

PROCEEDINGS  
NAMI/BREAKOUT VIII

A National Conference on PsychoSocial Rehabilitation and Deafness  
New Knowledge, New Perspectives



*September 8 - 12, 2004*  
*Washington, DC*

*NAMI Board Resolution on*  
*Outreach to the Deaf community*

*The following Board Resolution came out of the Marketing and Outreach Committee and was passed by the NAMI Board of Directors:*

*WHEREAS NAMI is an organization committed to diversity and inclusion at all levels of society, BE IT RESOLVED THAT*  
*The NAMI Board of Directors is committed to outreach to the deaf community affected by mental illness and to obtaining funding to further this endeavor.*

September 8, 2004



***It is a great pleasure to welcome you*** to NAMI's 25<sup>th</sup> Anniversary Convention. NAMI is always looking for ways to open our doors as widely as possible to ensure that all people affected by mental illnesses become a strong and vital part of our movement.

We know we will benefit from your contributions to our convention - both to the program and to our knowledge base on the best ways to reach out to deaf, hard of hearing, deafblind, and late deafened consumers, family members, and providers. We are equally confident that you will benefit from the wide array of educational, networking, and social opportunities available to you at our 25<sup>th</sup> Anniversary Convention.

This packet of materials is full of information that will help make sure that you have a fruitful time at our convention. Please review the final convention program to decide what sessions you think will be most beneficial to you. We have arranged for sign language interpretation for all Breakout sessions and for many sessions within the NAMI program. These sessions are specially marked in the program.

There is a special desk set up for Breakout participants in our registration area - in fact, it's where you picked up this packet. This desk will stay open throughout the convention and sign language interpreters will be available there. Should you have questions or encounter any difficulties during the convention, please go to this desk for assistance.

Our convention program is packed full of useful information. We promise you an exciting four days here. But, we also caution you that for first-timers at our convention, the experience can sometimes be a little overwhelming. We encourage you to plan your convention schedule in advance and to be sure to set aside time for rest breaks. Enjoy yourselves. We're very glad you're here. Best regards,

Margaret A. Stout  
M.S.W. President, NAMI Board of Directors

Michael J. Fitzpatrick,  
NAMI Executive Director





**NAMI/BREAKOUT VIII, 2004**  
**A National Conference on PsychoSocial  
 Rehabilitation and Deafness**  
**New Knowledge, New Perspectives**  
**PROGRAM NOTES**

**Conference Planning Committee**

- ◆ Randall R. Myers, Ph.D., LCSW-C, Breakout Conference Liaison to NAMI and Chair of the NAD Mental Health Committee
- ◆ Connie Schantz, NAMI Staff Conference Liaison to Breakout
- ◆ Ann Nagle, Conference Director
- ◆ Marty Raaymakers, Chair, NAMI Consumer Council
- ◆ Tom Lane, Former Director of the NAMI Office of Consumer Affairs
- ◆ Gayle Bluebird, National Advocate
- ◆ Bruce Riley, PreConference Interpreter Coordinator/Sue Tyler, On Site Coord.

**Thank you to:**

- ◆ Phil Kirshner without whom this partnership would never have been formed
- ◆ Mental Health/Deaf Services State Coordinators for supporting this milestone partnership for our consumers
- ◆ NAMI Board for passing a resolution on Deaf community inclusion
- ◆ Ann Nagle and Connie Schantz for welcoming and coordinating Breakout into NAMI's biennial conference event
- ◆ Finally, Bruce Riley, Danielle Puzio, and Susan Tyler at Gallaudet Interpreter Services for providing top quality interpreter and coordination services

**Conference interpreters coordinated by Gallaudet Interpreting Services**

Nancy Bender	Meryl Troop	Jayne Tubergen
Paul Harrelson	Diana Thorpe	Sue Tyler, On Site Coordinator
Bruce Riley	Anne Leahy	



**Conference Sponsors**

National Technical Assistance Center (NTAC) Kevin Huckshorn and Sarah Callahan for helping to bring Mental Health/Deaf Services State Coordinators to the conference States of Pennsylvania and Maryland for helping to bring deaf mental health consumers to the conference





## NAMI/BREAKOUT VIII, 2004 PROGRAM SCHEDULE

A National Conference on PsychoSocial Rehabilitation and Deafness  
New Knowledge, New Perspectives



Wednesday, September 8, 2004 (All sessions below are interpreted)

### Breakout Sessions

### Breakout Speakers

9:00 AM - 12:00 PM Opening Plenary

Welcome, Orientation, and Keynote

Randall R. Myers, Ph.D., LCSW-C,  
NAMI/Breakout Liaison and  
NAD MH Comm Chair  
Marty Raaymakers,  
NAMI Consumer Council Chair  
Phil Kirschner, NAMI, New York  
Keynote: Stephen Weiner, Ph.D.

*12:00 PM - 1:30 PM FREE*

1:30 - 4:30 PM Star Center Roundtable  
Participatory Dialogue  
(with NAMI Consumer Members participating)

Gayle Bluebird (Florida),  
Kathy Muscari, (West VA)

*4:30 - 7:00 PM FREE*

7:00 - 9:00 PM Deaf State Coordinators  
Meeting

State Coordinators, Council Members

~~2:30 - 3:30 PM NAMI Candidate~~

~~Speeches~~ September 9, 2004 (All sessions below are interpreted)

4:00 - 5:30 PM NAMI Opening Plenary

~~8:30 - 9:30 AM NAMI Legislative Plenary~~

8:00 - 10:00 PM Open Mike - Talent Showcase

~~Theme: Best Practices~~

9:30 - 11:00 AM Paper Presentations

1. Reducing/Eliminating Use of Phys. Restraint - Vreeland & Hoover (MA)
2. Pragmatics of Group Therapy - Wax (NC)
3. Interpreter Perspective: Mental Health Issues Panel - Mayer (MO);
4. State Training Project - Apa (PA); State Needs Assessments - Myers (MD); Crump (AL)
5. Improving Competency in Community-based Psychiatric Units - Thorpe (Illinois)
- 6.
7. Psychological Assessments & Services - Hardy-Braz (NC)
8. Clinical Case Management Services-Harbaugh (ME)

11:15 AM - 12:45 AM Paper Presentations

12:45 - 2:30 PM FREE

NAMI Sessions

Friday, September 10, 2004 (All sessions below are interpreted)

Breakout Sessions

Breakout Facilitators and Presenters

Theme: Consumer and Family Involvement

8:45 - 10:15 AM Roundtable

Gayle Bluebird (Florida), Kathy Muscari, (West VA)

10:30 AM - 12:00 PM Roundtable, Cont'd

*12:00 - 2:00 PM FREE*

2:00 - 6:15 PM Breakout Workshops

2:00 - 3:15 PM Session 1

Session 1: Deaf Consumer Group: Making Ohio Work Better - Day (New Hampshire)

3:30 - 5:00 PM Session 2

Session 2: Changing Group Dynamics: Creating a Bicultural Work Group - Kent (New Hampshire)

5:00 - 6:15 PM Session 3

Session 3: Promoting Health Knowledge - Perlman (IL)

*5:00 - 8:00 PM FREE*

8:00 - 9:30 PM Special Performances - Including our own Sherry Hicks

Saturday, September 11 (All sessions below are interpreted)

NAMI Sessions

Breakout Speakers/Presenters

8:30 AM - 10:00 AM Research Plenary

10:30 AM - 12:00 PM Ask the Doctor Sessions

"Deaf Doc" - Dr. Ken Duckworth

*12:00 - 2:30 PM FREE*

2:00 - 3:30 PM NAMI Annual Business Meeting

2003-2008 NIDRR Deaf/MH Research Grant  
Ahearn (New York)

3:45 - 5:00 PM Research Workshops

*5:00 - 5:30 PM FREE*

5:30 - 6:30 PM Breakout Closing Plenary

Testimonials and Future Deaf Involvement

Breakout, 2006, Ohio  
Conference Evaluation

*6:30 - 7:30 PM FREE*

7:30 - 9:30 PM NAMI 25th Anniversary Awards Dinner

Written Keynote by JOANNE GREENBERG, Author and Writer

What a pleasure it is to be part of a convention of people involved in mental health issues when members of the Deaf community are participating. Why? The deaf are a tiny minority of our population, and the deaf mentally ill a tiny minority of a tiny minority. Who will listen? Money is appropriated by groups of officials keenly aware of blocs, populations, and interest groups. Programs for the mentally ill deaf that I saw and some that I helped set up in the 1970s and 80s are closed now, as the hospitals have emptied their patients into the streets, assuming that the right drug, the right mix of drugs would take the place of an often problematic system of personal care. We want to yell at politicians, bureaucrats and the dozens of agencies responsible for the nation's' mental health. What we demand, what we have been demanding, hasn't come. Meanwhile, many of the mentally ill deaf disappear.

Where will we look for them? First, in the prisons. It's an ugly little secret that deaf prisoners are over-represented in the nation's jails and prisons, primarily for sex crimes. It's also true that deaf prisoners are more likely to be abused in prison than the hearing inmates. The deaf are more likely than the hearing to have been abused as children. The prisoners, because of their deafness, cannot usually avail themselves of even the modest therapeutic opportunities hearing prisoners might get.

There's pain in what I am saying, I know. No one wants to face the fact that the percentage of sexual offenses among the deaf is greater per capita than the percentage among the hearing. Their crimes are often brutal, their rates of recidivism high. A few moments of thought will tell you that where communication has been truncated or limited to simple expressions and the most basic information, subtle and complex ideas about sex, love, nudity, need, libido, and appropriate behavior are hardly likely to be transmitted. All of us know examples of misinterpretation between Deaf and Hearing, differences in each other's style and moves. Even so basic a Deaf cultural signal as eye-contact or touch may lead to misunderstandings. Many deaf people suffer intense frustration in their daily lives and have a low tolerance for the long prologue, the gradual coming to "yes" and the seemingly sudden "no."



★ Many of the mentally ill deaf have never been seen by a professional who understands deafness or the deaf sub-culture, although most of the prison staffs know or intuit that they are disturbed. In only one prison in the country are deaf prisoners housed together. In all the other states the deaf are separated from their fellows. This precludes any long-term visitation program or special therapy for the deaf inside the institution. Now and then, an interpreter may be provided for special needs. Now and then, interested parties will visit only to be worn out and frustrated by the extra layers of bureaucratic hoops to jump through, added to the ordinary hoops applied to other prison visits. It has been in nobody's interest inside the institutions to see that deaf prisoners socialize and share programs with other prisoners in other buildings or areas in the system, even though the buildings in a correctional complex may be within short walking distance.

★ Where else are the deaf mentally ill found? At home. Those of us who praise ASL, as I do, must also realize that for the hearing parents of deaf children, ASL is a daunting language to learn and requires a long, difficult course of study, which not many hearing can manage, and none as native speakers. This disjunction creates a major barrier between parents and children. If the adult deaf son or daughter is mentally ill and in the home, how is real communication to be carried out?

★ For the deaf, mentally ill individual, not hospitalized or in prison, therapy may be available, but most of it involves interpreters. Now, I'm imagining myself sitting in a psychiatrist's office, or with a social worker. I am speaking my anguish to an interpreter who will give a literal translation of my words. Many psychiatric and psychological concepts aren't readily available English-ASL, as many ideas are the same struggle ASL-English. Then, there's the intimacy problem. A third person mediating the most personal unlocking, unfolding, and inspecting of intimate secrets is nothing any of us would choose unless there was no other option. The frustration for the patient is daunting enough. Consider the frustration for the doctor, who is far more likely to misinterpret many facets of the deaf sub-culture and misdiagnose the problem. (Few psychologists, social workers, or doctors are expert in sign language and with a family background in deafness.) The doctor is also far more likely to feel he isn't getting through to a deaf patient and prescribe more and higher dosages of psychotropic medications to deaf people with psychological problems.

★ Now comes the difficult part: No prince is in the wings with immense bags of money to whisk these problems away. Changes of leadership won't do it and neither will campaigning for a slice of the pie, which, after AIDS, Alzheimer's, Parkinson's, and all the other ailments is liable to amount to a single withered blueberry with no whipped cream at all. It's about time we stopped taking up inordinate time and energy to go after elusive and ephemeral government grants. We can do more, ourselves; we should.





We might campaign to get prisoners and mentally ill deaf people in group therapy situations and these will be easier to institute when deaf people are housed together, or have convenient day-clinics where they can be seen together. We might inform our lobbyists to help this happen. Then, it would be easier to get the local associations for the deaf, and the mental health and NAMI people, to be available for them. This is difficult but do able. There will be balking, but the charm of my idea is that it is cheap, will yield the prisons very good P.R. and will help break the ice of deaf resistance to volunteering their time and energy. This last is a piece of the puzzle that is necessary and sorely missed.

Deaf people are used to being clients, cases, recipients of services. Many are frightened by bad experiences with hearing professionals, but Signers are no longer mistaken for retarded or mentally ill people; Sign is no longer considered "jargon." Deaf people need to step forward as many hearing have, to visit prisons and hospitals where their fellows are lodged and establish contact with them. It's time to get past the passivity in which the deaf community has, with some notable exceptions, been slumbering.

My next suggestion is that deaf people begin to be trained as therapists, and that deaf volunteers be trained to do therapy with the addition of good treatment programs and supervision by professionals. Programs using such workers have been in the hearing world for years, in churches, as peer counselors, and in mental health centers throughout the country. Volunteering sounds like such a balsa-wood and paper solution to such a major problem, I know, but would it surprise you to learn that ninety percent of the nation's city fire departments are volunteer based and that fifty percent of paramedics and that almost 100 percent of all mountain, and up country, rescue groups are run and staffed by volunteers? Our churches, and synagogues, our scout troops and school sports events are volunteer run. If deaf people want services, they are going to have to begin to provide them for each other without reference to the now-you-see-it-now-you-don't of government aid. Training programs are available. Doctors and social workers have been enlisted to set up these paraprofessional resources. Church groups have non-religious programs of outreach which can provide psychological training.

There are programs for counseling and mental health care for deaf people presently in existence. These need to be supported by groups of deaf friends, in the same way we support our other interests.

I'm helping to support a group of mentally ill people and their friends who have established a day drop-in center, where troubled and mentally ill people can meet and find a sympathetic and knowledgeable hearing from others who are or have been mentally ill, themselves. These free-standing clinics exist all over the country. Why don't the deaf have them? Don't let lack of money





★ prevent these small advances from taking place. Private subscription can cover it. The clinics function that way. Often, just the  
★ knowledge that mentally ill people don't always have to be on the receiving end is a great help in their recovery. Why not this for  
★ the deaf as well?



**Star Center Roundtable Participatory Dialogues  
NAMI/Breakout, 2004**

**Introduction**

Two roundtable sessions were held: The first at the beginning of the conference on Wednesday, September 8th and the second on Friday, Sept 10, 2004.

- Thresholds of Chicago and Deaf Reach of Washington, DC set up Breakout biennial conference in 1989 focusing primarily on the continuing education needs of professionals.
- *This* year the focus is on consumer and family member inclusion through a mutual partnership with the National Alliance for the Mentally Ill.
- ADARA focuses on professionals, including mental health, who serve people who are deaf or hard of hearing,
- Gallaudet University trains professionals, including mental health professionals.
- NAMI focuses on consumer and family involvement and recovery.
- There needs to be a balance between professional and consumer involvement to include the feelings, experiences, and efforts of people who are deaf or hard of hearing and their families.

Approximately 30 to 40 deaf consumers, family members, NAMI representatives, professionals, and NAMI conference attendees attended each session, seated in a circle, representing the states of Maryland, Virginia, California, New York, Pennsylvania, North Carolina, Missouri, Florida, West Virginia, Ohio, Michigan, Wisconsin, Washington, DC, Tennessee, Rhode Island, Canada, Illinois, and Delaware.

**In Roundtable I on Wednesday, the following issues were discussed:**

- warm up, introductions,
- cultural differences,

- diversity of group in attendance,
- history of participatory dialogues See on the Web:  
[http://www.mentalhealth.samhsa.gov/publications/publications\\_browse.asp?ID=4&Sort=Format](http://www.mentalhealth.samhsa.gov/publications/publications_browse.asp?ID=4&Sort=Format)
- how to mix NAMI and Breakout together in the future,
- how to urge NAMI chapters to address Deaf issues in their respective states,
- how could consumers and family members become more involved, and
- what could National NAMI's role be?
- prevalence & incidence of hearing loss.

**In Roundtable II on Friday, the following issues were discussed:**

What we call ourselves: members, consumers, survivors, Deaf, Hard of Hearing...

What we need: Empowerment, self determination, collective, positive change, independence, strength in numbers, share strengths, support.

**Two Questions:**

What is your personal experience with consumer and family involvement in your state?

What is one challenge that has made your involvement difficult?

- Lack of invitation to consumer movement;
- Lack of professional and support services;
- Knowledge and communication gaps;
- Wanting to be more involved and included;
- Stigma of becoming involved;
- Difficulty of self-disclosure;

- Difficult finding consumers and family members who want or can get involved;
- Lack of appropriate tools to educate and encourage involvement;
- Counselor knowledge of how to best support consumer and family member involvement to teach steps in recovery and advocacy;
- Getting allied community professionals to help people to empower themselves;
- Need to establish affiliate groups of deaf people within NAMI state affiliates;
- Hard of hearing people often do not self-identify-need different assistive technology;
- Bring deaf/blind together with fully accessible training;
- Consumers and family members must ask for help at the state level;
- Our responsibility to educate the public.

### Ideas for Consumer and Family Involvement

- Connect with a NAMI Affiliate in your state;
- Establish your own affiliate in your state;
- Become involved in an independent advocacy organization in your state;
- Education for the Deaf and Hard of Hearing community and the general public;
- Get parents involved;
- Collaborate with NAD State Associations;
- Educate on consumer rights;
- Establish a NAMI affiliate on college campuses, e.g., Gallaudet University;
- Set up leadership training opportunities through CONTAC, West Virginia Leadership Academy
- Work with NAMI National to see about establishing a national affiliate or advisory group.

Thanks to:

**Gayle Bluebird, RN**

Advocacy Center for Persons With Disabilities

2901 Stirling RD. Ste. 206  
Fort Lauderdale, FL 33312  
(954) 967-1493.

**Kathy Muscari, Director**  
Consumer Organization & Networking  
Technical Assistance Center (CONTAC)  
910 Quarrier Street, Suite 414  
Charleston, West Virginia 25301

For their help preparing these roundtables, facilitation, and notetaking.





**To create meaningful and sustainable change, restraint reduction efforts must focus on points #2 and #3.**

**The Process**

The steps we took (it is actually more a circular process than finite linear steps) included the following:

- 1. Raise questions/challenge assumptions
- 2. Collect data
- 3. Research & outreach
- 4. Involve the community (staff, students, families)
- 5. Create a project team
- 6. Define tasks
- 7. Support emerging leadership
- 8. Establish plan & process for ongoing work

**To be effective, restraint reduction efforts must have the full support of the agency leadership, BUT the project cannot be a top down dictate. It must be an agency-wide effort to which staff have meaningful input and decision-making authority.**

**Team Structure**

Participation in the project team was open to all employees who believed in the goal, expected to stay with the agency for at least a year, and were willing to commit to attending monthly meetings and doing additional work.

Project Team: 15 volunteers representing all departments      Sub-Groups:

Research

Programming





★ Policies & Procedures

★ Training

★ Facilities

★ Youth Involvement

★ Family Involvement

★

★ **What We Have Done as of 8/04**

★ Reframing

- ★ • Reframed restraint not as an "intervention", but as a treatment failure - "what went wrong?".
- ★ • Increased the frequency of debriefings.

★

★ Research

- ★ • Had two presentations about other programs that have experienced success with similar efforts
- ★ • Formed visiting teams to go to other programs, gather information, and report back
- ★ • Gathered relevant articles and shared them with staff

★

★ Training

- ★ • Redesigned our staff training program and increased the amount of training.

★

★ Programming

- ★ • Developed a new strength based model utilizing the Circle of Courage
- ★ • Developed strength-based skill-building plans and redesigned our treatment plans
- ★ • Staff and residents signed a community pledge to work together to prevent the need for restraint
- ★ • Developed a newsletter to keep parents and others informed of the project

★

★ Policies/Procedures

- ★ • Reviewed/revised policies and procedures to be in line with programming changes

★

★

★

★





★ **Data Collection**

- ★ • Began organizing and reviewing restraint data from a variety of perspectives.
- ★ • At this point, over the past 2 years, we have reduced restraints by about 60%.

★ **Current Challenges**

★ We still have a long way to go, and a comprehensive effort like this takes tremendous energy. The biggest challenge right now is to maintain the focus and keep the energy and work level high. We are adding new people to the Project Team, and will be planning presentations to all staff to keep them engaged and encourage them with evidence of progress.



**RECOVERY GROUP WORK WITH "PSYCHOLOGICALLY UNSOPHISTICATED" MENTALLY ILL DEAF PEOPLE**  
**TOVAH M. WAX, Ph.D., PSYCHOLOGY CONSULTANT**  
**DISABILITY DETERMINATION SERVICES**  
**RALEIGH, NC 27601**

This workshop was focused on demonstrating psychosocial rehabilitation (PSR) group work curricula and activities developed specifically to benefit deaf and hard-of-hearing people who also have other disabilities e.g., mental retardation, autism) that have made many interventions seem inaccessible or inappropriate. Below are tables that briefly summarize the characteristics of inpatient vs. outpatient therapies, characteristics of "unsophistated" consumers and examples of PSR content constructed n a modular format ranging from the most basic ("arousal") to the more sophisticated ("problem-solving") of cognitive-behavioral functions. The actual group activities/exercises were borrowed, adapted, or designed to be compatible with individuals having extremely limited ("unsophisticated") cognitive or mental health resources, but are not limited to them, or even deaf/hard-of-hearing individuals, per se.

**ADDITIONAL CHARACTERISTICS OF "PSYCHOLOGICALLY UNSOPHISTICATED" PATIENTS**  
**(INCLUDING DEAF AND HARD-OF-HEARING)**

**CHARACTERISTICS OF ACCESSIBLE GROUP WORK**

- VISUAL AND ACTION COMPONENTS (VISUAL-KINESTETIC APPROACHES AND STRATEGIES)
- ASSERTIVE REHABILITATION: SELF-AWARENESS, AUTONOMY, PERSONAL REPSONSIBILITY
- PSYCHOSOCIAL REHABILITATION: INTEGRATION WITH DEAF COMMUNITY; INCLUSION IN LARGER COMMUNITY(IES)
- CULTURALLY AFFIRMATIVE: [DEAF] CULTURAL COMMUNITY AND LINGUISTIC CONTEXT RECOGNIZED AND RESPECTED

<b>INPATIENT VS. OUTPATIENT GROUPWORK</b>		
	<b>OUTPATIENT</b>	<b>INPATIENT</b>
<b>TYPICAL METHOD(S)</b>	OPEN-ENDED SESSIONS FREE ASSOCIATION EXPLORATION OF PAST TALKING OUT OR TALKING THROUGH INTERPRETATION OF DYNAMICS THERAPIST "NEUTRALITY"	"SINGLE-SESSION" TIME FRAME STRUCTURED, DIRECTIVE, ACTIVE INTERACTIVE "HERE-AND-NOW" THERAPIST SELF-DISCLOSURE

<b>ADDITIONAL CHARACTERISTICS OF "PSYCHOLOGICALLY UNSOPHISTICATED" PATIENTS (INCLUDING DEAF AND HARD-OF-HEARING)</b>			
<b>POOR COGNITIVE-</b>	<b>POOR LINGUISTIC</b>	<b>POOR BEHAVIORAL</b>	<b>POOR PSYCHOLOGICAL</b>
LOW INTELLIGENCE LIMITED KNOWLEDGE CONCRETENESS POOR WORK ABILITIES	LIMITED SIGN USAGE REPETITIVE SIGNING POOR CONTEXTUAL CUE	AGGRESSIVE SELF-INJURIOUS POOR SOCIAL SKILLS SEXUALLY INCORRECT CRIMINAL BEHAVIORS POOR ADLs	ABUSED AND ABUSIVE SUBSTANCE ABUSE AXIS II DIAGNOSES ERRATIC EMOTION

**PLE MODULES: PSYCHOSOCIAL REHABILITATION**

SURVIVAL SKILLS	SELF-CONTROL SKILLS	INTERPERSONAL SKILLS
AROUSAL ATTENTION CONCENTRATION/FOCUS BASIC MEMORY PERCEPTUAL-MOTOR COORDINATION BASIC COMMUNICATION ADLs	SURVIVAL+ MEMORY SEQUENCING BASIC SELF AWARENESS BASIC PROBLEM SOLVING BASIC SOCIAL SKILLS EMOTION MANAGEMENT SYMPTOM MANAGEMENT	SURVIVAL+ SELF-CONTROL+ ADVANCED SELF-AWARENESS ADVANCED PROBLEM SOLVING ADVANCED COMMUNICATION SKILLS ADVANCED SOCIAL SKILLS CURRENT EVENTS

**SAMPLE SUB-MODULE: ATTENTION**

AROUSAL	BODY LANGUAGE
AWAKE OR ASLEEP?	EYE CONTACT BODY ORIENTATION BODY POSITIONING

**SAMPLE SUB-MODULE: PROBLEM SOLVING**

ATTENTION	CONCENTRATION	MEMORY	SEQUENCING	PROBLEMS
AROUSAL BODY LANGUAGE BASIC COMMUNIC'N	FOCUS (NON-DISTRACT)	RECALL RECOGNITION	REASONING LOGIC	PRACTICE EXERCISES



- For example, to date, the percentage of mental health work fluctuates between 50-90%. Some interpreters will not, or do not have the certification level, to do the specialized work.

### **Mental Health Interpreting**

- The presence of an interpreter alters the relations between the therapist and the Deaf client.
- Much of the importance to the therapy often gets lost in the process of interpretation: humor, sarcasm, and metaphors are all difficult to render appropriately in a second language.

### **Panel Discussion**

- Interactive panel of interpreters who are trained to work in mental health in the United States.
- The panelists will have opportunities to share their expertise in the mental health issues with deaf consumers.

### **Qualified Interpreters in Mental Health Setting**

- Professional , Certified by NAD, the RID and by states that have an interpreter certification process, Excellent language skills, Mental Health Specialized Interpreting Training/Certificate

### **What Mental Health Settings do Interpreters work in?**

- Intake and consent, Testing and diagnosis, Telephone conversations, Counseling-individual and group, Community and social services, Religious settings, Rehabilitation education, Outpatient services, Legal

### **In Conclusion . . .**

- We need to educate the community about the lack of standard of care in mental health services and interpreting in the United States.
- There is a drastic decrease in qualified personnel staff in that serve Deaf Americans.
- We need to increase mental health interpreting education/ training to reduce poor work quality and high stress-related illness among working interpreters (University of Rochester Medical Center)
- We need to continue to spawn service programs to address the underserved treatment needs and provide linguistically and culturally appropriate care of the deaf and hard of hearing population.

### **Here are the questions that were ask of the panelists as follows:**

1. State your background, training, skills and where you work.
2. What basic knowledge and requirement is necessary to work in the mental health setting?
3. Why is mental health training important if the interpreter is already a level 5?
4. What training or education, if any, should interpreters have before going into the mental health field?
5. What are the challenges in mental



**Changing Group Dynamics:  
Creating a Bicultural Work Group  
By Stephanie Jo Kent, M.Ed., CI<sup>®</sup>**

Mental health professionals occasionally find themselves providing services for individuals who are deaf or hard-of-hearing and rely on sign language as their means of communication. This requires the insertion of a sign language interpreter into the communication process, which complicates diagnosis, treatment, and the delivery of services. Effective communication can only be accomplished if service providers deliberately recognize monolingual biases and cultivate a bicultural environment that is sensitive to the nuances of communicating through an interpreter.

This presentation generalizes patterns I've noticed over a decade as a working interpreter, particularly a disjuncture between intention and practice. For instance, groups using an interpreter often set up communication rules (take turns, wait to be recognized by the facilitator before taking your turn, agree on who will be the facilitator) and then promptly violate them. Non-deaf persons speak spontaneously, deaf persons' attempts to be recognized for a turn are often unnoticed, and the facilitator rarely intervenes. Obviously, no one intends to be disrespectful or limit communicative inclusion: there are always severe time pressures, force of habit, and usually a lack of experience communicating cross-culturally.

Basic skills that need to be developed by non-deaf persons in these situations are first of all to use your eyes. This may seem commonsensical, but ASL is a visual language and deaf people communicate visually, not auditorily. Non-deaf persons need to look for and respond to visual cues. Secondly, non-deaf persons need to be aware that there is a time disjuncture: it is as if

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the deaf and non-deaf persons are slightly "out-of-phase." Communicating "as usual" exacerbates this time gap and reproduces the experience of oppression for deaf individuals. Under these circumstances, when a deaf person "finally gets the floor", they utilize it as best they can to share something of their perspective and educate the non-deaf about what matters to them.

These are dimensions of difference along phenomenal perceptions of time, cultural judgments about informational and educational salience, and restrictions in structural opportunities for mutually-intelligible cross-cultural communication. Without deliberate, conscious, and constant attention to the visual, temporal, and structural aspects of the communication process, stereotypes are inevitably and unwittingly reinforced. Deaf people perceive non-deaf persons as always being in rush, ethnocentric, disrespectful and uninvested. Non-deaf people perceive deaf persons as wasting time, tangential, and disrespectful. A reminder: these are generalizations and don't always play out, however they are unfortunately more frequent than rare.

**Remedies are everyone's responsibility. First, trust your perception and intuition - if something seems "wrong" or "off" in the interaction, it probably is!! Assume responsibility for the communication process and therefore responsibility for the relationship. The interpreter mediates but is not "in charge" of what happens between you and your deaf client or colleague. You are.**



Needs Assessment - Deaf Services

1. How do we approach needs assessment planning? Do we look at how the system is functioning or do we ask community members how well they receive services? Or both? There are important considerations, such as confidentiality and knowing where to look for data and input on where Deaf people are being served.
2. What is important, however, is the investment and involvement of stakeholders in the process, for example, Deaf community organizations, Advisory Councils, the State Department of Mental Health, and advocates from many different fields who share the common concern of making services accessible for this population.
3. In addition, a core task force group should be created to carry the project forward, synthesize the data, and utilize the information that comes out of the study.
4. As the needs assessment project progresses, there should be formative and summative reports produced to keep stakeholders up-to-date on progress and to provide input where needed.
5. Community meetings are essential to build cohesiveness, involvement, feedback, and info dispersal when the project is completed.
6. The use of multiple data sources is inevitable and needed due to the dispersed, underserved, low-incidence nature of the population.

Randall R. Myers, Ph.D., LCSW-C

REPORT RE: NAMI Performance

With master storyteller Sherry Hicks

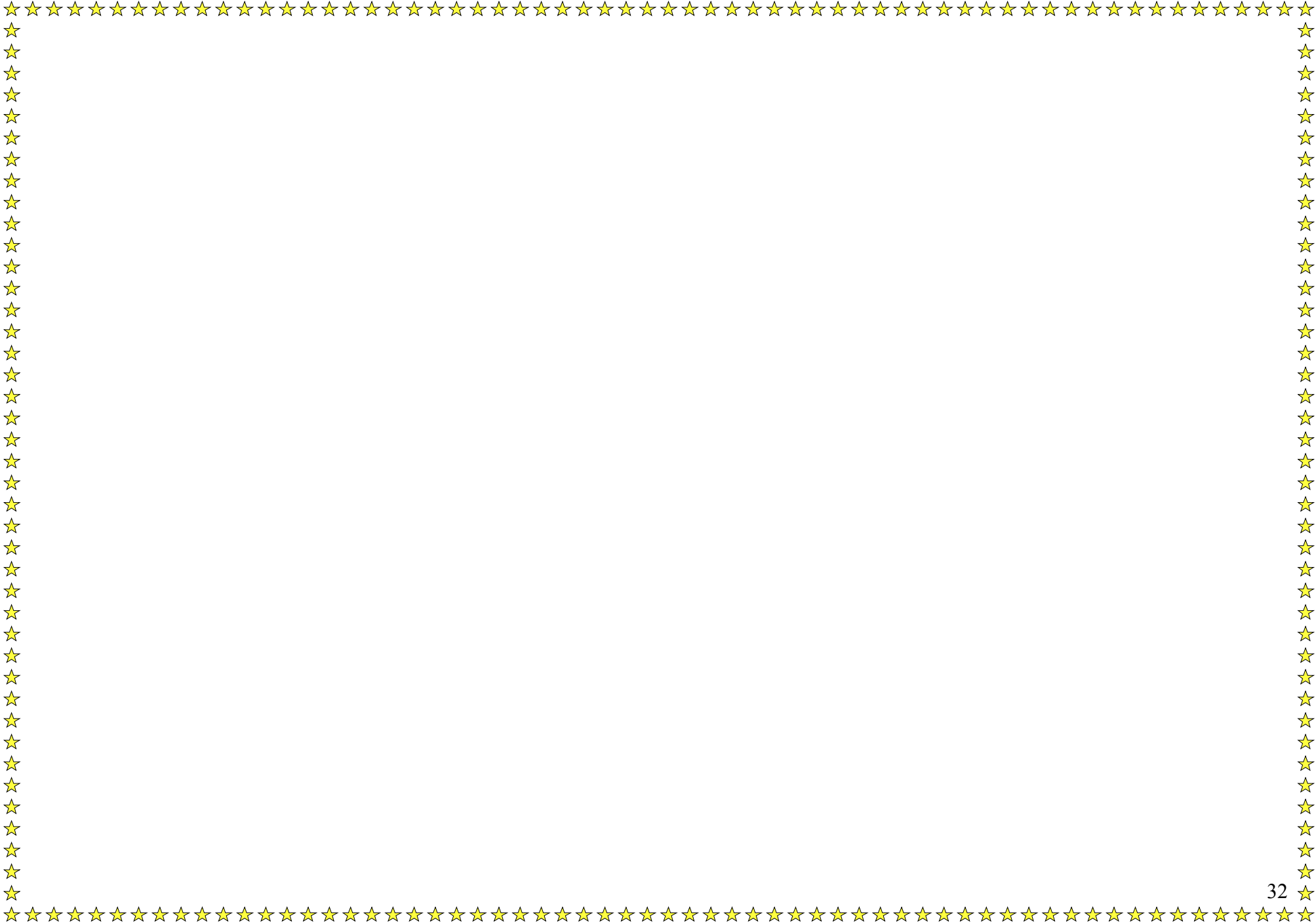
Sherry Hicks

[sherrythe1@aol.com](mailto:sherrythe1@aol.com)

The NAMI Conference was recently held in Washington DC. Among the performers was Sherry Hicks, ([www.half-n-half.com](http://www.half-n-half.com)) master storyteller and performer whose work blends the crafts of music and multimedia with her fluent skills as a native user of American Sign Language, (ASL). This array of Deaf characters brings a wealth of Deaf cultural information and enhanced sensibilities to the audience about Deaf life, perspective, and world view.

Thoughtful funny characters such as the ever popular Mabel, a Deaf senior citizen, are brought to life for all to see and share in an up-close look at what is Deaf! Through storytelling and performance of musical selections translated into ASL and blended with the craft "musically inspired ASL storytelling", (which does both personal and cultural translation of the lyrics making them Deaf-centric); people who experience this craft are mesmerized. It is truly a feast for the eyes not to be missed!

**UNI-Que Productions** was first established in 1992 with the clear purpose of putting a concerted effort into creating performance and literary works that are coda-centric and Deaf-centric in nature. These literary works include scripts, one act plays, and multimedia video documentation of music sign language videos and signing performance ensemble work. Reflected in these works are the following elements including American Sign Language, ASL, ASL improvisation, aspects of the visual vernacular (a term coined by Bernard Bragg) and musically inspired ASL storytelling (Hicks 2001). As this body of work expands, the literary nature is becoming a more solidified into an independent and unique genre.



NAMI/BREAKOUT VIII, 2004  
A National Conference on PsychoSocial  
Rehabilitation and Deafness  
New Knowledge, New Perspectives



**Presenter Biographies**

**★ Keynote Address**

★ **Stephen F. Weiner, Ed.D.** is an associate professor in the Department of Communication Studies at Gallaudet University. He has served as adjunct professor in departments of Counseling, Deaf Studies, and Psychology. Prior to his present job, he has served in different capacities as an administrator, counselor, and dean in different settings in California, Texas, and at Gallaudet University. Originally from Brooklyn, NY, today, he lives with his wife, Dr. Tammy Weiner who is an associate professor in the School Psychology program at Gallaudet, and two children in Davidsonville, Maryland.

★ Dr. Weiner's professional experience is not the real reason for being with you today. He is here today because of his experience as a deaf person growing up in deaf family with a member of the family with serious mental illness and its attendant consequences and impact on the family. His family's amazing journey though the crucible and maze of mental health services or the lack of it that continues to this day should be heard by everyone in the mental health field. Snippets of his journey has been privately heard by individuals over the years. This will be the first time he will attempt share the totality of his experience in a public forum.



★ **Joanne Greenberg**

★ Born in Brooklyn, New York, Joanne Greenberg graduated from American University, Washington, D.C., with a major in anthropology and English literature, and she has studied at the University of London and the University of Colorado. After her marriage, she and her husband Albert moved to Golden - when Dr. Garvin had his office on Washington, and Dr. Jennings had his offices over the bank.

★ When Mr. Greenberg worked as a vocational rehabilitation counselor with a caseload of deaf clients, Mrs. Greenberg became interested in communicating with the deaf, and since then has assisted in the setting up of mental health programs for the deaf in various hospitals throughout the country. This interest also led to her novel IN THIS SIGN, which has been dramatized on television.

★ Mrs. Greenberg and her husband live in a mountaintop home near Lookout Mountain. Their two sons are grown. She writes daily; tutors in Latin and Hebrew; teaches cultural anthropology and fiction writing at the School of Mines; and is active in the Beth Evergreen congregation, conducting bar mitzvah preparation as well as other involvements. She is a past member of the Lookout Mountain Fire Department and the Idledale Rescue Team. She is a frequent participant in writers' seminars and workshops all over the country, and has conducted classes in writing for military personnel in Japan.

★ **Roundtable Facilitators**

★ **Gayle Bluebird**, a national advocate who works in the state of Florida for the state Protection and Advocacy Center. Gayle has developed a national arts network, Altered States of the Arts and produces shows for national consumer conferences. She is also known for work to reduce the use of seclusion and restraint and has developed comfort rooms as a calming strategy.

★ **Kathy Muscari** is Director of the Consumer Organization and Networking Technical Assistance Center, a national self-help project of the West Virginia Mental Health Consumers' Association, funded by the Center for Mental Health Services of SAMHSA. Kathy oversees several recovery-oriented educational and vocational activities involving



★ leadership, recovery and wellness, supported employment, nonprofit governance, etc. Having both academic expertise and life experience gives her a unique perspective for working with consumers of mental health services across the nation, including those with physical disabilities.

★ **Marty Raaymakers** is the NAMI Consumer Council Chair. She is from Michigan and prefers to target her advocacy towards recipient rights, changing services to be offered in the contract, person-centered planning, self-determination, and recovery. Marty works towards helping persons who happen to have a psychiatric diagnosis realize that there is truly hope through recovery and that it is reasonable to expect persons who have a psychiatric diagnosis to have a quality of life that is not just liveable, but one they can enjoy. Marty is an experienced trainer for In Our Own Voice and for the NAMI MI Education Series. She is a public speaker who gives workshops, keynotes and plenary presentations on recovery, person-centered planning and self-determination.

★ **Workshop Presenters**

★ **Jana Harbaugh, LCSW** is a 1992 graduate of Brigham Young University and a 1996 graduate of Gallaudet University's MSW Program. She was hired in 1996 by Community Counseling Center as the first therapist for the Deaf in a community based mental health center in Maine, and worked alone in that position until June of 1998 when the program expanded. She became the program supervisor and team leader in 2002 and has been instrumental in bringing the program statewide. In 2003 she was asked to become the director of the program. She resides in Portland, Maine with her husband and three children.

★ **Steven Hardy-Braz** is a nationally certified school psychologist who specializes in working with students who are deaf or hard of hearing. He completed both his M.A. in Developmental Psychology and his Psy.S. in School Psychology at Gallaudet University. He is currently the President of the North Carolina School Psychology Association and a past-chairman of the state mental health advisory board. He is a certified trainer in non-violent crisis prevention, a national trainer on the classroom and statewide behavior management program, Cooperative Discipline, and an official national trainer of psychologists on the Stanford-Binet 5, Battelle Developmental Inventory II, and the K-ABC/K-TEA II tests.







★ **Jennifer McCann, LCSW** has been working in the field of mental health for 14 years. She has been involved with counseling, clinical case management, group work and advocacy with a variety of Deaf and Hard of Hearing Consumers. Jennifer has worked at CCC's Deaf Services program for 6 years with Deaf families to support children with mental health needs to stay in their home communities.

★ **Randall R. Myers, Ph.D., LCSW-C** is a hearing son of deaf parents from New York City who has served the Deaf community in several human service roles over the past 25 years as sign language interpreter, independent living specialist, job placement specialist, mental health therapist, and state coordinator for the states of Illinois and Virginia. He earned his masters degree in social welfare from the University of California, Berkeley in 1985 and his Ph.D. in mental health policy from the Union Institute in 2002. Dr. Myers has served as Chair of the National Association of the Deaf Mental Health Committee since 1998 and currently works as a Care Manager for Magellan Behavioral Health in Columbia, Maryland.

★ **Amanda O'Hearn, Ph.D.**, is an Assistant Professor of Psychiatry (Psychology) at the University of Rochester Medical Center since September, 2001. She is a graduate of Gallaudet University's Clinical Psychology doctoral program. Prior to being recruited to the Deaf Wellness Center to direct clinical services and launch her academic research career, she completed a post-doctoral fellowship at the University of Miami's Deaf and Hard of Hearing Outpatient Program. Her current research interests lie in efficacy studies of psychotherapy with deaf clients.

★ **Dr. Toby Perlman** is a licensed clinical psychologist in Chicago, Illinois. She has been the manager of the Deaf and Hard of Hearing Program at Advocate Illinois Masonic Medical Center for 7 years and has over 17 years experience providing social services to members of Chicago's Deaf and Hard of Hearing (DHOH) community. She recently wrote and produced a health education film on depression in which all the actors are Deaf and communicate in American Sign Language. Her program is collaborating with the DHOH program at Sinai Health System to develop an eight-week depression self-management program for members of Chicago's DHOH community.

★ **Diana Thorpe CI/CT, MHP** is the part-time Deaf Clinical Liaison/Consultant for Advocate Health Care in the Chicago metropolitan area. She worked with the Thresholds ACT program for 10 years and has taught beginning mental health interpreting workshops. She lives in Chicago where she also maintains a part-time interpreting private practice.





★ **Judy Vreeland** has worked with deaf children and adults as an educator, mental health therapist, and program administrator. ★  
★ She has been the director of Walden School, a residential treatment program serving deaf children and youth, since 1990. She ★  
★ initiated the No Restraint Project at Walden School in the fall of 2002. ★

★ **Tovah M. Wax, Ph. D., LCSW** is currently Psychology Consultant for the Raleigh office of Disability Determination Services ★  
★ (Social Security). Previously, she was Program Director for the Deaf Services Unit at Dorothea Dix Hospital in Raleigh, NC and ★  
★ on the faculty for the Liberal Arts and Human Development Departments at National Technical Institute for the Deaf, ★  
★ Rochester Institute of Technology, Rochester, NY. During that time, Dr. Wax was associate professor of psychology, and chair ★  
★ of Psychological Services and held adjunct faculty positions in education, social work, and school psychology departments. Dr. ★  
★ Wax has also been Coordinator of Statewide Mental Health Services to Deaf and Hard-of-Hearing Persons in Washington, and ★  
★ assistant professor at the Department of Counseling, Gallaudet University. Her primary areas of professional interest are ★  
★ mental health and disability issues, constructivist psychology approaches, and cultural diversity issues, "pragmatics" of group ★  
★ therapy with psychiatric inpatients. ★





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