

Signs of Mental Health



**TODAY'S INTERNS ARE
TOMORROWS
MENTAL HEALTH LEADERS**

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Alabama Department of Mental Health

Office of Deaf Services

P.O. Box 301410, Montgomery, Alabama 36130



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On The Cover:

Left to right: Jaime Condon (social work intern) Amanda Somdal (Social work Supervisor), Brian McKenny (Interpreter Supervisor) Autumn Anderson (interpreting intern) pose outside the RSA Union Building that houses ODS offices. Both interns will be wrapping up their stay with ODS. Read their stories on page 3.

Congratulations to STEVE HAMERDINGER

Steve Hamerdinger, Director, Office of Deaf Services (ODS), Division of Mental Health and Substance Abuse Services of the Alabama Department of Mental Health (ADMH) was announced recently as the recipient of the Boyce R. Williams Award, the highest award presented by the American Deafness and Rehabilitation Association (ADARA).



“To receive an award named after Boyce Williams is incredible and humbling. Dr. Williams was one of the most influential deaf men in the history of the United States,” Hamerdinger noted. “He isn’t well known outside of human services, but almost every major advance in social services to deaf people can be traced directly to some initiative he either started or funded.”

In 2015, Hamerdinger also received the Frederick C. Schreiber Award, which recognizes Dr. Fred Schreiber, the first Executive Director of the National Association of the Deaf, in recognition of his enduring commitment to ADARA.

This award is given to an individual for outstanding contributions to ADARA.

Hamerdinger added he’s never dreamed of receiving these two honors years apart, as only one person had previously been awarded both the Schreiber Award and the Williams Award, Dr. William McCrone. “When ADARA presented me with the Schreiber award, I was very grateful. Never did I dream they would also give me the Williams award some years later– it just doesn’t happen,” Hamerdinger explained.

Hamerdinger has been at the helm of ODS, serving the Alabama Department of Mental Health (ADMH) for over 18 years. Nationally and internationally renowned,

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Editor’s Notes

Another year has come and gone. We might finally be emerging from our long lock down. COVID-19 has created both challenges and opportunities. Some of those are highlighted in this issue, as the Bryce-based give readers a unique look behind the scenes.

We welcome a new member of the staff to ODS, Mary Ogden. If the name sounds familiar, it is because her daughter, Liz, spent a year with ODS as an interpreter intern. ✍

Meet Our Latest ODS Interns

Autumn Anderson, Interpreter Intern

Troy University



I have had the pleasure of growing with this incredible group of people since August of 2020 and will be graduating in May of this year. I am originally from Central Florida, but I have been living in Montgomery, Alabama for nearly eight years.

With the support of ODS, I have learned about the many aspects of interpreting that cannot be taught in a classroom. Exposure to research and interpreting for clients with language deprivation, language dysfluency, and dDeaf+ identities has been a truly enriching experience. Post-graduation, I will be working towards obtaining a 4.0 on the EIPA within a year and then passing the NIC performance by 2024. Meanwhile, I will be working in the educational field as an ASL/English interpreter thanks to the opportunities afforded to me through my scholarship. I believe the experiences I have had with ODS have set a strong foundation that I will continue to build upon for the rest of my career.

Although practicum and internship have been my priorities for the past seven months, I have also tried to schedule time to do things for self-care. My hobbies are reading, sewing, and playing with my pet rats, Hubble and Kepler. I do love a good hike/being out in nature in general and look forward to one day visiting all of the national parks. ✂

Jaime Condon, Social Work Intern

Gallaudet University



I am from Cleveland, Ohio, home of LeBron James. I will be completing my master's degree in social work at Gallaudet University.

Prior to pursuing my master's degree, I attended Kent State University for my bachelor's in ASL/English Interpreting. I attended a two-day workshop on mental health interpreting my senior year of undergraduate school. It was upon attending Steve Hamerdinger's workshop that I began to explore the possibility of becoming a mental health counselor for the Deaf and Hard-of-Hearing community. The ODS staff, especially my supervisor, fosters growth by building up and equipping future generations of social workers. ODS investing in my professional development, with creating a succession plan and guiding me to independently achieve my goals, allows me to develop the skills and knowledge needed for career advancement.

I love to travel and try new things. I've visited Jamaica, Haiti, Iceland, Thailand, Israel, and Canada. I am itching for my next destination once it is safe for us to return to normalcy. I am recently engaged and will be married at the end of this year! Unsure of where life takes up; I am as free as the wind! ✂

INTERESTED IN INTERNING WITH ODS?



For potential clinical or interpreting practicums/internships contact Steve Hamerdinger at steve.hamerdinger@mh.alabama.gov



QMHI Spotlight: Leia Sparks

As I write this article, I am remembering my journey to obtaining my QMHI through the Alabama training. After becoming RID certified in 2010 I knew I wanted to be a legal interpreter. After trying the SC:L and not passing, I was even more determined to try again. You can imagine my disappointment when RID sunsetted the SC:L. I had no intention of pursuing Mental Health interpreting. I realized with the legal work I had done, Mental Health was parallel and engrained in the legal settings.



*Leia Sparks
MS; NIC Master; Q-MHI 2016
Milwaukee, Wisconsin*

This epiphany became a new path I pursued. After the week-long training in Alabama, I immediately signed up for my practicum that I would complete entirely in Wisconsin. I was extremely proud and honored to be the first student in the history of MHIT to complete their 40-hour requirement practicum within their own community.

Interpreting is a practice profession. Working as a Mental Health interpreter, I use Demand-Control Schema (DC-S) to be an active participant in the communication event and emphasize all factors in an assignment that go beyond just language and culture (Dean & Pollard, 2009. Pg.2). I have utilized mentor/mentee debriefs, case conferencing and self-reflection to apply other controls in the work I do. By obtaining my QMHI, I have been requested to provide interpreting with specific customers which in turn instills trust, consistency, and human connection. “Mental Health Interpreters possess a unique skill set which enable them to ethically and responsibly facilitate communication between Deaf patients and hearing entities” (Callis, 2015. SignNexus). My work with different interpreters and mentoring other interpreters has proven challenging and rewarding. These relationships allow me to connect with other QMHI credentialed interpreters. We discuss best practices, work through ethical situations that occur with every job we encounter and most of all we cry, laugh and affirm our work.

Deaf consumers deserve competency from both Deaf and hearing interpreters. I often review and stress any interpreter wanting their QMHI review the following four requirements as stated in the NAD position statement on Mental Health Interpreting Services with People who are Deaf— Intrapersonal Awareness, Expertise in Language and Culture, Confidentiality and Professional Boundaries, and Ethics, Supervision and Peer Consultation.

My successes in Mental Health interpreting is going into every job prepared, calm and willing to be a part of the team. I will have demands that I can’t foresee and will implement controls that are not always conservative and surely aren’t always the best choice. My ability to do what is best for the consumers and myself, in the moment, means my work is successful. Time to doubt, question and be afraid does not help the team dynamic. I have been able to use my training from Alabama to ensure what I bring to the Patient/Provider team is glue that bonds not only the patient/provider’s relationship but my individual bond with the patient and the provider simultaneously.

My hope is anyone pursuing Mental Health Interpreting complete the Alabama training and obtain their QMHI. The time you invest will prove beneficial to your own work and the relationship with your patient/provider team. ✍



References:

- Callis, Lydia. 2015. Mental Health Interpreting. SignNexus. www.signlanguagenyc.com/mental-health-asl-interpreting/
- Dean, Robyn K. and Pollard, Robert Q. 2009. Effectiveness of Observation-Supervision Training in Community Mental Health Interpreting Settings. University of Rochester School of Medicine. Pg. 1-17.
- National Association of the Deaf (NAD). 2021. Position Statement on Mental Health Interpreting Services with People who are Deaf. www.nad.org

BEHIND THE SCENES

We wanted to offer our readers a glimpse “behind the scenes” of the average day of our Bryce-based ODS staff members.

Allyssa Cote, Mental Health Interpreter

A typical day at Bryce is about as predictable as the weather in the south, where we sometimes have four seasons in a day. You know what to expect, given the variables, but you never really know what to expect until you’re in the moment. My day may consist of attending a treatment planning conference where I may be faced with challenges of interpreting for deaf staff, hearing staff and deaf clients – all with possible different language abilities. I may be called to interpret a medical appointment on the Unit with a physician or registered nurse to check an athlete’s foot flare up to stomach pains. I could then be called to Keyboarding to interpret between the Scheduling Coordinator and a Deaf Care Worker about a leave request. On the other side of the hospital, I could be called to interpret a mandatory fire safety drill for staff.



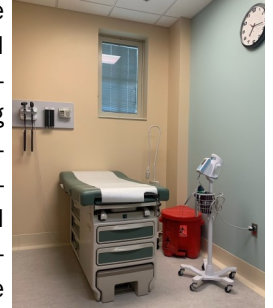
Secured Hospital Doors at Bryce.

The Communication Access Team (CAT) based at Bryce Hospital consists of two other colleagues and myself. This would be our Visual Gestural Specialist (VGS) and a Qualified Mental Health Interpreter. I am able to work with both while on assignments on-campus and off-campus. We also have daily morning meetings to discuss the day – pending the previous night’s 24-hour report. On top of being available to interpret at a moment’s notice on the Unit, I also work on other projects such as co-planning MHIT Alumni sessions and Communication Assessment Reports.

Every day is a new adventure at Bryce and COVID-19 has also presented a new challenge for us. Masks have proved to be one of the biggest challenges in this new world, especially when so many of our patients have some degree of language deprivation and severe mental illnesses that causes them to depend, one way or

another, heavily on non-manual markers and facial expressions. It has forced us to adapt in ways we did not expect, but we have all developed a skill of communicating with that aspect missing.

Isolation is another daunting challenge as many patients cannot see their family, or even have the prospect of transitioning back into the community. It leaves the halls and areas that were once filled with patients and staff mingling and gathering – empty. COVID-19 has created a surreal sense of the world now even inside a state psychiatric hospital, yet I remain grateful. As this hospital operates 24 hours and 365 days of the year, the staff here and CAT did not have the telework option so many others have, it allowed for a sense of normalcy in a time of uncertainty and unrest.



An Exam Room at Bryce.

Hopefully, we will again see the hallways and common areas full of life, soon enough, where daily life resumes as it once was and the challenges during COVID-19 serves as a memory of growth and appreciation.

Brian Moss, Visual Gestural Specialist

Each day starts off with a temperature check upon entry and going through five heavy metal doors to arrive at my office. First on my daily agenda is to learn what events took place during the night by way of Bryce Morning Meetings. This is made up of several Living Areas that make up the Phase II Unit of Bryce and their staff – social workers, registered nurses, peer specialists, assistant director of nursing and the Phase Director. Afterwards, I meet with the rest of the Communication Access Team at Bryce to discuss the day’s interpreting schedule and where I may be needed. This could range from teaming a treatment planning conference, suicide screening, to a monthly notes check-in by the nurse practitioner.



Depending on which day of the week it is, I also would set up

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Behind the Scenes

(Continued from page 5)

a time to meet one-on-one with our deaf patients. This allows them to have some type of outlet for however they are feeling that day. Meanwhile, this benefits me as I continue to observe and learn their preferred signs, or this also allows me to observe any changes in their communication abilities that differs from their baseline.

Other times, I work with individual deaf patients on their treatment plan goals, such as learning their medication names or their diagnoses. As the saying goes, ‘necessity is the mother of invention’— due to the COVID-19 limitations at a psychiatric hospital, I developed what has become known as Alternative Therapeutic Activities (ATA). This allows for other offsite ODS staff to sign up to remotely interact with the deaf patients at Bryce several days a week. This allows opportunity for the teaching of coping skills, games, and current events. Our deaf patients have come to absolutely love the ATA sessions and seeing all the different staff volunteering.



A meeting room for various patient meetings and patient videophone use at Bryce.

When there is down time and I am not working with deaf patients, I work on skill building and take online courses/trainings to increase my understanding of the interpreting process, as I am working towards my national Certified Deaf Interpreter credential. I also coordinate with other members on the Clinical Team and Communication Access Team to see if my services are needed outside of Bryce at any of the Community Mental Health Centers. If so, I coordinate paperwork for my travel and develop a toolkit to use while working with a deaf client. In addition, several times a year, I co-teach a three-day training on Conducting Serious Incident Investigations. This is an interesting dynamic because it is a remote training and my colleagues are hearing instructors. We have a great process in place as instructors that allows for lecture, breakout groups, discussion and role-playing, with the addition of interpreters from CAT.

Working at Bryce during the COVID-19 pandemic, has really changed my entire thought process and approach to working. I am always constantly worried that I might unintentionally give any patient COVID-19 because I work in their home. I was so used to working face-to-face with deaf

patients, as we all were, and at times my work involved a lot of face touching or general touching to communicate or get a deaf patient’s attention, or walking through the hospital halls and having to open metal doors after hundreds of people have already touched it, all the while reminding myself not to touch my face while signing. American Sign Language is my main form of communication and the extra precautions that I take, for myself and others, perhaps gets even more tiring than for a hearing person. Throughout it all, however, I remain positive around all patients and staff, as we are all doing the best that we can during these uncertain times. ✍

Announcing Our New ODS ASA!



Mary Ogden, ASA III

The Office of Deaf Services is thrilled to introduce to our readers, our latest team member, Mary Ogden. Starting on April 20, she has become our Administrative Support Assistant III. Ogden also brings to the table some ASL skills to which we are excited to have as it will be a strong asset to not only our deaf staff but any deaf or hard of hearing consumers who come to our main office in Montgomery.

Ogden comes to us from the Montgomery Police Department where she did similar work. ✍



Congratulations to Steve Hamerdinger

(Continued from page 2)

ODS serves 300 individuals who are deaf and more than 1,500 hard of hearing individuals with severe and persistent mental illnesses and trains hundreds of people in deaf mental health care annually.

Hamerdinger has played a pivotal role in the deaf mental healthcare community for nearly 30 years. Prior to his appointment at ADMH, he was the Director of the Office of Deaf and Linguistic Support Services at the Missouri Department of Mental Health for ten years. His career has expanded into owning and operating a mental health consulting firm that provides consultation and training on mental health and deafness. Hamerdinger's commitment to supporting deaf services reminds everyone that there are no boundaries to what one can achieve.


"I grew up hearing statements such as, "You are deaf, you will never amount to anything. I would like to think I have proven those early distracters wrong," Hamerdinger continued.

His motivation to support the deaf community comes from recognizing the importance of mental health care driven by deaf people.

"For us, By us. Nothing about us, without us," noted Hamerdinger. "As a deaf person who also lives with mental illness, this work is very real to me. I have been lucky and blessed in life. But far too many deaf people have not had the same opportunities I have had and have struggled with challenges far worse than mine. I feel that Providence called me to this work."

He noted that as he enters the late twilight of his career, his goal now is to effectively transition the program to a new generation of leadership, so the work thus far does not diminish.

"I'm grateful to Commissioner Kimberly Boswell and Associate Commissioner Dr. Tammie McCurry, for their support of developing a continuum of care for deaf people – including establishing a new deaf unit in our hospitals that can become the hub of crisis care, where deaf people can have access to American Sign Language fluent clinical care," he explained.

"This path for getting deaf services to where it should be has long been a dream of mine, and it is exciting to see the possibilities are there. I want the program to continue to build on those possibilities and aim for even greater things in the future." 

Originally published in the ADMH Outlook Newsletter MAR/APR 2021 edition.

New QMHI Practicum Sites Now Available!

Alabama (Statewide)

[Keshia Farrand & Brian McKenny](#)

Georgia (Atlanta)

[Sereta Campbell](#)

South Carolina (Statewide)

[Nicole Kulick](#)

Pennsylvania

[Denise D'Antonio](#)

Wisconsin (Milwaukee)

[Kate Block](#)

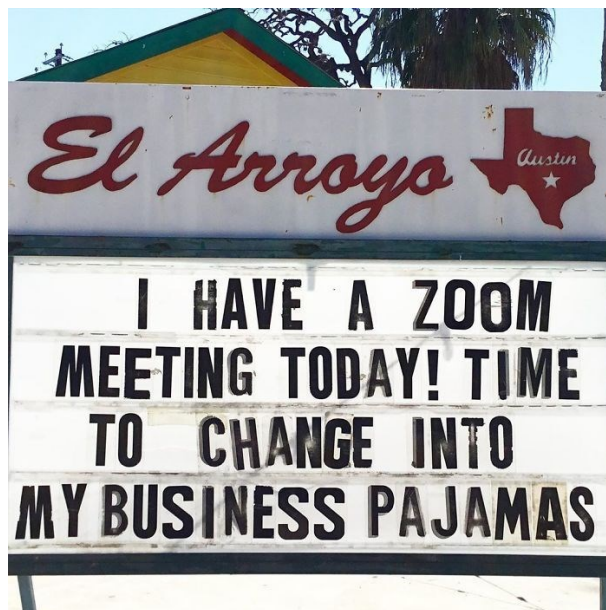
Minnesota (Minn/St. Paul)

[Bridget Sabatke](#)

New Mexico

[Andrea Ginn](#)

Download site descriptions and information [HERE](#). For questions related specifically to the sites, you may contact the site supervisor. For general questions related to the practicum, please click [HERE](#).





Dear Keshia



What seems to be the issue with using a relay service with my deaf clients for their appointment?

- A curious provider

With the pandemic came the “new normal” of remote meetings and telehealth appointments. Many of us went from going into the clinic for a routine appointment to making sure our phones were set to loud or vibrate so we didn’t miss the call with our doctor. But what about when that appointment requires the use of an interpreter? For many, using Video Relay Services (VRS) was so commonplace that using it for a routine appointment didn’t seem like that much of an adjustment. For others, it made the appointments easier because they could call each of their clients the same way without needing to switch to another app or making sure they had a separate device available. However, particularly for mental health appointments, what are the possible implications of this? For Community Mental Health Centers and hospitals providing mental health treatment through the use of interpreters, this has been a big question.

While VRS companies work to ensure their interpreters are qualified (some through national certification, others through screenings), they have not yet recognized the distinction between the “regular” calls – to friends, family, or for business meetings – and mental health calls. This means that any call that comes into a VRS provider is not prioritized into a queue with interpreters who are qualified in the specialization of mental health interpreting. The Alabama Department of Mental Health, Office of Deaf Services has spent the past 18 years training interpreters in the specialization of mental health interpreting. Interpreters who successfully make it through this training, and the accompanying 8-hour exam, are granted the Qualified Mental Health Interpreter (QMHI) designation. This means that interpreters have demonstrated not only their skills in interpretation, but also their abilities to navigate the nuances of mental health work with the goal of working

with the clinician to ensure the client is receiving appropriate services.

In addition to the importance of proper qualifications, we also need to keep in mind that the stakes can be higher in mental health work. Whether that means a misdiagnosis or overmedication, interpreters are the bridge between the clinician and the client. Through the use of a dedicated interpreter – VRS also does not have the capabilities of assigning calls to the same interpreter each time – the client and clinician are able to develop therapeutic rapport and continuity of care. Due to a developed familiarity with the client, when working with individuals with Language Dysfluency or Language Deprivation Syndrome, a dedicated interpreter is better able to recognize any linguistic changes and share them with the clinician.



Though VRS may seem more convenient to use in the moment, it is important to remember that the Americans with Disabilities Act states that interpreters must be qualified for the setting they are in and holds the agency or therapist legally responsible for the content of the message. By choosing to use VRS

interpreters, or even family members, agencies or therapists are increasing their liability. Further, Alabama Community Standards specify that interpreters must be qualified, with the QMHI credential being preferred. While it is best practice to conduct appointments face-to-face, the current pandemic has definitely required all of us to make adjustments and accommodations in order to stay safe. ✍





Important Recent Articles of Interest

Daly, B., & Chovaz, C. J. (2020). Secondary traumatic stress: Effects on the professional quality of life of sign language interpreters. *American Annals of the Deaf*, 165(3), 353–368.

In Canada, sign language interpreters (SLIs) often work in environments where they are exposed to traumatic material, such as mental health settings, but may lack adequate supports and/or specialized training to manage the potential negative implications associated with working with trauma. The primary aim of the present study was to examine whether SLIs were experiencing significant levels of secondary traumatic stress (STS) and to determine how their STS may have affected their professional quality of life (PQL). The study used a sample of 85 Canadian SLIs and examined their experiences of STS and PQL by studying their responses on measures of STS, burnout, and compassion satisfaction. The results revealed a significant relation between STS and burnout, which indicates that SLIs working in trauma-related fields may require specialized training and support to ensure that they possess the necessary skills to manage the potential effects of STS.


Lumsden, K., & Black, A. (2020). 'Sorry, I'm dead, it's too late now': barriers faced by D/deaf citizens when accessing police services. *Disability & Society*, 1-20.

Police organisations have been slow with regards to the integration of services which are accessible and responsive to the needs of D/deaf citizens. This qualitative study explored the barriers which D/deaf citizens face when accessing police. It considered the impact of police initiatives designed to widen the avenues through which D/deaf people can contact them including information and communication technologies (i.e. Emergency SMS Text Services and Video Relay Services) and interpreters. The study involved focus groups with D/deaf citizens, interviews with police officers, and a review of police practices in England. The findings focus on cultural, technological and interactional barriers, and demonstrate that despite indications that members of this community are likely to be vulnerable in terms of victimisation, current policies, procedures and training do not address access requirements.

Peñacobá, C., Garvi, D., Gómez, L., & Álvarez, A. (2020). Psychological well-being, emotional intelligence, and emotional symptoms in deaf adults. *American Annals of the Deaf*, 165 (4), 436–452.

Psychological well-being is a key aspect of mental health. However, it is the focus of few studies among the deaf population. The present study explored the possible relationship between emotional intelligence and psychological well-being in a sample of 146 deaf Spanish adults compared to 146 typically hearing controls. The influence of anxiety, depression, and alexithymia was also assessed. Significant differences were found between deaf and hearing participants regarding anxiety, depression, alexithymia, and psychological well-being. No differences were found between deaf and typically hearing participants regarding emotional functioning. Mediation analysis showed that emotional intelligence significantly predicted psychological well-being both directly, and also indirectly through depression. Effects of anxiety and alexithymia were not significant. Differences observed between deaf and typically hearing participants regarding psychological well-being are discussed in terms of greater depression rates among the former. Deaf participants' intragroup differences are also discussed.

Schnack, K. (2020). Social Isolation, Anxiety, and Stress Among VRS/VRI Sign Language Interpreters During the COVID-19 Pandemic. *Theses/Capstones/Creative Projects*. 117

The coronavirus pandemic has resulted in increased Video Remote Interpreting (VRI) and increased remote working for interpreters who work in Video Relay Services (VRS) as many have received temporary permission to work from home rather than a central call center. While certain occupational health risks such as stress and burnout for sign language interpreters who work in VRS have been studied, no one has studied general mental health among VRS sign language interpreters under the current pandemic (Dean et al., 2010; Schwenke, 2015; Wessling & Shaw, 2014). This study aimed to collect data on sign language interpreters' experiences of social isolation, anxiety, and stress, and to identify measures that VRS and VRI companies have implemented to mitigate the impact of the pandemic. An online survey was sent out to sign language interpreters working in VRS/VRI through two organizations' registries of interpreters. There were 10 respondents. Results showed that many respondents experienced normal levels of stress and anxiety, experienced varying degrees of social isolation, and that their employers have made efforts such as Zoom calls and team group chats to keep respondents connected to colleagues. 



From the ODS Case Files: *Challenging Cases, Creative Solutions*

*By Beth Moss, QMHI,
Bryce-Based Mental Health Interpreter III*

Sometimes communication assessments and observations provide a clear picture of the person's language abilities and weaknesses. This helps to differentiate lack of language exposure from language related issues tied to cognitive abilities or mental illness. Sometimes there are such a myriad of possibilities that teasing out one potential cause from the other can become difficult.

Case Study #1 (*Identifying information including names, settings etc. have been altered for the privacy of those involved*)

The Case

Tom is a 30-year-old African American male who is Deaf and uses sign language to communicate. He is diagnosed with Schizophrenia, Borderline Personality Disorder, and Impulse Control Disorder. He has a history of getting into arguments when he perceives things as unfair, such as others getting attention or opportunities when he does not. For his diagnoses, Tom receives several medications including an antipsychotic, a SNRI (Serotine-Norepinephrine Reuptake Inhibitor), an anticonvulsant, and antidepressants.

Tom also has multiple medical concerns. He has Diabetes, Type 1 and Glaucoma. His diabetes is poorly managed and is difficult to control, and he is referred to as a brittle diabetic. One moment his blood sugar can be extremely low and later it can spike up into extremely high numbers.

Tom appears to have a profound bilateral hearing loss of unknown etiology with presumed onset at birth or an early age. Tom grew up attending multiple schools for the Deaf from kindergarten until he aged out at the age of 20 with a Certificate of Completion.

Tom grew up with his mother and 2 siblings, though often he was away at school. Tom's family did not sign with him, he reported that his mother could gesture a little and his siblings would do the same. He is not currently in contact with his family members. Tom does not use any assistive listening devices such as a cochlear implant or hearing aids.

Tom uses American Sign Language as his primary form of communication, however, shows signs of Language Deprivation Syndrome. When signing to communicate, he often leaves out pertinent information such as the subject, pronouns, and time indicators. Receptively, Tom tends to nod along and indicate that he understands, however he usually comes to erroneous conclusions or must be told instructions again after failing to follow them correctly.

His reading and writing skills are around a 2nd grade reading level equivalence and he has difficulty reading and understanding complete sentences, especially when they contain complex instructions or information. Fingerspelling is also a struggle for Tom. He often struggles to clearly fingerspell words and must try multiple times before becoming frustrated. He is also not able to understand fingerspelled words unless they are words he already recognizes and are spelled slowly and clearly.



Discussion

This case has several considerations:

- Tom's mental health diagnosis and medications. His mental health diagnoses can cause him to have erratic behavior, especially when he feels agitated or that he is being treated unfairly. He often tries to take back control of a situation through negative behaviors. Tom is taking several medications that can cause cloudy thinking, drowsiness, memory impairment, involuntary muscle spasms, and a lack of concentration.
- Tom's medical conditions. These should always be a consideration when watching his behavior. His blood sugar can rise and fall quickly and without warning, which could contribute to his erratic or aggressive behavior. It can also have an impact on how much information he is able to process and comprehend.

(Continued on page 11)

From the ODS Case Files

(Continued from page 10)

- Tom's family and educational background. Tom was not exposed to formal language until he enrolled in a School for the Deaf for kindergarten. He shows classic symptoms of Language Deprivation Disorder, such as fund of knowledge deficits, poor vocabulary, missing referents, and a lack of time indicators (Glickman, 2007).
- Tom's inability to indicate when he is unable to understand. He often nods and then either drawing his own conclusions or misunderstanding what he was told.

Recommendations

- Utilization of a sign fluent therapist or qualified mental health interpreters when working with a therapist familiar with deaf consumers.
- When signing new information, sign it clearly and in smaller "chunks", allowing time between chunks of information for Tom to process and comprehend. Ask Tom to repeat the information after to ensure he understood and could retain the information.
- Utilize pictures and visual aids when possible to assist with message retention and comprehension.
- For difficult or abstract topics, the utilization of a Deaf Interpreter/Hearing Interpreter team.
- Writing and the use of lipreading/speechreading should not be used with Tom as a primary mode of communication.
- When Tom is experiencing high or low blood sugar, communication may need to be suspended until his blood sugar returns to a normal range.
- Due to the diagnosis of Borderline Personality Disorder and Impulse Control Disorder, clear and professional boundaries must be established and utilized when working with Tom. ✂

Notes and Notables

Events and Honors in the ODS Family

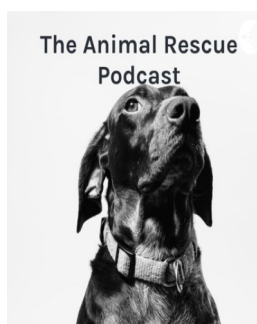
Kent Schafer has been hard at work on many things for his Ph.D. at The University of Alabama. His Poster Presentation Defense, *Evaluating Psychometric Properties of an Existing Functional Communication Assessment for Deaf Consumers*, is now public and can be found at the 2021 Southeastern Universities Graduate Symposium [website](#).

Katherine Anderson has welcomed a new furry addition to her family, Tate "Tater Tot" Anderson. He is a five-month old King Charles Cavalier and Havanese mix.



Tate Anderson

Check out the latest publication by **Charlene Crump**, Neil Glickman and **Steve Hamerding** in the Journal of the American Deafness and Rehabilitation Association. Click [here](#) !



Meanwhile, **Keshia Farrand** has been keeping herself busy with creating—*The Animal Rescue Podcast: What you always wanted to know but didn't know who to ask*. Farrand interviews individuals from rescue organizations, shelters, and others who are getting creative with supporting animal rescue efforts. Check out her podcast episodes on Spotify, Apple Podcasts, Google Podcasts, and [more!](#) ASL versions of episodes are also in development available on YouTube soon! ✂

As I See It
Paul Hamendy



“Zoom Commits To Improving Accessibility,” shouts a recent headline over at the “[Disability Scoop](https://www.disabilityscoop.com)” website, which caters mostly to people with developmental disabilities.

Zoom says it is enhancing its service in order to be more accessible to users with disabilities.

The video conferencing platform that’s become ubiquitous as the COVID-19 pandemic has kept people from meeting in person said it will add automatic closed captioning to its free accounts.

The functionality, which will be called “Live Transcription,” is expected to be available to all users this fall, according to Jen Hill, product marketing manager at Zoom.

In the interim, Zoom will offer automatic closed captioning to meeting hosts upon request, Hill said in a blog post about the new feature.

The move is part of an effort to “provide a platform that is accessible to all of the diverse communities we serve,” Hill indicated. <https://www.disabilityscoop.com/2021/03/05/zoom-commits-to-improving-accessibility/29225/>

This is a headline that only a hearing person who is not plugged into the deaf community could love. One gets tired of non-Deaf people telling the world that Deaf people would just **love** the latest audio-centric, anglophone trick to come down the pike. Even if it worked 100% of the time, which it most certainly does not, it still ignores that set of the Deaf Community which is not fluent in English.

But it makes hearing people **feel** good to “do something” for those “poor hearing-impaired people – Bless their hearts!”

Those “live transcription” things that people (looking to save money on the cost of interpreter/CART?) love to promote are usually not accurate enough to be reliable for any sort of critical or formal situation. For those that don’t believe me, here is an experiment: Go to YouTube. Turn on the auto-generated captions and compare them to what you actually hear. Or check out

<https://knowyourmeme.com/memes/youtube-automatic-caption-fail/photos> which has some real zingers. Example: “EP wetbacks SpongeBob SquarePants on Nickelodeon marry Nick miss you’re...” Huh?



Even the classics are not immune. In fact, the auto-captions are more likely to mess up well-known, but phonetically strange names. For example: “...was made in the land of more doors in the fives...” Now, I happen to know and like Tolkien’s classic *Lord of the Rings*. I even greatly enjoyed the Peter Jackson epic treatment of the same. So, I could recognize and even giggle about “more doors” for Mordor. But what about the average deaf consumer we serve? They are unlikely to have been versed in LOTR and even less likely to know anything about English phonetics. For those readers who aren’t familiar with LOTR, this is the passage in which the above blooper occurred:

But they were, all of them, deceived, for another Ring was made. In the land of Mordor, in the fires of Mount Doom, the Dark Lord Sauron forged in secret a master Ring, to control all others. And into this Ring he poured his cruelty, his malice and his will to dominate all life. “One Ring to rule them all.” One by one, the Free Lands of Middle Earth fell to the power of the Ring. But there were some who resisted. A Last Alliance of Men and Elves marched against the armies of Mordor and on the slopes of Mount Doom, they fought for the freedom of Middle Earth. Victory was near. But the power of the Ring could not be undone. —J.R.R. Tolkien

What is a source of merriment when you are watching YouTube for recreation can be a source of frustration, even danger when it is used as a substitute for linguistically appropriate services in serious settings. Places like the hospital emergency department, the

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As I See It

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court room, the mental health assessment, where exact interpretation can be vital, even life and death critical.

One of the things I initially thought Zoom did right was to at least have the option for plugging in live CART (computer assisted remote transcription) captions into the shell of the meeting. Alas, the end product wasn't as good as it could have been, primarily because of the huge time delay which can occur between the speaker's comments and the text appearing in the caption window. This is a problem because by the time the text appeared on the deaf person's screen, several seconds have elapsed, making it hard to be a participant instead of a passive observer. The lag time has always been a challenge with live captioning. Adding the time to bounce of 2 - 4 additional servers, depending on various factors, makes it worse.

At ODS, we have been using Zoom for large training events, such as the Interpreter Institute of MHIT (see the Summer, 2020 issue for details) the Alabama School for Alcohol and Drug Studies, and bi-monthly webinars. We have learned that accessibility is maximized when we have ASL on the screen (either the presenter or an interpreter) **and** a caption option through a 3rd party provider in a separate browser window. Convoluted, but it works.

Zoom, however, wanted to go further and have automatic captioning,

In the interim, Zoom will offer automatic closed captioning to meeting hosts upon request, Hill said in a blog post about the new feature.

In other words, YouTube video captioning. "More doors" and all. MS Teams does this too and does not have a ready option of plugging in live CART - which Zoom does - and I can tell you from experience that it is... horrible.

That this cheerleading is coming from a disability group is depressing. I thought they would know better. It certainly does not appear that they sought out feedback on the article from the Deaf Community before it was published.

People who aren't deaf spend a lot of time telling other people who aren't deaf what is best for deaf people. I would like to challenge them to depend solely on AI-powered auto-transcription for just a single day before praising the technology. Don't use your hearing at all. Block it all out (I know, that's impossible to do, but play along here.) See how well you cope.

Better than that, if they have some second language knowledge, like Spanish or French, or Chinese, then try to follow the translation in that language, phonetic bloopers and all. **Then** tell me how wonderful it is to get all of your information in this fashion, every day for the rest of your life.

The reason this rah-rah cheerleading sticks in my craw isn't that I hold any animosity toward the program developers. I applaud them, actually, for attempting to add a tool to our toolbox. No, the reason for my ire is that it will tempt the unscrupulous into ditching interpreter and live CART for something that costs them no money and will mislead the ones who want to do the right thing into thinking that auto-captioning is the next best thing to sliced bread.



Don't get me wrong, I have Live Transcribe on my phone and I use it in non-essential situations like talking to the person at Lowes when I want to decide which screw works best. And I confess, I have used it to check practicum interpreters at times. I might even use it if I am pulled over by the police - though I hope that never happens. But to use it when I am meeting with my Commissioner or talking to my financial advisor? No way.

It will not replace the accuracy of CART, or the immediacy of an interpreter. To use Live Transcription, you must have a strong command of English - including phonetics - to be able to work around the errors. For deaf people who are not on the right-hand half of the Bell Curve in terms of English literacy, auto-captioning is, at best, disheartening. It can be harmful in the doctor's office or in the classroom.

As I See It, society ought to be thinking about ways to be more inclusive of our most vulnerable, not inadvertently erecting yet more barriers to full participation. ✂

Deaf Services Group Homes

Job Announcement

LIFE SKILLS SPECIALIST- SIGN LANGUAGE PROFICIENT

Job Location: Woodville, Alabama

Site: Mountain Lakes Behavioral Health

Shift/Hours: PRN, (as needed)

Pay Grade: 11 (\$12.73-\$18.11) Starting pay is \$14.32 per hour

Required Qualifications: This position minimally requires a high school diploma or equivalent, valid driver's license, CPR and First Aid certification (on-the-job training provided), and shall hold at least Intermediate Plus level fluency in Sign Language as measured by the Sign Language Proficiency Interview (SLPI).

Summary of Responsibilities:

This is a direct service position for a group home for deaf and mentally ill residents. Duties will include assisting with day to day tasks of the home as well as helping develop basic living skills for the residents.

Additional Duties:

- Assist clients in program activities.
- Drive or assist driver of agency vehicles in transporting clients.
- Provide direct supervision and personal assistance with clients.
- Residential LSS must maintain MAC (Medication Assistance Certification) and current delegation through the Nurse Delegation Program.
- Implement activities in accordance with daily schedule or planned activities (e.g. learning modules; study assignments; recreational activities.)
- Provide information to supervisor regarding client's behaviors and progress.
- Document client behavior and activities, in accordance with supervisor.
- More specific responsibilities and assignments may be specified by the supervisor.
- Cooking, housekeeping and upkeep of living environment.
- Computer, keyboard and documentation skills.
- Assist clients with standing, sitting, walking, boarding and exiting van or other vehicle.
- Pushing, pulling, overhead reaching, lifting 20 to 80 pounds, for supply needs.
- Bending, stooping.
- Occasional climbing of stairs.
- Other duties as assigned

To Apply:

Resumes may be e-mailed to hr@mlbhc.com , faxed to 256-582-4161, or USPS to: MLBHC-HR, 3200 Willow Beach Road, Guntersville, AL 35976.

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Job Announcements

(Continued from page 14)

MENTAL HEALTH TECHNICIAN

Job Location: Clanton, Alabama (Deaf Group Home)

Site: Central Alabama Wellness

Two position available: Tuesday – Saturday, 8am – 4pm / Tuesday – Saturday, 4pm – 12am

To Apply: E-mail your resume to: recruiting@centralalabamawellness.org

Job Application: Click [here](#)

MINIMUM QUALIFICATIONS: HIGH SCHOOL DIPLOMA OR GED; SLPI RATING OF AT LEAST INTERMEDIATE PLUS; VALID ALABAMA DRIVERS LICENSE AND ACCEPTABLE DRIVING RECORD REQUIRED; FIRST AID AND CPR CERTIFICATION PREFERRED. ABILITY TO LIFT HEAVY OBJECTS (100 POUNDS). EXPERIENCE WORKING WITH PEOPLE WHO HAVE SERIOUS MENTAL ILLNESS PREFERRED. RELATED POST HIGH SCHOOL EDUCATION MAY BE SUBSTITUTED FOR EXPERIENCE.

PHYSICAL AND MENTAL REQUIREMENTS:

While performing the duties of this job, the employee will be required to communicate with peers, clients and/or vendors.

Performs duties that require the employee to stand and walk for extended periods,

Requires ability to operate a vehicle and make sound judgement while driving.

Work requires lifting of up to 100 pounds.

While performing the duties of this job, the employee is regularly required to stand, sit; balance, walk, talk, hear, push, pull, bend, reach, lift, grasp and use hands and fingers to operate home equipment and computer and telephone equipment.

PRIMARY JOB FUNCTIONS AND PERFORMANCE EXPECTATIONS:

Learns and utilizes Chilton Shelby Mental Health Center policy and procedures.

Directly supervises the clinical care of clients.

Observes clients taking medications and provides verbal assistance to clients as needed.

Provides BLS training (individual and group) based on the clinical needs of the clients and submits documentation that meets DMH/Medicaid requirements.

Responds to client crisis or emergencies as needed.

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 with 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.

Maintains productivity requirement of 25% of hours worked.

Completes other related duties as assigned by supervisor.

Executes these duties and responsibilities in a timely and accurate manner.



19th Mental Health Interpreter Training Core Program

August 2 - 6, 2021
A VIRTUAL TRAINING

A Presentation of:
Mental Health Interpreter Training Project,
Office of Deaf Services, Alabama Department of Mental Health.
In Partnership with ADARA

Application available [here](#).

Complete information at www.mhit.org

The Institute Is:

A 40+ - hour course designed to provide a sound basis for clinicians and interpreters to work effectively in mental health settings as part of a professional team. It includes lectures, demonstrations, exercises, evaluation and discussion to develop knowledge, skills and resources to ensure that services are linguistically and culturally appropriate.

- It will include introductions to:
 - ✓ Medical and mental health systems and culture, considering individuals who are deaf
 - ✓ Sources of communication breakdown associated with mental illness and treatment for individuals who are deaf
 - ✓ Clinicians and Interpreters: roles, tools, and resources,
 - ✓ Severe language dysfluency and Visual - Gestural Communication,
 - ✓ Psychiatric emergencies,
 - ✓ Support groups and Community Mental Health Services, and
 - ✓ Demand-Control Theory applied to mental health/deafness work.



Presenters include: Bob Pollard, Robyn Dean, Roger Williams, Steve Hamerdinger, Charlene Crump, Brian McKenny, Kent Schafer, Amanda Somdal, and others.

WHO SHOULD ATTEND:



Candidates for the Alabama Mental Health Interpreter Training (MHIT) Interpreter Institute are selected based on a screening process that ranks the suitability of registrants for available vacancies based on the following categories; Formal education, interpreting certification/licensure, interpreting experience, involvement in the mental health community, involvement

in the language community, continuing education, and residency. This training meets the pre-practicum training requirement of interpreters working towards Certification as a Qualified Mental Health Interpreter according to Alabama State Code 580-3-24.

	Through February 28	Through April 15	After April 15	Day Rate
Participants	\$340	\$390	\$425	\$110
Alumni	\$240	\$290	\$325	\$90

- Before July 1st refunds will be provided upon written request minus 15% processing and handling fee.
- **Refunds will not be provided after July 1st, however, registration fees will be applied to the subsequent year.**
- Discounts available for groups of six (6) or more from the same entity. Must have a single payer. See www.mhit.org for further information and restrictions
- Applications reviewed on first-come, first-serve basis.
Student participation is limited to four students. **Note: Students who apply for worker status must submit evidence of full time status in a recognized University Program along with faculty recommendation.** Contact info@mhit.org for more information.

CERTIFICATION QUESTIONS:

You do not have to be nationally certified to take the training. It is competitively based, however, which could impact an individual's acceptance into the program. Individuals who are Deaf, especially those working in the mental health field or who work as CDI's are encouraged to apply. Alumni of the program are welcome to attend. We reserve the right to cancel the training if minimum class size is not obtained. In the event of cancellation, registration fees will be refunded, however DMH will not be responsible for other costs incurred.

Get up-to-date information at the MHIT website: www.mhit.org. All information and updates will be posted there. If there are any discrepancies between this announcement and the information on the website, the website supersedes any information here.



MHIT ALUMNI SESSIONS

October 11 - 15, 2021

ONLINE

A Presentation of:

Mental Health Interpreter Training Project, Office of Deaf Services, Alabama Department of Mental Health.

In Partnership with ADARA.

Complete information at mhit.org/2021-institute.html

The Alumni Interpreter Institute Is:

MHIT Alumni Sessions is a separate conference that operates in conjunction with the Mental Health Interpreter Training. It is a 40-hour course designed to provide more in-depth and continuing education on topics related to mental health and mental health interpreting building on the foundational information acquired at MHIT.

WHO SHOULD ATTEND:

Candidates for the Alabama Mental Health Interpreter Training (MHIT) - Alumni Sessions have already completed the 40-hour MHIT Interpreter Institute, including but not limited to Qualified Mental Health Interpreters (QMHI), and QMHI—Supervisors. Participant acceptance is on a first come first serve basis.



MHIT CORE ALUMNI PARTICIPANT VS MHIT ALUMNI SESSIONS

Any person who has previously attended MHIT is eligible to attend MHIT Alumni Sessions. Registering for Alumni Sessions provides participants access to only the MHIT Alumni Sessions courses. If a participant would like the option to attend courses in both MHIT and MHIT Alumni Session, then the participant needs to apply for MHIT at the Alumni rate. MHIT and MHIT Alumni Sessions have separate application forms. Participants are required to complete both application forms.

COST OF TRAINING	Through May 31, 2021	June 1, 2021 through August 31, 2021	After September 1, 2021	Day Rate
PARTICIPANTS	\$225	\$275	\$325	\$75
QMHI	\$75	\$85	\$95	\$40

***QMHI-S registration fee is waived**

- A minimum of 4.0 CEUS/40 clock hours will be offered for the training
- Before September 1st refunds will be provided upon written request.
- All refunds will be provided via PayPal and minus 15% processing and handling fee.
- Refund policy remains the same regardless of the format of the conference
- Applications reviewed on first-come, first-serve basis.
- Contact: alumni@mh.it.org (ALUMNI) for more information

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 practicum and a comprehensive examination covering all aspects of mental health interpreting.

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

<i>Charlene Crump, Montgomery*</i>	Camilla Barrett, Missouri	Leia Sparks, Wisconsin
Denise Zander, Wisconsin	Angela Scruggs, Tennessee	Jamie Garrison, Wisconsin (Emeritus)
<i>Nancy Hayes, Talladega</i>	Andrea Nelson, Oregon	Deb Walker, Georgia
<i>Brian McKenny, Montgomery*</i>	Michael Klyn, California	Tara Tobin-Rogers, New York*
<i>Dee Johnston, Talladega</i>	Cali Lockett, Texas	Leah Rushing, Georgia
<i>Lisa Gould, Mobile</i>	Mariah Wojdacz, Georgia	<i>Keshia Farrand, Tusculumbia*</i>
Gail Schenfisch, Wyoming	David Payne, North Carolina	Lori Milcic, Pennsylvania
<i>Dawn Vanzo, Huntsville</i>	Amber Mullett, Wisconsin	Shawn Vriezen, Minnesota†
<i>Wendy Darling, Montgomery</i>	Nancy Pfanner, Texas	Melody Fico, Utah
<i>Pat Smartt, Sterrett</i>	Jennifer Janney, Delaware	Emily Engel, Minnesota
<i>Lee Stoutamire, Mobile</i>	Stacie Adrian, Missouri*	LaVern Lowe, Georgia
<i>Frances Smallwood, Huntsville</i>	Tomina Schwenke, Georgia	Paula MacDonald, Minnesota
<i>Cindy Camp, Piedmont</i>	Bethany Batson, Washington	Margaret Montgomery, Minnesota
Lynn Nakamoto, Hawaii	Karena Poupard, North Carolina	Rachel Effinger, Virginia
Roz Kia, Hawaii	Tracy Kleppe, Wisconsin	Karen Holzer, Wisconsin
Kathleen Lamb, North Carolina	Rebecca De Santis, New Mexico	Rebecca Conrad-Adams, Ohio
Stacy Lawrence, Florida	Nicole Keeler, Wisconsin	Dixie Duncan, Minnesota
Sandy Peplinski, Wisconsin	Sarah Biello, Washington, D.C.	Brandi Hoie, Minnesota
Katherine Block, Wisconsin*	Scottie Allen, Wisconsin	Renae Bitner, North Dakota
Steve Smart, Wisconsin	Maria Kielma, Wisconsin	<i>Jennifer Kuyrkendall, Birmingham</i>
Stephanie Kerkvliet, Wisconsin	Erin Salmon, Georgia	Jessica Minges, Kentucky
Nicole Kulick, South Carolina*	Andrea Ginn, New Mexico	Lisa Heglund, Wisconsin
Janet Whitlock, Georgia	Carol Goeldner, Wisconsin	Colleen Thayer, Oregon†
Sereta Campbell, Georgia*	Susan Faltinson, Colorado	Susan Elizabeth Rangel, Illinois†
Thai Morris, Georgia	Crystal Bean, Arizona	Tina McDaniel, Oregon
Tim Mumm, Wisconsin	Claire Alexander, Oregon	Melissa Klindtworth, Washington
Patrick Galasso, Vermont	Amanda Gilderman, Minnesota	Eloisa Williams, Washington
Kendra Keller, California*	Jolleen Hudson, Washington State	Donna Walker, Washington
June Walatkiewicz, Michigan	Melissa Marsh, Minnesota	Judy Shepard-Kegl, Maine
Melanie Blechl, Wisconsin	Bridget Sabatke, Minnesota	Lacey Darby, Washington
Sara Miller, Wisconsin	Adrienne Bodisch, Pennsylvania	Danielle Davoli, New York
Jenn Ulschak, Tennessee	<i>Beth Moss, Tuscaloosa</i>	Sandy Pascual, Oregon
Kathleen Lanker, California	Jasmine Lowe, Georgia	Christina Jacob, Virginia
Debra Barash, Wisconsin	Pam Loman, Georgia	J. Eric Workman, Tennessee
Tera Cater Vorpahl, Wisconsin	Lori Erwin, Georgia	Kacy Wilber, New Jersey
Julayne Feilbach, New York	Jenae Farnham, Minnesota	Cody Simonsen, Utah
Sue Gudenkauf, Wisconsin	<i>Katherine Anderson, Fultondale</i>	Laura Beth Miller, Alaska
Tamera Fuerst, Wisconsin†	Christina Healy, Oregon	Adeline Riley, North Carolina
Rhiannon Sykes-Chavez, New Mexico	Becky Lukkason, Minnesota	Debbie Lesser, Georgia
Roger Williams, South Carolina*	Leia Sparks, Wisconsin	Sarah Trimble, Minnesota
Denise Kirby, Pennsylvania*	Roxanna Sylvia, Massachusetts	Henry Yandrasits, Wisconsin
Darlene Baird, Hawaii	<i>LaShawnda Lowe, Prattville</i>	Claudia Mansill, New Mexico
Stacy Magill, Missouri	Jamie Forman, New York	<i>Kenton Myers, Hoover</i>

DEAF SERVICES DIRECTORY

Alabama Department of Mental Health

(Mailing Address) P.O. Box 301410

(Physical Address) 100 North Union Street, Suite 770, Montgomery, Alabama 36130

Central Office

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Mary Ogden, Administrative Assistant

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Region I

Kim Thornsberry, Therapist

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Kent Schafer, Psychologist/Therapist

(See Bryce Based)

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Bryce-Based

Kent Schafer, Statewide Psychologist

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Allyssa Côté, Interpreter

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