subject is growing, there is scant research on code-switching in the Deaf community. An earlier study examined the continuum present in the Deaf community and how that relates to code-switching (Hoffmeister-Moores, 1987). These researchers found that participants who were Deaf at birth and had Deaf parents used code-switching far more often than those who had recently learned sign-language and who had hearing parents. Members of the Deaf community may employ code-switching differently based on their familial and linguistic backgrounds. It is our personal belief that people who are Deaf children of Deaf parents possess a richer and more nuanced Deaf cultural schema, allowing them to understand the deeper chasms that demarcate the linguistic/cultural identities they engage with in their lives.

The adage, “lost in translation,” comes to mind when thinking about code-switching phenomena. When a Deaf
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person code-switches, they must alter the content of their messages. Most readers of Signs of Mental Health will already understand that every thought or message created in ASL may not be equally interpreted into English. So, in this way, Deaf persons must in some way alter the content of their ideas as they share interpersonal messages during their intercultural code-switching experiences. Alternatively, their messages must be altered by interpreters as they are recoded to be shared with hearing communication partners. Therefore, the fidelity of any intended message in an intercultural exchange with Deaf and hearing people may be influenced. We wonder if deception is taking place in these types of exchanges. We welcome your thoughts.

Implications for Deaf Mental Health and Concluding Remarks

We have so far discussed how cultural schemas may affect deception detection and how forms of code-switching may enact one’s ability to discern different cultural messages. Now, we will conclude with the psychological impact that Deaf persons receive both when code-switching and during their intercultural exchanges. The Deaf population largely lacks access to mental health care due to four reasons: language barriers, a large population of Deaf signers using public insurance, clinicians lacking the training to effectively treat Deaf signers, and a low adherence rate (Pertz et al., 2018). Clinicians thus remain generally uneducated about the Deaf community, and this lack of context disallows them from effectively communicating with Deaf patients; it also forces those patients to code-switch. We contend that mental health professionals ought to reduce the use of code-switching among their Deaf patients in their treatment sessions as much as possible. The first and perhaps clearest method of doing so would be learning more about their Deaf patients (language and culture), an act termed “language concordance.” Deaf patients statistically rate psychologists who practice language concordance higher than those who do not (Pertz et al., 2018). A reported 2% of psychologists rely on this practice. Until that number goes up, researchers suggest that the current pool of language concordant practitioners utilize telemental health services. Telemental services consists of practitioners treating their patients by way of video, thereby expanding their services to a larger pool of Deaf patients. This alternate approach in therapy also yields high ratings among the Deaf population. Learning of the culture of Deaf patients and using ASL and qualified interpreters during mental health practices is a vital step that must be taken.

Deaf persons face barriers to their mental health from childhood. Language deprivation has affected the Deaf community for generations. Many clinicians, teachers, parents, and other caretakers have embraced the notion that Deaf children should be raised either in a spoken-language only environment or in a sign language inclusive one. They all too often choose the former option. When children are deprived of learning an accessible language, such as sign language, those children undergo severe and lasting biological repercussions that negatively affect their healthy development (Hall, 2018). As such, many Deaf children will be affected with Language Deprivation Syndrome (LDS). The median rate of reading for Deaf people lies at the fourth-grade level. Evidenced-based therapies utilize a combination of talk therapy and workbooks. Thus far, none of these workbooks use plain English principles or sign language that would be suitable for a Deaf patient with LDS (Gulati et al., 2018). Further, clinicians ought to educate themselves on Deaf culture at large to better treat their Deaf patients. Again, we reiterate the importance of content-in-context in cross-cultural communication. Content-in-context may be applied outside the realm of deception. Theoretically, if clinicians better knew the context surrounding their patients—i.e., possessing a more thorough understanding of Deaf culture and ASL—they would more effectively grasp the content communicated to them via their Deaf patient.

Effective communication between mental health professionals and a Deaf patient can be difficult, leading to mistakes and erroneous information exchanges. In many ways, what happens when mental health experts lack context and receive wrong information due to a lack of linguistic understanding is not that different than what can happen when someone lies to another person. We have obviously
made some large leaps in some of our thinking about communication, deception, and cross-cultural communication. Using deception and deception detection as a means to understand communication at large, we have underscored the cross-cultural divide that affects many Deaf patients and their clinicians. Much of what we have written here are our thoughts on these topics, and so we urge you, the reader, to contact us with your thoughts, opinions, critiques, or questions on these topics. 🌐

Christian Bender is an Undergraduate Researcher at The University of Alabama. He focuses on cross-cultural communication, and how one’s cultural background influences the methods and motives through which they lie. He is from Pittsburgh, Pennsylvania, and will graduate from The University of Alabama in May 2020 with a BA in International Studies and Theatre. Email: cbender@crimson.ua.edu

Darrin Griffin is an Assistant Professor at The University of Alabama, and much of his work focuses on Deaf advocacy and effective communication. He is a child of Deaf adults and was raised in Austin, Texas where he got his undergraduate degree at UT in Deafness Studies. His MA and PhD degrees are in Communication Studies where he focused his research topics on Deaf communities. Email: djgriffin1@ua.edu

LGBTQ Workshop Great Turnout

On November 4, 2019, we were fortunate to be able to host Jerry Buie, MSW, LCSW, from Utah to present “Queer Eye for the Straight Provider.” This was a foundational workshop, with the goal of increasing the understanding of cultural nuances within this population, as well as the social intersections and implications of being Deaf and LGBTQ. Attendees were also able to discuss different sign choices that may be used within this population. Buie took attendees through recent LGBTQ history. He also discussed barriers to therapy and how therapists can foster an environment of inclusivity within their services. We had a great turn out with attendees from throughout Alabama, as well as Tennessee.

Buie has been providing counseling services since 1994 when he graduated from the University of Utah College of Social Work. In 1996, Buie developed Pride Counseling in Salt Lake City Utah, as an LGBTQ mental health facility and maintains his practice today. He has been providing therapy to the LGBTQ community since this time and has addressed issues such as sexuality, identity, relationships, conflict resolution, spirituality and religion, coming out, and gender-related issues. Buie’s work experience also includes working for the Department of Corrections, Division of Child and Family Services and well as non-profit organizations addressing victim and perpetrator issues around sexual violence.

ODS Region I Interpreter Coordinator, Keshia Farrand and workshop presenter Jerry Buie.

Buie is currently a full-time Assistant Professor/ Lecturer at the University of Utah College of Social Work specializing in Reflexive Social Work Practice (Social Justice and Diversity), Clinical Practices including Solution Focused Therapy, Cognitive Behavioral Therapy and the exploration of Spirituality in Social Work. Buie has also served on vast boards and consulted in a variety of issues, including Sage Utah, Naraya Culture Preservation Council, Utah AIDS Foundation, Gay Men’s Health Movement and Reconciliation and Growth. 🌐
Last August, I gave a talk at the MHIT Alumni sessions which focused on how deaf people have been treated in the mental health system down through the ages. The talk started with Socrates and ended with present times. One of the psychiatrists I quoted was the Norwegian psychiatrist, Terje Basilier, who practiced in the 60s and 70s. He said, “If staff does not know sign language, then therapy is bitterly slow if present at all.” Basilier practiced during a time when there were few specialized programs for deaf people with mental illness. Psychiatry was beginning to pay attention to the needs of deaf people. Basilier went on to say, “It is funny that we, when we want to do something for the deaf, immediately concentrate on the faculty of hearing which they do not have, instead of working with those senses which they do have, and the possibilities which lies in their use.” (quoted by Madsen, Øyvind 2011.)

I am reminded of this when I look at incident reports involving deaf patients in hospitals around the country and consumers in our own programs here in Alabama. Many of these incidents end up entailing pro re nata (PRN) use of psychopharmacologic sedative agents. The use of such agents, intended to calm agitated patients, is unfortunately common. It is far quicker and easier to sedate a person than it is to talk them through a crisis. It is also easier and less traumatic on the provider than manual restraints or holds. Better optics, too, which is one reason it is used so much. Nevertheless the patient is still restrained, still traumatized.

The Center for Medicaid and Medicare Services has defined chemical restraint as “a drug or medication, or a combination, when it is used as a restriction to manage the patient’s behavior, restrict the patient’s freedom of movement, or to impair the patient’s ability to appropriately interact with their surroundings – and is not standard treatment or dosage for the patient’s condition.” (CMS 482.13)

While there is tremendous variation in state laws governing the use of chemical restraints, most have some version of the following verbiage: “generally used for the sake of staff convenience, discipline, or other non-medical reasons is prohibited.” Alabama law specifically labels the use of chemical restraints as “emotional abuse” (AL Code § 13A-6-191 (2017) and it is covered in mandatory reporting laws related to elder care.

No reasonable person would think that using chemicals to restrain or punish a person because of an inability to talk to that person would be appropriate. Indeed, the entire concept of crisis intervention is based on verbal de-escalation. But what do you do when you cannot communicate with the patient or consumer who is agitated? This is a situation that we observe all too often in programs with deaf people.

It is never called chemical restraint, of course. Because the agents used are usually the same ones that are used to treat psychiatric conditions, albeit in significantly higher dosages. Medications used include benzodiazepines, haloperidol, olanzepine, even ketamine. All can be used for treating certain disorders, thus evading the “not standard treatment” restriction. The argument then comes down to the dosage and the whole discussion gets off the point that the medications where used to mask the fact the staff are unable to communicate effectively with deaf patients.

ODS has been tracking incidents involving deaf people in the public mental health sector for some time. We have observed that when staff cannot effectively communicate with their consumers, the number of incidents go up. Actually, we can make a bolder statement than that. We can say with some level of confidence that the more effective a given staff person is in communicating with their consumers the less likely it is that there will be a reportable incident in a “deaf program” such as one of our group homes. That’s not to say it never happens, but it happens far less often when the staff can match the communication of the patient. Some reasons for this can be gleaned from the excellent article by Griffin and Bender starting on page 6 of this issue. They contend that many issues faced by deaf people in mental health settings are a direct result of cross cultural and cross linguistic misunderstandings. This occurs even when all parties know ASL, but not to the same level of fluency due to different backgrounds.

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Now, what about a place where the staff varies greatly in their communication skills? Let’s use, for example, a psychiatric emergency department. If an agitated deaf person is brought in, what is the likelihood that the ED staff will be able to verbally de-escalate the patient? What is the likelihood that some psychoactive medication will be used to sedate that patient?

That brings us back to Dr. Basilier’s quote mentioned at the beginning of this column. He was so convinced that it was not possible to effectively care for deaf patients without knowing sign language that he insisted that all the nurses and at least one psychiatrist at the Diakonesses Hospital at Lovisenberg learned Norwegian Sign Language. It should be no surprise that Dr. Basilier reported positive outcomes for deaf patients admitted to that program.

It was evident in 1964, and should be evident today, that most humane and effective way to handle an agitated deaf person is to talk to them. Not with speech and hearing but with the language they can most readily understand – some form of visual language. To put it another way, clinicians need to meet with patients where they are, not expect the patients meet the clinicians’ language needs.

A practice in some states is to assign to a specific unit within a state psychiatric hospital the care of deaf people with severe mental illness requiring hospitalization. There are, perhaps, a dozen such units around the country. The staffing at those units is highly variable. Few, if any, are exclusively deaf. All-deaf units have largely vanished. Units like the Deaf Unit at Westborough State Hospital in Massachusetts, or the Deaf Unit at Springfield State Hospital, in Maryland, models for the now defunct Bailey Deaf Unit in Alabama, are all but gone. Downsizing and fallout from the Olmsted Supreme Court decision have shuttered many of them. They were premised on the concept, espoused by Basilier, that the staff working with deaf patients should be fluent in the language used by those patients.

Today, it is likely that the deaf patient needing psychiatric hospitalization will be placed, at best, in a mixed unit. The only question will be how many people on the staff will be able to effectively communicate with them. In a few places, such as Worcester Recovery Center in Massachusetts and Morganton State Hospital in North Carolina, they will be placed in unit that has some signing staff assigned to the floor. The problem is that because these units have both hearing and deaf patients mixed together, it cannot be solely an ASL/deaf environment. That means, depending on the ratio of deaf to hearing, there will likely be more non-signing staff than signing staff. Depending on the shift and the day, there could be times when there are no signing staff on duty at all.

It is not surprising that the use of chemical restraints increases during times when signing staff are not available. Therein lies the rub. Is the use of psychopharmacologic agents a replacement for communication? If it is, is this use not for the convenience of the staff? Can this practice be defended on ethical grounds?

Note, this is happening in programs that are ostensibly set up for the care of deaf people with mental illness. What about the deaf person who finds himself in a unit that is not set up for that purpose? Are they even getting treatment at all, other than being chemically restrained – or worse – physically restrained?

In the latter part of the 19th century and the early part of the 20th century, “treatment” was often barbaric. Doctors truly believed that restraints, like spinning chairs, wet wraps, chaining patients to the wall and the like, were “therapeutic.” They all were based on controlling the patient, not on treating them. We are supposed to be better than that now, are we not? We might not be physically restraining deaf patients, but we are chemically restraining them.

It doesn’t have to be that way. We know, and have known for nearly 60 years, that management and treatment of severe mental illness in the deaf population is best accomplished in a place where everyone, from the psychiatrist to the direct care staff are fluent in sign language. As I See It, the only thing stopping us is the stubborn and persistent belief held by all too many people that deaf people are “no different than hearing people.”
In Alabama, South Carolina, Georgia and Pennsylvania, communication assessments are required by law for any person who is deaf and receives mental health services. Informal historical attempts to analyze sign language used by deaf persons have not always been effective or ideal. A quality communication assessment can provide and assist in treatment and educational interventions.

“The need for communication assessments of deaf persons with complex or idiosyncratic means of communication is becoming more recognized by those who work in the field of deafness. This is partly in response to the growing awareness about the highly diverse ways deaf people communicate, and more appreciation that ‘knowledge of sign language’ in staff is no indication they are qualified to meet these communication challenges. This interest in communication assessments is also a response to the growing recognition of how language deprivation remains a problem for some deaf people and how this deprivation impacts the development of language, communication, cognitive, and psychosocial skills” (Williams & Crump, 2013).

December was a busy month for Communication Skills Assessment training, with two trainings conducted. The first training occurred December 5 – 6 in Montgomery, Alabama and included a combined training of newer staff members from the Office of Deaf Services with the Alabama Department of Mental Health and Deaf Services at the Georgia Department of Behavioral Health and Developmental Disabilities. This training was led by Charlene Crump and Amanda Somdal. Participants included a range of professionals including communication specialists, interpreters, therapists, and a community services coordinator. This was the first time that training has occurred simultaneously between the two Deaf Services department, and Georgia DBHDD sent Kaitlin Wells, Patricia Spurlin-Kyle, and Paige Green. The directors of both state Offices of Deaf Services, Steve Hamerdinger and Kelly Sterling, are enthusiastic that this partnership will lead to increased opportunities for training and mutual assistance.

“The Georgia Department of Behavior Health & Developmental Disabilities – Office of Deaf Services was pleased to be able to send three newly hired staff to attend the Communication Skills Assessment Training in Montgomery, Alabama. The training provided by Alabama Deaf Services and hosted by Charlene and Amanda provided the opportunity to learn the assessment process and hone the necessary skills in providing communication assessments for the population we serve. All of the staff who underwent the training have reported that the training was absolutely fantastic! Our staff were thrilled and deeply appreciated the opportunity to take part in the training. The learned knowledge, skills, and abilities has given them confidence to provide effective communication assessments.” Kelly Sterling, Director Deaf Services, Georgia DBHDD

The second training was conducted in Nashville, Tennessee at Bridges for the Deaf and Hard of Hearing (a non-profit organization servicing middle Tennessee, northern Alabama, and southern Kentucky) and was led by Charlene Crump. The staff at Bridges consisted of four Youth Center staff, three from the Interpreting department, two from Empowerment and Advocacy, and two from the administrative staff. All of whom may at some point, be involved in the process of evaluating language via the

(Continued on page 15)
ODS staff Kim Thornsberry, Kent Schafer and Charlene Crump were selected to present at the 2019 Southeast Regional Institute on Deafness conference in Huntsville. In addition, Katherine Anderson and Jennifer Kuyrkendall were also selected to be on the conference interpreting team for SERID. Crump’s topic was Understanding Language Dysfluency and Its Impact on Our Work, while Schafer teamed up with former ODS staffer Ben Hollingsworth to talk about “The Psychology of More.” Thornsberry teamed up with Michael Deuel, of the Huntsville Regional Center of the Alabama Institute for the deaf and Blind to discuss “The working Alliance Between AIDB Case Managers and ADMH ODS Therapists.”

Above: Charlene Crump.
Below, left to right: Ben Hollingsworth, Kent Schafer

In addition to the on-site training, participants are provided ongoing access to a community of practice via a Facebook group relevant to those providing communication assessments where individuals from across the country can work together to ensure that assessments provided are done so with integrity and consistency.

Alabama DMH has worked to develop materials which support the practice of the evaluation, increasing the resources and competencies of assessors. Over time, a database of signs specific to the deaf population in Alabama has grown to include videotaped vocabulary such as signs by members of the older deaf community, black deaf community, name signs for cities, towns, hospitals, group homes, and archived copies of yearbooks from the school for the deaf which can aid in historical context. For those who are interested, the signs by members of the older deaf community in Alabama may be viewed at https://www.dropbox.com/sh/mfcndz2ose01n1m/AABRNZfcCib1pmZMmhRgAwtoa?dl=0.

The ultimate goal of providing a competent assessment is to allow providers to work together to gain a deeper understanding of language use and patterns of deaf individuals with dysfluent language so that services can be optimally provided to the person in their best language.
A Personal Farewell from Miranda Nichols, Former Region V Therapist

I have been fortunate to have been able to spend over three years with ODS – as both an intern and a full-time employee. Over the years, I learned a great deal about deafness, mental health, and language deprivation. I have met and worked with some of the greatest partners in the state to collaborate on services to make sure the needs of our clients were met. It is with genuine sadness that I have left ODS, however, I have decided to relocate to the northeast to be closer to my family.

During my time working with ODS, I have had the pleasure of working with wonderful clients and getting exposed to various language models within the deaf community. I would say this aspect of the job was the most beneficial to me to enhance my skills as a second language user and also as a clinician. While there were times when this job was challenging, I have enjoyed it very much and will look back on my time here fondly. The Region V Therapist position is an excellent position for future interns or clinicians looking for a challenge and exposure to a wide range of mental illnesses and language models while being given the opportunity to collaborate with other community resources to provide great services for the deaf community throughout Alabama. Thank you for being the foundation of my career path and helping me learn.

In October, our Region II Interpreter Coordinator, Jennifer Kuyrkendall, presented a 2-hour presentation on “Utilizing Interpreting Services with Deaf Populations” for 80 Physician Assistant students at the University of Alabama Birmingham. In November, she also gave this presentation to 35 Nursing program students at Shelton State Community College in Tuscaloosa.

Amanda Somdal has added another certification to her Mental Health First Aid Instructor package and can now offer Youth MHFA. She and fellow instructor Steve Hamerding will be adding a new round of classes in the Spring of 2020. Watch for more information in www.mhit.org.

Save the Date: MHIT 2020
August 3—7, 2020
Information and Applications will be available in January
The ODS family held its annual two-day meeting December 19 – 20. In what has been a long running tradition, the first day was devoted to their annual meeting, while the second day featured a training provided by David Kingsbury, Director of the Office of Deaf Services at the Missouri Department of Mental Health. There is a long history of ties between the two programs, starting when Steve Hamerdinger was the director of the Office of Deaf and Linguistic Support Services in the 1990s.

A Share Shop Thursday afternoon gave ODS staff members a chance to show and tell innovative things they are doing. Breakout sessions that afternoon gave the clinical team, led by Amanda Somdal, and communications access team, led by Charlene Crump, a chance to go over important items of interest to them. A final breakout on Friday afternoon, led by Kent Schafer, gave the staff who have been supporting the deaf unit at Bryce a chance to coordinate things as well.

It wasn’t all work. The planning committee, led by Amanda Somdal and Beth Moss, has fun things planned throughout the two days. One activity was trying to guess which paper tree belonged to who based on clues about favorite movies, favorite foods, even the worst Christmas present ever received. We are still trying to figure out what raccoon is considered a holiday food!

Operation Deaf Santa, for the 10th year, collected and distributed gifts for deaf people in residential programs who would otherwise not have a Christmas. Shannon Reese coordinated collecting and distributing the twenty-two gifts collected from benefactors across the state, which were wrapped and delivered to consumers by ODS regional staff.

The annual December meeting is one of the two times each year when all of the ODS staff gather. This year there are two vacant positions, but the room was still full, as the staff was joined by interns Marissa McBride (Counseling) and Liz Odgen (Interpreting). Even the contracted interpreters were veterans of either MHIT or were former interns with ODS. It is a time to reflect on things done in the past and to plan for things to come in the new year. And what a new year it looks to be. With Dr. Sanjay Gulati coming in February, a slew of training events scheduled, both for the staff and the community, new partnerships being developed, a new Associate Commissioner for Mental Health and Substance Abuse Services, and new staff coming on board in the next couple of months, ODS will...

This chapter will focus on the factors that contribute to the health inequities of a unique, liminal community, namely the Deaf community. Defined as a minority community, both by language and by culture, members of this community experience health inequities differently from other minority communities. Research indicates that Deaf people find it more difficult to establish relationships with health and allied professionals, and to access mental health services because of discrimination, lack of understanding, and practical obstacles experienced within the health system. It is further reported that 80–90% of Deaf and hard of hearing people with severe and persistent mental illness are not accessing mental health services. The literature suggests a higher prevalence of mental health problems for those who are culturally Deaf than in the general population. The most common factor preventing access to services, including assessment, intervention, and follow-up, as well as to mental health prevention materials is inadequate communication. This chapter will explore how a unique form of oppression that relates to the oppression by hearing people of those who are deaf (i.e., audism, the notion that one is superior based on one’s ability to hear or behave in the manner of one who hears), results in health and mental health care disparities. The chapter will conclude with a discussion on recommended practices to facilitate effective engagement with members of this minority culture.


A considerable amount of research exists covering the efficacy of play therapy training models; however, research is not robust when looking at the best training methods applicable for practitioners who may encounter a deaf or hard-of-hearing client. The purpose of the current qualitative study was to explore lived play therapy training experiences, including supervision experiences of mental health professionals who have used play therapy with deaf and/or hard-of-hearing clients. Questions explored the lived experiences and perceptions of both preservice and mental health professionals regarding their play therapy training experiences related to people who are deaf as well as what they perceived to be the effectiveness of their training. Several salient themes emerged to include access to play therapy training and supervision, the value of kinesthetic practice, the importance of process-oriented supervision, depth provided by intensive workshops, and participants’ difficulties adapting play therapy for deaf and hard-of-hearing clients.


Unlike professionals who work with hearing consumers, those of us working with deaf and hard of hearing individuals invariably will encounter our consumers outside of the work environment. Should professionals who work with deaf and hard of hearing clients in vocational rehabilitation, social work, mental health, post-secondary settings or other human service agencies socialize with their clients? How should professionals deal with the number of dual relationship issues that arise on a regular basis? Is the significance of dual relationships different for hearing and Deaf professionals? Whenever we as professionals are operating in more than one role, and when there is potential for negative consequences, it is our responsibility to develop safeguards and measures to reduce (if not eliminate) the potential for harm. Though the potential for dual relationships exists in a variety of human services settings (i.e., case management, assessment, employment services), this article describes a framework for clinical considerations about dual relationships in counseling settings. The focus of this article will be on clinical considerations for counselors that could also be applied to other individuals working in human service areas.


To compare chronic health and mental health conditions between mid-to-older deaf lesbian, gay, bisexual, transgender, and queer (LGBTQ) and mid-to-older non-LGBTQ adults who are 45 years or older. Methods: Medical conditions and mental health disorders data were gathered from 981 mid-to-older deaf adults (178 LGBTQ and 803 non-LGBTQ) who took the Health Information National Trends Survey in American Sign Language between 2015 and 2019. Modified Poisson regression with robust standard errors was used to calculate relative risk estimates and 95% confidence intervals for all medical conditions and mental health disorders with self-reported LGBTQ status as the main predictor, adjusting for known health correlates. Results: Consistent with the LGBTQ health disparity in the general population, our study findings indicated health disparities for certain medical conditions (e.g., lung disease, arthritis, and comorbidity) and mental health disorders (e.g., depression and anxiety) among mid-to-older deaf LGBTQ compared
with non-LGBTQ deaf adults. Conclusion: Like the LGBTQ counterparts in the general population, deaf LGBTQ adults may require more frequent and comprehensive health care services. Culturally and linguistically competent care by providers may be invaluable in reducing such health inequities, particularly when provider education and training is undertaken through an intersectional framework that considers the interaction and context of multiple patient and provider social identities.


Forensic inpatients who experience hallucinations and delusions present with complex clinical needs, which can be exacerbated through additional individual difficulties and disabilities impacting responsivity. Experiences of hallucinations and delusions are shaped by the individual’s context and culture; however, to date this has not been explored with regards to the experience of deaf persons. The current study employed Multiple Sequential Functional Analysis to conceptualize the developmental nature of hallucinations and/or delusions in a sample of three Deaf men from a secure specialist Deaf service. No evidence was found of unique experiences shaping the content and themes of hallucinations; however, participants reported a learning history of associating deafness with being inferior, which later emerged in delusions of grandeur. Across all three cases, there was a noticeable lack of clinical information available in case notes and a lack of targeted interventions offered by forensic service providers.


This article discusses the existence of a cultural and professional obsession with pathology which has jaded mental health assessments of consumers. The importance of incorporating ecological and strengths perspectives into the assessment process is discussed. It is suggested that individual and environmental strengths need to be taken into consideration for a more positive, respectful and empowering shift in assessment paradigms to occur. Deaf knowledgeable mental health professionals have an ethical obligation to consider the strengths and meanings of various d/Deaf, hard-of-hearing and late deafened realities as well as the individual's ancestral, cultural, spiritual and gender realities. A strengths based transactional deafness paradigm allows us to assess and incorporate the strengths and limitations of the person-environment fit and paves the way for a more humane and respectful approach to intervention.
Central Office

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

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

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

**Joyce Carvana, Administrative Assistant**  
Joyce.Carvana@mh.alabama.gov  
Main Number: (334) 353-4703  
FAX: (334) 242-3025

Region I

**Kim Thornsberry, Therapist**  
Kim.Thornsberry@mh.alabama.gov  
DD Region I Community Services Office  
401 Lee Street NE, Suite 150  
Decatur, AL 35601  
Office: (256) 217-4308  
Text: (256) 665-2821

**Keshia Farrand, Regional Interpreter**  
Keshia.Farrand@mh.alabama.gov  
DD Region I Community Services Office  
401 Lee Street NE, Suite 150  
Decatur, AL 35601  
Cell/Text: (256) 929-9208

Region II

**Kent Schafer, Psychologist/Therapist**  
(See Bryce Based)

**Jennifer Kuyrkendall, Regional Interpreter**  
Jennifer.Kuyrkendall@mh.alabama.gov  
1305 James I. Harrison Jr. Parkway,  
Tuscaloosa, AL 35403  
Cell/Text: (334) 328-7548

Region III

**Jag Dawadi, Therapist**  
Jag.Dawadi@mh.alabama.gov  
Region III Community Services Office  
3280 Dauphin Street, Building B, Suite 103  
Mobile, AL 36606  
Office: (251) 234-6038  
Text: (251) 721-2604

Region IV

**Lee Stoutamire, Regional Interpreter**  
Lee.Stoutamire@mh.alabama.gov  
AltaPointe Health Systems  
501 Bishop Lane N.  
Mobile, AL 36608  
Cell/Text: (251) 461-3447

Region V

**Amanda Somdal, Therapist**  
Amanda.Somdal@mh.alabama.gov  
Montgomery Area Mental Health Authority  
2140 Upper Wetumka Road  
Montgomery, AL 36107  
Office: (334) 440-8888  
Text: (205) 909-7307

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

Bryce Based

**Kent Schafer, Statewide Psychologist**  
Bryce Psychiatric Hospital  
1651 Ruby Tyler Parkway  
Tuscaloosa, AL 35404  
Kent.Schafer@mh.alabama.gov  
Office: (205) 409-4858 (VP)  
Text: (334) 306-6689

**Beth Moss, Interpreter**  
Beth.Moss@mh.alabama.gov  
Cell/Text: (334) 399-7972

**Brian Moss, Visual Gestural Specialist**  
Brian.Moss@mh.alabama.gov  
Text: (334) 339-0537

**Vacant, Interpreter**
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 practice, and a comprehensive examination covering all aspects of mental health interpreting.

(Alabama licensed interpreters are in Italics) † Denotes Certified Deaf Interpreters. *Denotes QMHI- Supervisors.

Charlene Crump, Montgomery*
Denise Zander, Wisconsin
Nancy Hayes, Talladega
Brian McKenny, Montgomery*
Dee Johnston, Talladega
Lisa Gould, Mobile
Gail Schenfisch, Wyoming
Dawn Vanzo, Huntsville
Wendy Darling, Montgomery
Pat Smartt, Sterrett
Lee Stoutamire, Mobile
Frances Smallwood, Huntsville
Cindy Camp, Piedmont
Lynn Nakamoto, Hawaii
Roz Kia, Hawaii
Kathleen Lamb, North Carolina
Stacy Lawrence, Florida
Sandy Peplinski, Wisconsin
Katherine Block, Wisconsin*
Steve Smart, Wisconsin
Stephanie Kerkvliet, Wisconsin
Nicole Kulick, South Carolina*
Janet Whitlock, Georgia
Sereta Campbell, Oregon*
Thai Morris, Georgia
Tim Mumm, Wisconsin
Patrick Galasso, Vermont
Kendra Keller, California*
June Walatkiewicz, Michigan
Melanie Blechl, Wisconsin
Sara Miller, Wisconsin
Jenn Ulschak, Tennessee
Kathleen Lanker, California
Debra Barash, Wisconsin
Tera Cater Vorpahl, Wisconsin
Julayne Feilbach, New York
Sue Gudenkauf, Wisconsin
Tamera Fuerst, Wisconsin†
Rhiannon Sykes-Chavez, New Mexico
Roger Williams, South Carolina*
Denise Kirby, Pennsylvania*
Darlene Baird, Hawaii
Stacy Magill, Missouri
Camilla Barrett, Missouri
Angela Scruggs, Tennessee
Andrea Nelson, Oregon
Michael Klyn, California
Cali Luckett, Texas
Mariah Wojdacz, Georgia
David Payne, North Carolina
Amber Mullett, Wisconsin
Nancy Pfanner, Texas
Jennifer Janney, Delaware
Stacie Adrian, Missouri*
Tomiia Schwenke, Georgia
Bethany Batson, Washington
Karena Poupard, North Carolina
Tracy Kleppe, Wisconsin
Rebecca De Santis, New Mexico
Nicole Keeler, Wisconsin
Sarah Biello, Washington, D.C.
Scottie Allen, Wisconsin
Maria Keilm, Wisconsin
Erln Salmon, Georgia
Andrea Ginn, New Mexico
Carol Goeldner, Wisconsin
Susan Faltinson, Colorado
Crystal Bean, Arizona
Mistie Owens, Utah *
Claire Alexander, Minnesota
Amanda Gilderman, Minnesota
Jolleen Hudson, Washington State
Melissa Marsh, Minnesota
Bridget Sabatke, Minnesota
Adrienne Bodisch, Pennsylvania
Beth Moss, Tuscaloosa
Jasmine Lowe, Georgia
Pam Hill, Georgia
Lori Erwin, Georgia
Jenae Farnham, Minnesota
Katherine Anderson, Birmingham
Christina Healy, Oregon
Becky Lukkason, Minnesota
Leia Sparks, Wisconsin
Roxanna Sylvia, Massachusetts
LaShawnda Lowe, Prattville
Jamie Forman, New York
Leia Sparks, Wisconsin
Jamie Garrison, Wisconsin (Emeritus)
Deb Walker, Georgia
Tara Tobin-Rogers, New York *
Leah Rushing, Georgia
Keshia Farrand, Muscle Shoals *
Lori Milicic, Pennsylvania
Shawn Vriezen, Minnesota†
Kathleen Drerup, Colorado
Melody Fico, Utah
Emily Engel, Minnesota
LaVern Lowe, Georgia
Paula MacDonald, Minnesota
Margaret Montgomery, Minnesota
Rachel Effinger, Virginia
Karen Holzer, Wisconsin
Rebecca Conrad-Adams, Ohio
Dixie Duncan, Minnesota
Brandi Hoie, Minnesota
Renae Bitner, North Dakota
Jennifer Kuyrkendall, Tuscaloosa
Jessica Minges, Kentucky
Lisa Heglund, Wisconsin
Colleen Thayer, Oregon †
Susan Elizabeth Rangel, Illinois†
Tina McDaniel, Oregon
Melissa Klindtworth, Washington
Eloisa Williams, Washington
Donna Walker, Washington
Judy Shepard-Kegl, Maine
Lacey Darby, Washington
Danielle Davoli, New York
Sandy Pascual, Oregon
Christina Jacob, Virginia
J. Eric Workman, Tennessee
Kacy Wilber, New Jersey
Cody Simonsen, Utah
“Structurally speaking, language deprivation is incomplete neurodevelopment. Functionally, it is an intellectual disability. Because language mediates and underlies nearly every human activity, those seeking to understand language deprivation must explore concepts and research from a wide variety of fields. That no single authority takes responsibility for a child’s language development may be the main reason that the syndrome persists.” Sanjay Gulati, 2019

Service providers are often frustrated when approaches that work with most deaf consumers fail with those who present with additional language and behavioral challenges. Dr. Gulati will argue for the need to see this population through a new lens, one that recognizes the complicated and confusing mesh of behavior, cognition and language inherent in deaf people with inadequate early exposure to language. He will review the current literature on language deprivation with emphasis on neuro-development and how this influences psycho-social development. review recent research which validates the anatomical basis and time course of the critical period for first language acquisition, and which shows the risks to the development of executive functions, including empathic abilities among individuals who are language-deprived. The presenter will explore ways of adapting programming and service to be more effective with this population.
AUDIENCE: FOR DEAF AND/OR SIGNING PROVIDERS: This session is targeted at service providers who specialize in some aspect of deafness including Mental Health Professionals, Nurses, Social Workers, Counselors, Rehabilitation Counselors, Case Managers, Psychologists, MH, SA, and DD Providers, Group Home Staff, Educators, Educational staff, Interpreters in Mental Health, Community Interpreters, Educational Interpreters, etc.

During this training, participants will gain a thorough understanding of the impact of language deprivation syndrome on aspects of cognition and development within the deaf community.

- Discuss the ideal developmental period for language for a child and why this period is considered “critical.”
- Discuss anatomical details of changes to the cerebral cortex that impact language acquisition over time.
- Learn how language deprivation not only results in communication dysfluency but has significant ramifications for executive functioning, including the ability to empathize with other.

After the training, participants will be able to:
- Understand the causalities and implications of Language deprivation syndrome to executive functioning.
- Recognize developmental disabilities that are subsequent to language deprivation.
- Identify new strategies to engage deaf and hard of hearing consumers.
- Develop resource strategies for effective treatment and service options
- Discuss considerations related to communication approaches.

Sanjay Gulati, MD, graduated from Eastern Virginia Medical School and completed his residency in psychiatry at Albany Medical College, and then held a child psychiatry fellowship at Cambridge Hospital. Ever since, he has been on staff at the Deaf & Hard of Hearing Services at Cambridge Hospital and the Deaf & Hard of Hearing Program at Children’s Hospital, Boston. Dr. Gulati is also a professor at Harvard Medical School, researches in the area of language deprivation, and consults widely to schools and agencies. Drawing from personal experience as an individual with hearing loss, Dr. Sanjay Gulati is well-versed in the challenges and trials associated with deafness. The son of a surgeon and anesthesiologist, Dr. Gulati navigated medical school before the passage of the ADA. He surmounted each obstacle and, in the process, helped others to embrace hearing loss not as a constriction but as an opening door into a wider and better world.

Eligible participants must be in attendance for the full program to receive credit for completing the course.

Continuing education has been applied for in the following areas: nursing, social work, counseling, rehabilitation counseling. Flyer will be updated upon specific approvals.

The Alabama Department of Mental Health Office of Deaf Services is an approved RID CMP Sponsor. This activity has been awarded 0.50 CEUS in the area of Professional Studies by The Registry of Interpreters for the Deaf at the “some” Content Knowledge Level for CMP and ACET participants. Activity # 0263.0220.01.

The Alabama Department of Rehabilitation Services is approved by the Commission on Rehabilitation Counselor Certification (CRCC) to sponsor continuing education credits for counselors. Sponsor number 00060639.
REGISTRATION FOR THURSDAY, FEBRUARY 20, 2020 (DEAF/SIGNING PROVIDERS)

Changing our Mindset: Viewing Developmental and Behavioral Challenges of Individuals who are Deaf through a Different Lens with Sanjay Gulati, MD

Pre-registration is strongly encouraged. Registration fee waived for employees of ADMH, QMHI-Supervisors, employees of CMHCs, and contracted SA provider agencies.

Payment may be made by PayPal (CTRL+ click on your selection below)

Registration fees prior to January 1, 2020
- $50 Registration fee - Early Bird
- $25 Registration fee - full time ITP or Counseling Students (Non-certified, non-working)

Registration fees January 1, 2020 or after
- $60 Registration fee – Regular
- $30 registration fee - full time ITP or Counseling Students (Non-certified, non-working).

FOR ADDITIONAL INFORMATION, SPECIAL ACCOMMODATIONS, OR TO SUBMIT YOUR REGISTRATION:

Checks written to: ADARA/MHIT
Office of Deaf Services
Alabama Department of Mental Health
PO Box 301410, Montgomery, AL 36130
FAX: 334-242-0796
DACTS@mhit.org

In the event the workshop is cancelled, you will be notified by email. No refunds will be provided for participant cancellation.

Please print clearly. Once your registration is processed, you will receive a confirmation email. If you do not receive a confirmation email within 7-10 business days, please contact us at DACTS@mhit.org. Only individuals who have received a confirmation email are considered registered.

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_____ RID  _____ NBCC  _____ CRCC
_____ Social Work  _____ Attendance Only*  _____ Other: ________________

Signs of Mental Health 24
Alabama Department of Mental Health - Office of Deaf Services
Wings Across Alabama and ADARA PRESENTS

How is Working with Deaf People Different?
The Importance of Considering Development, Behavior, and Language in Working with Deaf Consumers

Friday, February 21, 2020
9:00 am to 3:00 pm (5.0 clock hours)
*Lunch on your own

Presenter
Sanjay Gulati, MD

Location
Alabama Department of Transportation
1409 Coliseum Boulevard, Montgomery, AL

“Perhaps once a century, a child with normal hearing experiences isolation from human contact so profound as to prevent learning a “mother tongue.” Among deaf people, by contrast, incomplete language acquisition is epidemic. Acquiring language – any language - is the greatest challenge that deaf children fact. Early language deprivation seems to cause a recognizable constellation of social, emotional, intellectual, and other consequences.” Sanjay Gulati, 2019

Dr. Gulati will review recent research which validates the anatomical basis and time course of the critical period for first language acquisition, and which shows the risks to the development of executive functions, including empathic abilities among individuals who are language-deprived. The presenter will discuss various aspects of working with individuals who are deaf or hard of hearing impacted by language deprivation and how this phenomenon has far reaching impact on behavioral, social, and cognitive development. Which in turn necessitates adaptation in service provision.

AUDIENCE: Hearing/Non-fluent signing/Non-signing providers: This session is targeted at service providers who do not specialize in some aspect of deafness including Mental Health Professionals, Nurses, Social Workers, Counselors, Rehabilitation Counselors, Case Managers, Psychologists, MH, SA, and DD Providers, Group Home Staff, Educators, Educational staff, Interpreters in Mental Health, Community Interpreters, Educational Interpreters, etc.
During this training, participants will gain an understanding of the impact of language deprivation syndrome on aspects of cognition and development within the deaf community.

- Discuss the concept that LDS is a socially constructed developmental disability
- Discuss anatomical details of changes to the cerebral cortex that impact language acquisition over time.
- Explore how language deprivation not only results in communication dysfluency but has significant ramifications for executive functioning, and impact on all areas of social functioning.
- Explore how to foster a more effective environment in education, rehabilitation and treatment settings.
- Explore the consequence of utilizing interpreters in settings with language deprived clients.

After the training, participants will be able to:
- Discuss intellectual and developmental disabilities that are subsequent to language deprivation.
- Identify strategies related to education, rehabilitation and treatment involving deaf and hard of hearing consumers.
- Discuss the implications of Language deprivation syndrome including time, sequencing, cause and effect, abstract concepts, and fund of information
- Discuss the implications of Language deprivation syndrome to executive functioning.
- Develop resource strategies for effective treatment and service options
- Discuss considerations related to communication approaches when utilizing interpreters.

Sanjay Gulati, MD, graduated from Eastern Virginia Medical School and completed his residency in psychiatry at Albany Medical College, and then held a child psychiatry fellowship at Cambridge Hospital. Ever since, he has been on staff at the Deaf & Hard of Hearing Services at Cambridge Hospital and the Deaf & Hard of Hearing Program at Children’s Hospital, Boston. Dr. Gulati is also a professor at Harvard Medical School, researches in the area of language deprivation, and consults widely to schools and agencies. Drawing from personal experience as an individual with hearing loss, Dr. Sanjay Gulati is well-versed in the challenges and trials associated with deafness. The son of a surgeon and anesthesiologist, Dr. Gulati navigated medical school before the passage of the ADA. He surmounted each obstacle and, in the process, helped others to embrace hearing loss not as a constriction but as an opening door into a wider and better world.

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REGISTRATION FOR FRIDAY, FEBRUARY 21, 2020 (Hearing/Non-signing providers)

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The Importance of Considering Development, Behavior, and Language in Working with Deaf Consumers with Sanjay Gulati, MD

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| _____ Social Work | _____ Attendance Only* | _____ Other: |
NEW TRAINING COURSE

Sign Language Deprivation and Dysfluency in Deaf Consumers
Understanding and Responding Skillfully as Interpreters
Presented by NEIL GLICKMAN AND CHARLENE CRUMP

DATES AND TIMES
Friday, April 17, 2020
6-9 p.m.
Saturday, April 18, 2020
8 a.m. – 5 p.m.
Sunday, April 19, 2020
9 a.m. – 12 p.m.

AUDIENCE
Mental Health Interpreters
Must have at least 40 hours of mental health interpreter training. Training will be presented in English. ASL interpreters may be requested when registering.

LOCATION
Country Inn & Suites
1250 South Moorland Road
Brookfield, WI 53005

COST
$300

FOOD
Snacks provided throughout the weekend. Lunch provided on Saturday.

CEUs
RID: 1.4 Professional Studies
Alabama QMHi: 14 hours

This training will focus upon the growing problem for interpreters of working with deaf consumers who are not effective users of either sign or spoken language. We will discuss recognized patterns of dysfluent sign, distinguishing these from variation in sign communication due to region, age, race or the ASL to Sign English sign language continuum. We will also discuss the condition now being called Language deprivation syndrome (LDS), sharing what is known and not yet known about this condition. We will discuss how quality communication and language assessments can assist interpreters, and we will review emerging interpreting strategies for responding to undear and dysfluent language. Finally, we will discuss best practices in collaboration between mental health clinicians and sign language interpreters, especially when the consumer is dysfluent and diagnosis is dependent upon an accurate understanding of the nature of the dysfluency.

The training will be lead by Neil Glickman, a nationally recognized leader in the emerging Deaf mental health clinical specialty and Charlene Crump, a nationally recognized expert in mental health interpreter training and communication assessment. The workshop format will be lecture, review of some video clips of dysfluent signers, and discussion, with opportunities for participants to share their own experiences with dysfluent communication.

Neil S. Glickman, PhD, is a licensed psychologist in Massachusetts, United States. He was co-founder of the Mental Health Unit for Deaf Persons, a Deaf psychiatric inpatient unit at Westborough State Hospital in Massachusetts, where he worked for 17 years, 14 as unit psychologist and director. He is the author of Cognitive Behavioral Therapy for Deaf and Hearing persons with Language and Learning Challenges (Routledge, 2009), and Preparing Deaf and Hearing Persons with Language and Learning Challenges for CBT: A Pre-Therapy Workbook (Routledge, 2017). He is also editor of Deaf Mental Health Care (Routledge, 2013), and co-editor (with Michael Harvey) of Culturally Affirmative Psychotherapy with Deaf Persons (Lawrence Erlbaum, 1996), and (with Sanjay Gulati) of Mental Health Care of Deaf Persons: A Culturally Affirmative Approach (Lawrence Erlbaum, 2003), and (with Wyatt Hall) of Language Deprivation and Deaf Mental Health (Routledge, 2019). Neil was on the editorial board for the Journal of Deaf Studies and Deaf Education for six years. Neil is on the faculty of the University of Massachusetts Medical School, and has a private psychotherapy and consultation practice. Neil has given well over 100 keynote presentations, seminars and workshops on various aspects of Deaf mental health and cognitive behavioral therapy throughout the United States and in Europe.
NEW TRAINING COURSE

PROFESSIONAL INTERPRETING ENTERPRISE

Sign Language Deprivation and Dysfluency in Deaf Consumers
Understanding and Responding Skillfully as Interpreters
Presented by NEIL GLICKMAN AND CHARLENE CRUMP

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CEUs
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Alabama QMHI: 14 hours

Charlene Crump, M.S., CRC, NCC, CI/CT, QMHI-S, is the State Coordinator for Interpreting Services with the Alabama Department of Mental Health. In this capacity, she has developed and runs the Mental Health Interpreter Training Project and a supervised mental health practicum program. She has established certification standards codified into state law in Alabama, the only state in the nation to certify individuals as qualified to work in mental health. Her work has received national recognition by the National Alliance of Mentally Ill. Charlene is a contributor to the RID's and NAD's Standard Practice Papers on Mental Health Interpreting and has served on several expert focus groups regarding mental health interpreting. She has established an ongoing online discussion forum related to current research in mental health and deafness/interpreting. Her work has earned her recognition as employee of the year for the state of Alabama. Additionally, she has been recognized as Interpreter of the year from COSDA and SERID, Lifetime Achievement Awards from ALRID and COSDA, and an Outstanding Alabama Citizen Award from the Alabama Association of the Deaf. Previously she assisted in the passage of state law that recognizes ASL as a foreign language and served two terms as Chair of the State Licensure Board. She is a frequent presenter on regional and national levels and has published several book chapters and articles related to work in mental health interpreting and communication access.

PIE is an Approved RID CMP Sponsor for Continuing Education Activities. This professional studies program is offered for 1.4 CEUs. Some knowledge is required. Workshop will be presented in spoken English with ASL interpretation. Any request for accommodations must be made by March 20, 2020.

SPONSORED BY:

EVENT NUMBER: 0210-0420-01
Help Wanted — Join Our Team

Deaf Therapist II

**SALARY RANGE:** $55,327.20 - $84,350.40

**WORK LOCATION:** Birmingham, AL

**MINIMUM QUALIFICATIONS:**
- Promotional from Deaf Therapist I.
- OR
- Master’s degree in Counseling, Social Work, or Psychology. Must be licensed in discipline.

*Note: If these minimum qualifications cannot be met, the application may be considered for a Deaf Therapist I position.*
- Deaf Therapist I (B9000) – Master’s degree in Counseling, Social Work, or Psychology.

**NECESSARY SPECIAL REQUIREMENTS:**
- Must maintain licensure in discipline. If hired at Deaf Therapist I must demonstrate continual progress toward obtaining licensure.
- Must have near native-level signing skills equal to Advanced Plus level or higher of signing skills in American Sign Language (ASL) as measured by the Sign Language Proficiency Interview (SLPI).
- Must have a valid driver’s license to operate a vehicle in the State of Alabama.

**KIND OF WORK:**
- Serves as a therapist providing clinical services to deaf and hard of hearing consumers in an 11-county area.
- Ensures client files are up-to-date using mental health center protocol.
- Attends, completes, and remains current on all required training at each of the mental health centers served.
- Conducts clinical and communication assessments.
- Participates in Sign Language Proficiency Interview (SLPI) ratings as needed.
- Provides clinical supervision over University interns.
- Completes various reports and paperwork required.

**REQUIRED KNOWLEDGE, SKILLS, AND ABILITIES:**
- Knowledge of mental illness and the effects thereof upon individuals who are deaf or hard of hearing (D/HH).
- Knowledge of psychotropic medications, their use and side effects.
- Knowledge of deaf culture.
- Knowledge of community mental health and community substance abuse service providers.
- Ability to use American Sign Language fluently.
- Ability to utilize the computer, internet resources, and various software packages.
- Ability to communicate effectively both verbally (i.e. spoken English and American Sign Language) and in writing.
- Ability to acquire understanding of visual-gestural communication approaches used by consumers who are dysfluent.

**METHOD OF SELECTION:** Applicants will be rated based on an evaluation of their education, training, and experience and should provide adequate work history identifying experiences related to duties and minimum qualifications as mentioned above. All relevant information is subject to verification. Drug screenings and security clearance will be conducted on prospective applicants being given serious consideration for employment and whose job requires direct contact with clients.

**HOW TO APPLY:** Use an official application for Professional Employment (Exempt Classification) which may be obtained from this office, other Department of Mental Health Facility Personnel Offices, or visit our website at [www.mh.alabama.gov](http://www.mh.alabama.gov). Only work experience detailed on the application will be considered. Additional sheets, if needed, should be in the same format as the application. Resumes will not be accepted in lieu of an official application. Applications should be returned to Human Resource Management, Department of Mental Health, P.O. Box 301410, Montgomery, Alabama 36130-1410 or RSA Union Building, 100 North Union Street, Montgomery, Alabama 36104. Copies of License/Certifications should be forwarded with your application. A copy of the academic transcript is required. Appointment of successful candidate will be conditional based on receipt of the official transcript provided by the school, college, or university.

**DEADLINE:** Until Filled

Click Here to Apply: [https://tinyurl.com/y2pxr4sr](https://tinyurl.com/y2pxr4sr)
Help Wanted at the Civitan Group Home, Clanton, Alabama

The Civitan House is a six bed coed home serving deaf people with mental illness transiting from a hospital setting or in need of diversion from hospitalization. All staff are required to pass a sign language proficiency screening before hire to ensure that the environment is culturally deaf.

Job Description

We are seeking individuals that enjoy spending time with and caring for people! We have full-time and part-time positions working days, evenings and nights in a residential group home setting.

Current Openings:

- Friday-Mon 12a-8a
- Sunday-Thurs 4p-12a
- Sat-Mon 8a-4p

Primary Responsibilities:

Directly supervises the clinical care of clients.

- Observes Clients taking medications and provides verbal assistance to clients as needed.
- Develops and implements clinical programming as designed by recommendation of Home Manager.
- Responds to client crisis or emergencies as needed, assuring client safety and welfare through adherence to Emergency and Safety Policies and Procedures.
- Maintains policy of Confidentiality with regard to client files and other pertinent information.
- Assists Home Manager with tasks related to client admissions and discharges.
- Interacts appropriately with family and associates of client.
- Responsible for facility maintenance.
- Maintains household supplies.
- Maintenance of security and safety measures.
- Maintenance of interior and exterior of residential facility.
- Menu and meal preparation.
- Prepares weekly menus along with clients.
- Maintains weekly food supply within specified budget as directed by the Home Manager.
- Provides transportation of clients as needed.
- Properly operates vehicle in accordance with Center Vehicle Policies and Procedures.
- Safely ensures the well-being of clients while transporting to the Center and other appointments as necessary.
- Strictly enforces Center regulations such as fastening seatbelts while van is in operation.
- Consultation and Education.
- Establishes and maintains effective working relationships with members of community, representing members of the community, representing funding sources, Center staff, and other persons critical to the quality operation of the program.
- Attends and participates in-service training and staff meetings.
- Completes other related duties as assigned by supervisor.
- Executes these duties and responsibilities in a timely and accurate manner.
- Treats such duties with same importance with relationship to confidentiality and priority as other duties and responsibilities unless otherwise instructed.
- Physical Requirements: Must be able to lift up to 100 pounds

MINIMUM QUALIFICATIONS:

HIGH SCHOOL DIPLOMA OR GED; VALID ALABAMA DRIVERS LICENSE AND ACCEPTABLE DRIVING RECORD REQUIRED; ABILITY TO LIFT HEAVY OBJECTS (up to 100 POUNDS). EXPERIENCE WORKING AS MENTAL HEALTH TECHNICIAN OR MEDICAL ASSISTANT HELPFUL. ABILITY TO PASS SIGN LANGUAGE PROFICIENCY INTERVIEW- (SLPI) AT INTERMEDIATE PLUS LEVEL OR HIGHER.

Job Types: Full-time, Part-time
Happy Holidays
from all of us at the
Office of Deaf Services