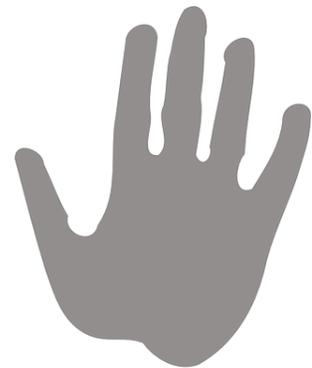
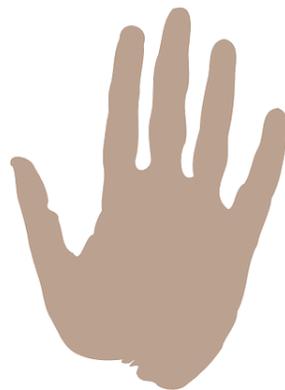
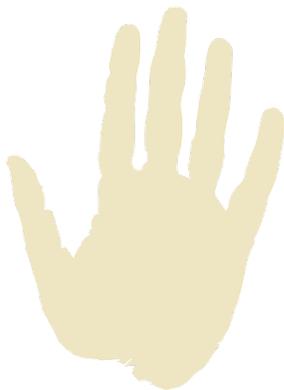
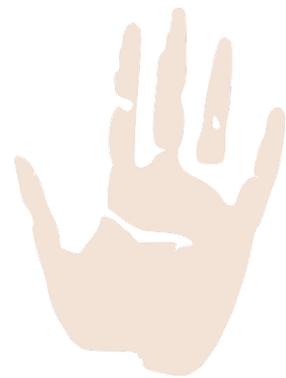




ADARA



Deaf BIPOC: Unpacking the Needs in the Community

ADARA Update

**Professionals Networking for Excellence
in Service Delivery with Individuals who
are Deaf or Hard of Hearing**

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ADARA

2020, Issue 3

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Editorial Policy: ADARA Update strives to be a conduit for the voice of its members to express their ideas, opinions and share information beneficial to the membership. The views expressed by individual writers and columnists may not reflect that of ADARA as an organization or its Board of Directors.

For more information, or to submit an article/column to this newsletter, or information on how to place an advertisement, please contact Jamie Chapin at newsletter@adara.org.



Editor's Notes: *Jamie Chapin*

You may notice that there are more embracing changes since the last newsletter. One of the current important focus is facing, unpacking, and understanding systemic racism, especially in our Deaf community. We have an article featuring on Deaf BIPOC: Unpacking the Needs in the Community on page 6.

Another embracing change includes the accomplishment of passing the bill for "Mental Health for Individuals who are Deaf or Hard of Hearing Bill of Rights Act" (ACT644) in Arkansas. The article on page 9 explains further how this bill became a success.

There are also additional changes within ADARA as well, especially the new logo! Learn more about this on page 13.

If you or your organization are providing innovative services and want to be featured, please submit an article to newsletter@adara.org.

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Reflections: President's Column **Damara Paris**

Honoring Our History and Embracing Change

It has been a hectic but productive three months since our last newsletter. There have been some positive changes as the board moves forward with conducting ADARA business. I would like to highlight a few of the changes that have occurred recently. I will briefly mention some of the changes, and then discuss the 100th anniversary of vocational rehabilitation.

ADARA Logo. As you may notice, there has been a change in the ADARA organizational logo. Please refer to the article in the newsletter that highlights the change for the new look, the historical information related to the previous logo, and our reasons for the change. We hope you like the logo as much as we do!

ADARA Office Coordinator. For the past two years, Jessica Bellewood has served as our office coordinator. She has worked hard on streamlining our procedures, especially the coordination of monthly revenue and expenditures, maintained communication with our membership, and running the day-to-day operations. Unfortunately, Jessica has had to step down and focus on the needs of her family as well as graduate school. We are very fortunate to have John Gournaris as our new office coordinator. With over ten years of board membership and conference coordination, he truly is an asset to ADARA. John resigned as the past president and began his new role on June 1, 2020. He will continue to oversee social media channels, website maintenance, membership roster, JADARA subscriptions, and other relevant office duties.

ADARA 2021 Conference. The ADARA board continues to work steadily on the 2021 conference that will take place March 21-25, 2021 in Albuquerque, New Mexico. We are operating on the assumption that the conference will take place, while keeping a cautious eye on the ever-changing nature of the current pandemic. We have decided on the conference theme: *Soaring to New Heights*. Look for more information this summer regarding our conference including, a call for proposals, sponsorship opportunities, hotel information, and many more! We are also recruiting for new board members, so please consider joining our board as a President-Elect, Vice President, Secretary, Treasurer, and Member-At-Large (2 positions).

The 100th Anniversary of Vocational Rehabilitation



I would like to take an opportunity to recognize the 100 anniversary of the field of Vocational Rehabilitation. In actuality, Vocational Rehabilitation Services were established earlier, but focused on serving military personnel. The Smith-Sears Veterans' Rehabilitation Act of 1918 initiated a program to provide vocational assistance and employment support services to veterans who were disabled during World War I.

On June 2, 1920, President Woodrow Wilson signed into law the Smith-Fess Act. Referred to as "The National Civilian Vocational Rehabilitation Act," this law made possible the first federally funded program assisting people with disabilities who had not acquired their disabilities during military service. This was a significant expansion, as the U.S. transitioned from an agrarian economy and increased industrial-based employment. These positions also had high number of injuries and fatalities. According to the Morbidity and

Mortality Weekly Report (1999), the earliest systematic survey of workplace fatalities in the U.S. covered Allegheny County, Pennsylvania in 1906-1907, reported that 526 individuals died from work-related accidents in that county, and of that number, 195 were steelworkers. Thankfully, in the last few decades, workplace safety regulations have been put in place, reducing the number of workers dying or becoming disabled.

Vocational Rehabilitation Counselors have essentially belonged to one of the oldest professions that provide services to people, preceded by the field of social workers. This is in contrast to other social service fields such as mental health counseling, which is cited as one of the youngest professions during the 1970's (Pistole, 2001).

Although we have experienced a pandemic that has reduced our ability to travel or congregate in large numbers, those in the field, on a federal and state level, have still found ways to celebrate this historical event.

On the federal level and national level, there has been a continuously [updated website](#) through the Rehabilitation Services Administration (RSA) under the Office of Special Education and Rehabilitation Services (OSERS). A one-hour webinar entitled [VR100: A Century of Success](#) is available on YouTube and highlights successes of this 100 year-old legislation. A Vocational Rehabilitation Anthem entitled [Lead On](#) was recorded by George Dennehy and the voices of rehabilitation choir. It also features a host of professional musicians, a choir of students with disabilities from Wilson Workforce as well as Kathy Lafon and Jennifer Kirkland.

Various states have recognized the event as well, most choosing to download the [VR 100 logo](#) and links to the VR100: A Century of Success webinar. Washington State's Governor Jay Inslee proclaimed June 2020 as the [VR 100 Anniversary Month](#) and the Washington State Department of Social and Health Services named several state [Champions of V.R.](#) on their website. The governors of the states of [Texas](#), [Idaho](#), and [Wisconsin](#) also issued proclamations on the recognition of VR 100. The [Oklahoma Rehabilitation Services](#) interwove the VR 100 theme with historical information pertaining to the legislative history and Oklahoma rehabilitation statistical information on their website. The state of Colorado division of Vocational Rehabilitation plans [celebrations in October 2020](#) during Disability awareness month.

What are your plans for celebrating this historical event? What is your state V.R. division or employment-related organization's plans? We would love to hear about your recent or upcoming events related to VR100. Send us an e-mail with the information, or post this on our ADARA Facebook page! Until then, stay safe and we look forward to connecting with you in our next newsletter or through the 2021 conference!

Damara Paris, Ed.D., CRC, NCC, LPC

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Morbidity and Mortality Weekly Report (1999). Achievements in public health, 1900-1999: Improvements in workplace safety -- United States, 1900-1999. *MMWR*, 48(22):461-469

Pistole, M.C. (2001). Mental health counseling: Identity and distinctiveness. *Eric Digest*. Contract EDO-CG-01-09.

2021 ADARA CONFERENCE



March 21-25, 2021

Hotel Albuquerque at Old Town
800 Rio Grande Blvd NW
Albuquerque, NM 87104

[Hotel Video](#)

More information at

www.adara.org

Deaf BIPOC: Unpacking the Needs in the Community

Written by: Kristie Medeiros, M.ED, Devonta Thomas, BA with Andrea Wohl, LMHC



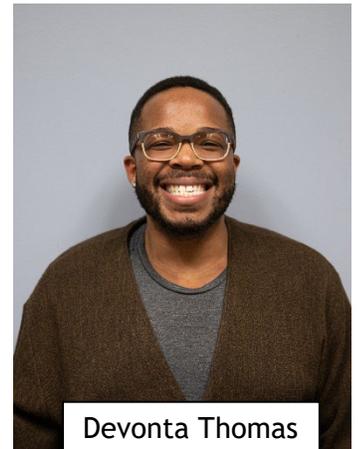
Kristie Medeiros

In many ways, the Deaf community parallels the hearing community in America in that the majority of research, information, and education is geared towards the WHITE Deaf community. When you research the Deaf community, you will find information relating to the white educated Deaf community. Only recently can you begin to find information about and pertaining to the Black and Indigenous People of Color within the Deaf Community (BIPOC). Deaf BIPOC have historically lacked access to information (information controlled by white Deaf people), been deprived of equal access to education and language, been left out of outreach efforts by social services and faced scores of systemic racism in health care access, insurance,

health care information, general community information and the like. In short, systemic racism is alive and well within the Deaf community.

Deaf BIPOC are not a homogeneous group. Some are Christian. Some Muslim. Some Atheist. Some are gay or lesbian or transgendered. Some are Latina, Caribbean, African American, Puerto Rican, Asian, and Native... the list goes on. BIPOC with more than one identity are referred to as having *intersectional identities*. Therefore, Deaf Black people will automatically have intersectional identities. Do we identify as Black or Deaf? Latino or Gay or Deaf? Who does it matter to and why?

We both work at Walden Community Services providing Therapeutic Mentoring (TM) or Therapeutic Training and Support (TTS) to families where the youth has been identified as having emotional or behavioral needs. We function as role models in a therapeutic context, primarily using a Wraparound model of intervention. We work as part of a larger team who works with the entire family to address issues the family identifies.



Devonta Thomas

It is considered a “best practice” and a culturally competent practice for Deaf children and families with a Deaf member to receive clinical support using a professional with direct communication (typically in ASL). If that cannot be obtained, then a certified ASL interpreter should be provided along with clinicians. The same reasoning is why, as BIPOC’s (one Deaf and one hearing) we feel passionate about ensuring all families and youth of color have professionals of color as providers and mentors. We feel it is not only culturally competent, but should be considered a “best practice” as well. This article will reflect on the work we have done via anecdotes. It should be noted that Massachusetts does not have a single state school for the Deaf. Each of the three cases below represents experiences from three different day schools for the Deaf in the state. To us, this illustrates how pervasive systemic racism is and how much work is needed to support Deaf BIPOC’s.

Devonta works with a Black Deaf boy of Caribbean ancestry--we will call him B. B. lives with his hearing aunt and attends a Deaf school. His aunt insisted that B. have a Black mentor as she believes he is struggling to understand what it means to be Black in a white world. She is also concerned about his hearing loss and being the only Deaf person with a close hearing family and extended family. B’s aunt and Devonta discussed his intersectional identities. His aunt mentioned she felt comfortable discussing this with a Black man. She stated that there were too many white professionals making decisions and felt Black representation was lacking in B’s life. She stated: “representation is so important.” The team decided that

B. had plenty of Deaf peers and mentors at school, but NO Black male mentors. It was easy to decide that Devonta would be a perfect fit as a TM. Because, as his aunt noted: *Representation IS so important.*

After the killing of George Floyd, B. made a video and posted it on a social media site. In it, he expressed his perception of how he may have been racially profiled and oppressed. In the video, he shared how he started off in one academic group, but slowly saw his white peers advance while he felt left behind. He goes on to express that he was forced to get additional academic support because his signing was not up to par with the rest of his peers. B. concluded he was a victim of racial discrimination by watching vlogs from others speaking up about how they were discriminated against as well. B. and Devonta are able to discuss systemic racism (being left behind his white peers in academic settings) and learn how he can help advocate for himself. He is also learning how to get support within the Black Deaf community and the Black community. Devonta and B. plan to continue to work to explore what racism means and how B's intersectional identities as a Black Deaf young man will impact him. They will work to advocate for B. so that B. can get the kind of educational opportunities he deserves.

Kristie works as a Therapeutic Mentor with a Black Deaf transition-aged female from a Caribbean Island culture--we will call her J. J. She was homeless, living with an interpreter from her school after having been traumatized in her family home. The first time Kristie and J. met was at a Care Planning Team meeting. All the providers and the interpreter where she lived, were white. That team had been working with J. for several months, and getting nowhere. Some of the providers were Deaf, and everyone was fluent in ASL, but there was not a single provider of color at the meeting--until Kristie arrived. When J. saw Kristie, her eyes lit up. J. quickly told Kristie what she wanted from the meeting, and Kristie was able to share this with the team. A plan was then put into place where Kristie worked with J. to teach her about her rights as a Deaf Black woman. Kristie helped empower J. to speak up when she wanted something. Kristie and J. spend long hours together discussing what it means to be independent and self-sufficient. Kristie encouraged J. to see a therapist to help deal with past traumas.

J. saw a white, male, hearing, signing therapist a couple of times but felt it wasn't right for her. At one point during their work together, Kristie disagreed with a Deaf white female clinician to model for J. how to disagree with a professional and stand up for herself. Kristie encouraged J. not to get stuck in the past, and to envision a future for herself. With Kristie's support, J. graduated High School and applied to (and was accepted to) a local community college. J. will be moving to her own apartment in a few weeks and is now connected to both Deaf community resources and the DIPOC community in Boston. She creates her own agenda for meetings and is working hard to achieve her goals. She is solidly on the road to success. Kristie and J. credit J's success with being heard and seen and validated. Through Kristie, J. was able to feel represented and begin the process of advocating for herself.

Devonta and Kristie both work with another family of a Deaf female who is Black and Dominican--we will call her C. C. attends a school for the Deaf and has emotional disabilities. Since the age of four, she has had difficulty maintaining positive relationships with adults and peers. Her teachers report her as "rambunctious, inconsiderate and lazy." The school has filed several reports of child neglect with the State's child protective services agency. Each time the agency has been unable to find any evidence of neglect. The relationship between the school and the family has deteriorated to the point that the family does not engage with the school. C's mother feels that the school targets her family and other families of color in reporting neglect. The mother also feels that there is no representation of Latinos or people of color at the school or "around the table" during IEP meetings. She feels she, her daughter, and her family and community are targets of racism by the school. We felt that it would be appropriate for Devonta to work with the mother and family as a Black hearing man, while Kristie, as a Deaf Black woman would work mentoring C. This is the first time C. worked with another Deaf female of color. We are optimistic that C. and Kristie will be able to develop a strong and authentic relationship. Again, we are struck by the importance of *representation*.

All people need representation. All people deserve to see a version of themselves in schools, communities, and workplaces. Deaf people, mostly white Deaf people, worked hard to make sure that Deaf individuals taught and mentored Deaf children. BIPOC who are Deaf deserve to have teachers, counselors, and mentors who represent this intersectionality. We hope that in providing this to youth and families in our community, we can empower these young people to live lives they find fulfilling with families and communities that support their dreams and goals. It is also our hope that additional studies can be done to validate the importance of representation in the lives of Deaf BIPOC. Ending systemic oppression of Deaf people AND racism will take time. We feel we are uniquely suited as professional Deaf and BIPOC to help families in this endeavor. For more information on the services provided by Walden Community Services, please visit our website: <https://www.tldeaf.org/behavioral-health/walden-community-services>



MHIT Goes Virtual*

Written by MHIT Staff



Alabama's Mental Health Interpreter Training Project

A Partnership between the Alabama Department of Mental Health's Office of Deaf Services and ADARA

The Mental Health Interpreter Training (MHIT) Project will be conducting its eighteenth training August 3-7, 2020. This year has been full of challenges for our nation. One of those challenges has been the COVID-19 pandemic, as a result, the leadership of MHIT decided that for everyone's safety, the training would be conducted remotely. This has been a major undertaking for our office. Most webinars consist of a one-off workshop of various lengths, but MHIT is a cluster of workshops from multiple presenters in several locations across the United States presenting to participants from all over. The presenters have been and are the best in the field when it comes to mental health interpreter training and we are delighted that they have been willing to enter in this new adventure to make sure that MHIT occurs this year. One of the aspects of MHIT is always the "extras" and the amount of detail that has been included in the planning - maintaining all of these features (OTJ, Poster sessions, Diversify, meeting the presenters, networking with others in the field, etc.) are challenges to consider.

As with all opportunities for growth, comes change. One significant change is the decision to run the MHIT Alumni consecutively. The Alumni track open to anyone who has taken MHIT in a year prior to 2020 and will run August 10-14, 2020. This allows us to conserve bandwidth from our central location and to rally resources in a consecutive manner. It also opens up the opportunity for alumni who register for the CORE training to attend both weeks and earn up to 8 CEUS/80 Clock Hours.

The trainings will run through Zoom and CourseSites. A section of the training will be included in an asynchronous format on CourseSites which will offer additional continuing education opportunities to participants and reduce some of the time learning through Zoom. The Zoom classes will be live.

For updates please check: <http://www.mhit.org/2020-institute.html>

*Re-printed from Signs of Mental Health, Volume 17, No. 2 Issue.

The Making of ACT 644: An Unexpected Story of Events

Written by: Kerry D. Ingram, LPC-S, TA-S, Ed. S



Prior to January of 2016, I had no exposure to Deaf culture, including Sign Language, other than a random TV show or the occasional appearing of a Sign Language interpreter on the news. I had no training or education on working with the Deaf community and the specialized skills required for mental health providers to effectively deliver services that would meet the needs of Deaf client and their families. In fact, the word “deaf” never was mentioned in any of my graduate or undergraduate courses in my counseling program. Therefore, after becoming licensed as a mental health counselor in 2008, with at least three years of working in the field of mental health prior to obtaining my license, I was the typical counselor who assumed there was no difference in mental health services offered to the hearing population and the Deaf community. However, my first day on the campus of the Arkansas School for the Deaf was an experience that I will never forget. I had unknowingly walked into a “whole new world” (insert song from the Disney movie *Aladdin*).

I work for Behavioral Health Services of Arkansas (BHSA), which is a division of Youth Home, Inc., located in Little Rock, AR. Through BHSA, we have an array of community-based mental health services that include two outpatient counseling clinics for children, adolescents, and adults; two adolescent foster-care group homes; and a School-Based Mental Health (SBMH) program. In September of 2015, I was hired by BHSA as a school-based clinician. Having more than ten years’ experience in providing mental health services in school settings at that time, I was more than confident as I accepted the job offer. In addition, within a short period of time I was promoted to the supervisor for the school-based program. Since I had also had similar leadership positions in the past, I was even more confident, and likely arrogant, as I took on the role of coordinating with local schools in the Little Rock, AR area. As the school-based supervisor, I was responsible for building up and developing the SBMH program by contracting with schools, allowing us to be the only agency with which the school will refer students to for counseling services. In return, we agreed to designate a clinician, and/or para-professional, who would be on their school campus during school hours each day of the week. This is a unique program model for several reasons: 1) the school has one therapist to contact if a student is needing help, rather than having to remember what agency and clinician work with all of their students that may need extra support at any time; 2) The assigned clinician for that school has a designated office within the school and is readily available; 3) The assigned clinician is not a school employee, but functions as an extension of our outpatient clinic on the campus of the school, and therefore, helps the school avoid the extra costs of hiring additional staff.

If you have read this far down, it is likely that you are thinking, “Why in the world is this guy explaining his work history, levels of arrogance, and the much less interesting point about their contracts and service delivery model?” I thought you would never ask! It is appropriate that I explain those experiences as it better sets up the story of the time when I fell *flat* on my face from being overly confident when I was asked if I would set up a contract for mental health services at the Arkansas School for the Deaf. This humbling experience made me realize something: *I was not prepared for working with Deaf clients.* My education and the years of experience that I was so proud of, was not effective when I “counseled” my new Deaf clients. Thankfully, the Deaf school arranged an interpreter that was constantly with me every day that I was on ASD’s campus for over a year. My interpreter was good. Not just *good*, but is one of the most skilled interpreters that I have had the privilege of working with. I am unable to disclose the name of my interpreter, or the several other interpreters that were my team members, due to the confidentiality of our work and the Deaf clients we serve. Regardless, they all taught me about the history, and the horror, regarding “mental health services” that had been forced on to the Deaf community for decades. It was at that moment, just a few months of “therapizing” at the Deaf school, that I realized I had no clue what I was

doing. Even worse, I was potentially providing mental health services to Deaf clients that were not offering/providing any benefits to them. I immediately began to eat, sleep, and breathe all things Deaf Mental Health. I immediately noticed that the specialized Deaf Mental Health services described in the research I had consumed, did not exist in my home state. I had Deaf adolescents needing more intensive services, but I refused to accept the available programs that would cause my clients to be in a facility for up to two weeks, without an interpreter. It took a few months, but I developed a proposal for an intensive, specialized therapeutic Deaf adolescent group home, and submitted it to the Governor's office for consideration. Initially, I was given the impression that money was available, but then was informed that it was not something that could be funded at that time, due to various reasons. However, I learned that even if it could have been funded, it could also be de-funded at any time in the future, unless it was a requirement for the state to maintain the program. I'm sure people around the world saw it, but a light bulb the size of Texas went off in my head! This, my friends, is what started the creation of HB1471 (now titled ACT 644), and is the story of how I unexpectedly became involved in making a change.

As a counselor, the process of drafting legislation was not something I knew anything about. In Arkansas, to propose a bill for legislation, a State Senator or State Representative must agree to "sponsor" the Bill. I was fortunate to be connected with an Arkansas State Representative, Charlene Fite, who wholeheartedly agreed to become the sponsor. She was, and still is, an incredible advocate for Deaf rights and guided me through the entire process. I am not exaggerating this at all, but the drafting of HB1471 was at least a six-month process, requiring several hundred exhausting hours of work. More than 15 individuals helped me with each of the four drafts until I was confident we had the best draft we could create. Using the National Association of the Deaf's (NAD) 2014 article, "Model Mental Health for Deaf and Hard of Hearing Individuals Bill of Rights Act", as the foundation for HB1471. Only a few modifications were made to the NAD's model in order to address the specific needs of Arkansas' Deaf community; as well as, how health care services are structured within our state. One of the many frustrations I encountered was that Arkansas has very strict rules for the language and structure of how a Bill of Rights Act can be written. For example, the word "deaf" was not able to be capitalized. Therefore, whenever HB1471 would refer to capital "D" Deaf, it did not visually differentiate as a culturally Deaf person would. Unfortunately, there was absolutely nothing that could be done to change that when drafting HB1471.

Every draft would be submitted to the assigned legislative drafting attorney to review, modify the wording and structure accordingly per Arkansas Code, and then send back to me within a couple of weeks. I would often feel defeated after seeing the changes that the attorney would make and go back to the drawing board. I continuously consulted with experts throughout the country, such as Neil Glickman, Steve Hamerdinger, and David Kingbury, with each having their "superpower". Neil knows Deaf Mental Health Care and what is required to successfully operate an effective Deaf program. He also helped me maintain awareness of myself as a hearing person and taught me the value of humility. Steve is like the "Yoda" of all things Deaf, especially regarding the history of how various states have attempted to deliver Deaf services, as well as the successes and failures that occurred. David, having such incredible knowledge of the specifics regarding wording and policy development, was also indispensable. He was so helpful in navigating through all the laws, regulations, and policies of countless states and federal statutes. Each of these three gentlemen would review every draft of HB1471, and return the draft with pages and pages of suggestions for improving HB1471. In addition, countless meetings were held on an almost daily basis during each of the four drafts. The participants of these meetings included Deaf community members, my team of interpreters, Deaf educators, and various advocates for the Deaf community.

Finally, after an exhausting six months, we had a draft of HB1471 that was exactly what was needed for the Deaf community in Arkansas. It was submitted to the appropriate committee for the initial hearing, though it was postponed at least twice before it was heard. Unfortunately, HB1471 did not pass at the first committee meeting (though I swear I heard more "yea's" than "nahs"). Even the voting process was not sensitive to the Deaf community, as the members of the committee voted verbally, rather than raising

hands. With HB1471 not passing during the first hearing, it only had one more opportunity for a passing vote, or it would be dismissed until the next legislative session two years later.



Myself (on left) with Rep. Charlene Fite (on right)
First hearing for HB1471- failed to pass by majority vote.



Myself (on right) and Deaf community member (on left)
during KARK4 interview in efforts to publicize HB1471.

With the disappointment of the first hearing results, I contacted local news to publicize the hurdles we were facing. Then, after slight modifications to a few words in HB1471, it was set for the second hearing. Though representatives from the Department of Human Services appeared to argue against it, HB1471 passed and was sent to the floor of the Representatives for their vote, resulting in a unanimous passing floor vote! This was so exciting, but it was only halfway through the legislation process. It was then sent to the Senate Committee, where heroes from the Deaf community defended HB1471 by sharing their personal experiences with the mental health system and gained the third victory for HB1471. Finally, it reached the Senate Floor for the fourth and final vote. With the guest section in the Senate Chamber full of Deaf individuals and advocates for the Deaf community, HB1471 was passed again with a unanimous Senate floor vote, thereby making it the first Bill of Rights Act of its kind to pass through legislation, with or without the threat of a lawsuit. It was truly a historical moment for the Arkansas Deaf community. The Governor of Arkansas signed HB1471 into law on April 4th, 2019, that is now titled, “Mental Health for Individuals who are Deaf or Hard of Hearing Bill of Rights Act” (ACT644).



(Above)
Hutchinson
on April 3rd,

Governor Asa
signing HB1471
2019



(Above) Representative Charlene Fite presenting me with the pen the Governor used to sign HB1471 into law!!!!

At this time, it has been more than a year since the Bill was signed by the Governor, and yet there are several requirements from the Bill that have not yet been implemented. I have learned that making a change can be a very slow process. However, I have also learned that it is critical to hold those that are responsible for implementing these changes accountable in order to make sure they all are following through with their responsibilities. In Arkansas, this is being done by the Arkansas Association of the Deaf and the Deaf community, using social media and other available communication outlets. It is clear that the easy part is over, and the hard work is just beginning. We have a great Deaf community in the State of Arkansas, and they should receive all the credit for this amazing accomplishment.

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Model Mental Health for Deaf and Hard of Hearing Individuals Bill of Rights Act. (2014, June 18). Retrieved June 10, 2018, from <https://www.nad.org/resources/health-care-and-mental-health-services/mental-health-services/model-mental-health-for-deaf-and-hard-of-hearing-individuals-bill-of-rights-act/>

Arkansas Code Title 20-40-1001. *Mental Health for Individuals who are Deaf or Hard of Hearing Bill of Rights Act.* (2019).

Editor's Note:

ADARA would like to congratulate Kerry D. Ingram for being the recipient of the **Golden Torch Award** from the Arkansas Association for the Deaf for his "leadership and advocacy contributions" in his home state! <https://www.arkad.org/aad-awards>

ADARA's New Logo: What's the Story?



ADARA logo from 1993 to 2020

You might immediately notice the new logo on the front cover when you download this newsletter. Curious? Let us start with a little bit of history first. Back in spring 2018, ADARA recognized the 25th anniversary of ADARA's organizational logo. The original ADARA logo was initially developed as a conference logo for the 1993 ADARA Conference that took place in San Francisco. The original design for the conference used a forest green logo on a white cream background. After the conference, Sharon Carter, who then was the executive director of ADARA, asked for and obtained permission to modify the conference logo as the organization's logo. The colors were changed to burgundy and cream white.

When the logo was developed in 1993 for the conference, the idea was to establish partnerships among various types of providers and organizations providing rehabilitation and mental health services with deaf and hard of hearing persons. ADARA embraced mental health therapists, vocational rehabilitation counselors, and other providers from multiple agencies, all working with individuals who are deaf and hard of hearing. The final design became four hands linking together in partnerships, using the sign for 'connections.'

Twenty-seven years after adopting the organizational logo, the ADARA board decided to give the logo a face-lift, but to preserve the initial intention behind the old logo as well as its colors. There are two significant reasons for the change. First, the old logo has been passed on from board to board over the years without retaining the original files of the logo. The quality of the image (logo) deteriorated over the years due to many copies being made and passed on or shared. Finally, the 'connections' hands in the logo were white. ADARA embraces diversity and welcomes people from all walks of life to all of our functions, particularly attending conferences and serving as board members. That said, we decided to make the human hands in the logo more abstract and in neutral colors, yet preserving ADARA's traditional colors. ADARA hired a deaf artist, Jill O'Leske, at [Impact Design, LLC](#), to create the new logo and to fully capture [our mission and strategic intent](#).

The new ADARA logo emphasizes the networking and partnership opportunities for our community. These professionals in vocational rehabilitation, behavioral health, research, independent living services, education/school, interpreting services, transition services, community-based/social services, and any support services in the helping professions that serve deaf, deafblind, late-deafened and hard of hearing individuals. The new logo abstractly represents 'partnerships' in ASL with hands put together in the form of solidarity. Finally, the circle in the logo also represents that we are all in this together in the endless circle of life.



New ADARA logo unveiled in 2020

ADARA sincerely hopes that professionals and providers in our fields will continue to partner together to enhance the quality of life with individuals who are deaf, deafblind, late-deafened, and hard of hearing for years to come, which is what the new ADARA logo seeks to represent.

Eye Movement Desensitization and Reprocessing (EMDR): Overview of an Empirically-Validated Trauma Treatment & Adaptations for Use with Deaf Clients

Written by: Kristie Trahan, LCSW-C and Christia T. Williams, Med-IP, CI

Language deprivation and its residual effects present a barrier to traditional therapy for Deaf and hard of hearing clients who use American Sign Language (ASL) to communicate. Even with the use of highly skilled ASL interpreters who specialize in mental health settings or direct therapy with ASL-fluent therapists, traditional talk therapies often fall short of addressing the trauma-related needs of these clients because of their heavy reliance on therapist-client dialogue. Because of the nature of ASL acquisition and the state of American Deaf Education, Deaf and hard of hearing clients often struggle to express and understand abstract concepts. They must monitor and adapt their language use to ensure they are expressing themselves in a way that is readily understood by the therapist. This puts an undue cognitive and emotional burden on the client that often leaves them frustrated, in addition to stunting their therapeutic progress. There is an alternative therapy; however, that does not depend on conventional dialogue or even therapist's full understanding of what is happening in their client's processing for healing and growth to occur: Eye Movement Desensitization and Reprocessing, (EMDR).



Kristie Trahan

EMDR is an evidence-based psychotherapy recognized by 15 worldwide organizations as an effective and comprehensive treatment for trauma that decreases nightmares, flashbacks, and triggers from traumatic experiences. The basis of the EMDR approach is Adaptive Information Processing (AIP), which leverages the brain's innate ability to heal and adaptively move towards health and well-being. There is no known research of this psychotherapy's use with Deaf or hard of hearing clients; however, anecdotally it is a powerful tool for treating trauma and disturbing experiences in this population.

In order to understand EMDR and its benefits for Deaf/ASL using clients, it is helpful first to understand how the brain processes daily events by using the Rapid Eye Movement (REM). An individual experiences REM sleep approximately 30-60 minutes after falling asleep. During REM sleep, our eyes automatically move back and forth from left to right. These eye movements occur while our brains process the events of the day, moving them from the emotion center of our brain into our long-term memory. This helps ensure we are not bothered by negative experiences that occur daily. For example, if we have an embarrassing experience during the day, that night, the REM processing moves that experience into our long-term memory. The memory is then stored without the associated feeling of embarrassment. Once there, we can retrieve the memory, but it is no longer bothersome to us.

In therapy, EMDR is understood to emulate the REM process while we are awake and recalling a traumatic memory. Eye movements or other forms of bilateral stimulation (BLS) (e.g., tactile or auditory) are utilized during sessions to replicate the REM process, which moves emotionally-laden experiences into the long-term memory. During an EMDR session, a client visualizes a serious physically or emotionally painful experience while identifying negative thoughts, feelings, and body sensations. The therapist helps the client to recall the traumatic event while ensuring they are feeling safe in the present. The therapist measures how upset the client is and guides the client through sets of eye movements or other BLS until the memory is no longer difficult. The effects of EMDR are long-lasting and provide dramatic results.

The framework of EMDR therapy consists of eight phases and a three-pronged protocol. This therapeutic approach incorporates all elements of a maladaptively stored memory and its subsequent

memory network(s), including the five senses, thoughts, emotions, body sensations, and beliefs, allowing the client to process in a variety of modalities, not limited to spoken language. In the initial sessions of EMDR therapy, the therapist will get a history and then start teaching skills for managing emotions and disturbance. The goal is for the client to reprocess memories stored in the emotion center of the brain without being re-traumatized. Its focus is on reprocessing information from today's perspective instead of reliving negative experiences. This may take several sessions, but generally, information moves much faster than in traditional talk therapy, helping clients feel better in a shorter amount of time.

EMDR can be used to treat trauma, phobias, complicated grief, anxiety, panic, disturbing memories, attachment disorders, depression, somatic disorders, performance enhancement, anger, behavioral issues, and many other emotional problems.

Overview of the eight phases:

Phase	Purpose	AIP	Procedure
Phase 1 History	<ul style="list-style-type: none"> Trauma-informed history Identify + & - memories Case conceptualization Treatment planning Identify appropriate EMDR elements to use based on ability to deal with high levels of emotion 	<ul style="list-style-type: none"> Symptoms caused by inadequately processed earlier memories Cognitive distortions = clinical themes Identify developmental gaps & deficits Identify any positive experiences used to build resources 	<ul style="list-style-type: none"> Standard biopsychosocial with trauma focus Review criteria & resources Identify available resources Identify disturbing past events, current triggers & future needs
Phase 2 Preparation	<ul style="list-style-type: none"> Build relationship Intro & education re: EMDR Informed consent Build / develop stabilization resources Identify secondary gain & blocking beliefs 	<ul style="list-style-type: none"> Identify availability of positive / adaptive networks Strengthen positive networks Identify client state change skills necessary for processing 	<ul style="list-style-type: none"> Educate re: themes powering the symptoms Introduce metaphors & resources for stabilization & personal mastery
Phase 3 Assessment / Accessment	<ul style="list-style-type: none"> Establish baseline response to specific target memory Access & activate specific components of memory to process 	<ul style="list-style-type: none"> Access & activate memory in it's distorted form 	<ul style="list-style-type: none"> Activate the memory & establish baselines with 7 magic questions
Phase 4 Desensitization	<ul style="list-style-type: none"> Reduce disturbance level Allow all types of responses, insights & associations regardless of emotional intensity SUD = 0 	<ul style="list-style-type: none"> Elicits insights & appropriate associations Associated memories may emerge Emotions not processed from the time may surface and be processed Learning takes place as connections to more adaptive information occur 	<ul style="list-style-type: none"> Use standardized procedures to facilitate spontaneous processing of emotions, insights, physical sensations & other memories Use advanced techniques to unstick blocked processing
Phase 5 Installation / Enhancement	<ul style="list-style-type: none"> Enhance association of positive belief with target memory VoC = 7 	<ul style="list-style-type: none"> Enhance connections to + networks Generalization of positives Blocks may emerge 	<ul style="list-style-type: none"> Identify best PC Enhance it to a 7 VoC
Phase 6 Body Scan	<ul style="list-style-type: none"> Evaluates & processes residual body sensations or disturbances with PC Clear body scan 	<ul style="list-style-type: none"> Blocks may emerge & require processing 	<ul style="list-style-type: none"> Process any remaining physical sensations
Phase 7 Closure	<ul style="list-style-type: none"> Debrief Ground & stabilize if needed Promote stabilization between sessions 	<ul style="list-style-type: none"> Shift focus away from target Processing continues after session ends 	<ul style="list-style-type: none"> Use established stabilizing resources Prepare client for between session experiences
Phase 8 Reevaluation	<ul style="list-style-type: none"> Follow-up & reassess progress & effects of processing on daily life Work toward thorough and comprehensive processing over the course of therapy 	<ul style="list-style-type: none"> Processing continues between sessions with improved behavioral effects New memories may emerge 	<ul style="list-style-type: none"> Explore any new experiences or observations: global, symptom, target specific Assess integration into larger system

*Table above credited to Lynda Ruf, EdS, LMFT, LMHC

Although there is no known published research on the use of EMDR specifically with ASL-using people in a mental health setting, anecdotal reports from ASL-fluent clinicians indicate EMDR is well-suited for use with the Deaf population, perhaps because the therapy itself is not bound by the linear limitations of spoken language. Beginning with phase two, preparation, which involves the development of resources/stabilization, throughout the process and to the final phase of reevaluation, EMDR allows for the five senses to guide clients on a path of healing. Therapists can use many ASL features to their advantage, including constructed action/dialogue, use of space, pronominalization, depiction, hypotheticals, and other

visual tools to support clients in processing through disturbing events. The process of EMDR is completed with limited interaction between therapist and client, further decreasing its dependence on expressive language.

In phase three, the therapist begins by assisting the client with accessing a disturbing memory that they will target during reprocessing. The target could be a traumatic memory, phobia, or other bothersome events. The therapist begins with intentionally-directed questions to stimulate both right and left brain activity. With the support of their therapist, the client will identify an image, negative thought, desired positive thought, the validity of cognition (VOC, how true the positive thought feels), emotions, subjective units of distress (SUD: 1-10), and body sensations. When necessary, visual aids such as cognition cards can support client and therapist during this phase. Cognition cards are designed to assist clinicians in eliciting negative and positive cognitions from the client. They are flashcards on which are printed, both negative and positive thoughts, along with images of associated facial expressions. Visual scales are another tool that can be used in assisting the client in identifying their SUD and VOC. These depict facial expressions ranging from very upset at a 10 to smiling at a zero-level of disturbance.

During phase four, desensitization occurs. The therapist and client will spend the majority of their time desensitizing and processing the targeted, traumatic event. This processing involves recalling the memory and exploring it, while at the same time presenting bilateral stimulus. This is when Adaptive Information Processing, which activates the brain's innate ability to heal itself, occurs. Clients begin the process with maladaptively stored thoughts and emotions and naturally move toward healthy, adaptive ways of thinking. During this phase, client and therapist do not engage in dialogue as they typically would in a conventional talk therapy session; rather, the client is encouraged to be curious, explore their thoughts, memories, feelings, etc., and occasionally provide feedback to the therapist about what they are experiencing at the moment as it surfaces. This feedback may simply be a thought, an emotion, a sensation in the body, a memory, a sound, a smell, an image, or whatever is coming to the client's awareness. The therapist does not provide feedback between the sets of bilateral stimulation so that they do not interrupt the client's process. They simply and briefly stop the BLS, ask the client what they are noticing. Once the client has responded, the therapist will use a short phrase to encourage continued processing. Examples of such phrases include "just notice," "keep going," "your brain is processing what it needs to," or "you're safe now," before resuming the BLS. This phase may take multiple sessions, depending on the client's needs. When the client identifies a level of 0 disturbance (SUD), indicating the disturbing memory is no longer bothersome, the therapist moves into phase five.

In phase five, the therapist assists the client in enhancing the association of a positive belief with the target memory. In phase six, any residual body sensations or disturbances are evaluated and processed while identifying a positive belief. Phase seven is for stabilization and closure of non-completed processing sessions. The therapist and client debrief about what was processed. The therapist facilitates resourcing to ensure the client is safe between non-completed sessions and is made aware of any possible residual effects between sessions. In phase eight, client and therapist identify the impact of the change within daily life and work toward comprehensive processing thus, integrating newly learned information and increasing the ability to apply it to daily life and future events. EMDR is useful as a three-pronged therapy, able to target past, present, and future obstacles. This assists clients in applying new, positive beliefs gained through healing to both current and future experiences.

The use of EMDR with the Deaf and hard of hearing population is a powerful yet underused tool for treating trauma-related issues. Due to a shortage of practitioners, Deaf clients seeking traditional therapies commonly struggle to find practitioners fluent in ASL. There are vastly fewer therapists who are both ASL-fluent and EMDR trained. To date, there have been no known EMDR training presented in ASL, though hopefully this will change within the coming years as more Deaf and ASL-using therapists become aware of its potential. With additional ASL-fluent and EMDR trained practitioners, the important work of research and development of best practices within the population can begin. In the meantime, as therapists navigate the utilization of EMDR with Deaf and hard of hearing clients, it is important that they maintain creativity and flexibility in their attempts to discover effective ways to elicit visual concepts and support clients on their journey to emotional well-being.

Write for the *ADARA Update*



Do you enjoy reading about what is happening in the community? Do you have something interesting to share? The *Update* is looking for *YOU!* Tell us what you have been doing in your community or organization.

The *Update* publishing schedule is listed below. In order to meet these deadlines, copy, including advertisement, must be in hand by the deadline date.

Submission Deadline

September 15, 2020

December 15, 2020

March 15, 2021

Projected Publication Date

October, 2020

January, 2021

April, 2021

Requirements: Have something interesting to share with our members about service provisions for Deaf and Hard of Hearing individuals.

If you are interested in writing, contact:

newsletter@adara.org



ADARA

Call for Nominations for ADARA Board Positions 2021 - 2023

ADARA is calling for nominations for Officers and Board Members for the 2021 - 2023 term, July 1, 2021 - June 2023. The available positions are:

President-Elect:

The President-Elect shall assume the duties of the President in the latter's absence. In the event the Presidency is vacated, he/she shall assume the office. The President-Elect shall also act as a member of the Bylaws Committee. After serving one term of office as President-Elect, he/she shall serve as President for one term of office.

Vice President:

The Vice President shall submit copies of the proposed agenda to the Executive Board for its review at least 120 days prior to the date of the Conference, and subsequently notify the membership of the approved agenda at least 90 days prior to the Conference.

Secretary:

The Secretary shall be responsible for the transcription of minutes of the business meetings of the Executive Board, at Conferences, and carry on general correspondence of the Association. The Secretary shall also serve as a non-voting member of the Nominations and Elections Committee.

Treasurer:

The Treasurer shall be responsible for the preparation of financial statements of all liabilities and assets for the Association prior to each Executive Board meeting. The Treasurer shall also serve as a permanent member of the ADARA Finance Committee.

Board Member-At-Large (2 positions):

Voting Board members shall be elected to four-year terms, such terms to begin July 1 of the biennial year.

Nominations are accepted from any member of ADARA. All nominees must be members of ADARA in order to be elected.

If you are nominating yourself for any of the board positions mentioned above, please include a statement of interest. If you are nominating someone else, please be sure that the nominee is interested/committed before submitting the nomination.

The deadline for all nominations is September 15, 2019

All nominations must be submitted to Stephen Roldan, President-Elect via email at stephen.rolدان@adara.org.



Now Accepting Nominations for 2020 ADARA Awards!

For many years, ADARA is proud of the contributions of members and has established several awards to recognize excellence in service provision and outstanding professional contributions. ADARA is seeking nominations for individuals deserving of one of the seven awards listed below. These awards are to be presented by ADARA at the 2021 Conference in Albuquerque, New Mexico in March 2021.

- **The Boyce R. Williams Award** is named for Dr. Boyce Williams, who dedicated his career in government to advance specialized programs and services for deaf and hard of hearing people. It is the highest award presented by ADARA and is given to an individual in recognition of a lifetime of exemplary contributions that lead to improvement in the lives of deaf people in the rehabilitation and behavioral health arenas.
- **The Frederick C. Schreiber Award** recognizes Dr. Fred Schreiber, who was the first Executive Director of the National Association of the Deaf (NAD). In recognition of his enduring commitment to ADARA, this award is given to an individual for outstanding contributions to ADARA.
- **The Eugene W. Petersen Award** recognizes Gene Petersen, who set the standards in serving with deaf adults across the spectrum. It is an award given to an individual who has demonstrated exemplary direct service provision to deaf adults with additional disabilities and/or language and learning challenges.
- **The McCay Vernon Outstanding JADARA Article Award** recognizes Dr. Mac Vernon who was a leading author in various specialized fields and for his role of editor of the Journal. It is an award given to a published JADARA author(s) upon the recommendation of the Journal Editorial Board.
- **The Boyce Williams Student Writing Award** recognizes exemplary student writing in the deaf rehabilitation and behavioral health fields.
- **The Martin Seligman Student Psychology Research Award** recognizes Dr. Marty Seligman for his outstanding contributions to the field of psychology. This award is to encourage student researchers pursuing careers in working with deaf and hard of hearing individuals in the field of psychology to conduct, present and publish research in this field.
- **The Legislative Award** recognizes an individual who has demonstrated tremendous contributions related to legislative activities and public advocacy that have a profound impact on individuals who are deaf, later-deafened, hard of hearing and deafblind.

Nominations for awards should be submitted by November 1, 2020 to ADARA, by e-mail to office@adara.org

Nomination letters should include a 150-word biography of the nominee and a 250-500 word letter explaining the attributes of the nominee and reasons for the nomination. Letters of support are also welcomed and should be included with the actual nomination letter.

JADARA

JADARA is a widely read publication which deals with research findings (pragmatic applications), program descriptions and articles on deafness, and the disciplines of rehabilitation, social services, mental health, and other related areas.

**Current Issue: Volume 53, Number 2 (2020)
Follow this link to gain access to JADARA!**

Articles:

[Reasonable Accommodation For Workers Who Are Deaf: Differences in ADA knowledge Between Supervisors And Advocates](#)

Hayley Stokar

Abstract

Despite the existence of the Americans with Disabilities Act (1990), workers who are deaf still struggle with reasonable accommodations in the workplace. The challenges relate, in part, to knowledge and training deficits among hearing supervisors. In order to understand the difference between supervisor knowledge and advocate knowledge around reasonable accommodation, focus groups were conducted with two populations: (1) supervisors in retail and food service who were all hearing, and (2) advocates engaged in training and education around deaf accommodation needs, who were either deaf or hearing. Findings identify similarities and disparities between the groups, highlighting that, while specific legal knowledge of reasonable accommodation may be low among supervisors, willingness to accommodate creatively and learn adaptive strategies is high among both supervisors and advocates. Working relationships that simultaneously foster familiarity with hearing loss and general collegiality contribute to understanding of reasonable accommodation. These insights may serve as guidance for the development of training tools and expand knowledge about deafness in the workplace.

[Teaming Together to Care for Our Deaf Patients: Insights from the Deaf Health Clinic](#)

Kate Panzer, Junghyun Park, Leslie Pertz, and Michael M. McKee

Abstract

Deaf patients often struggle with accessing culturally competent care. Poor communication and inaccessible health information negatively impact Deaf individuals, resulting in poorer health outcomes and inappropriate health care use. To address this problem, the [Blinded for review] Family Medicine Department established the Deaf Health Clinic in 2015 through the efforts of healthcare providers fluent in American Sign Language. After that, the clinic faced several management issues, and implemented strategies to address them. The paper discusses lessons learned and suggests potential and tested solutions to reduce gaps in health care for Deaf individuals.

Understanding Deaf and Hard of Hearing College Student Experiences of School Social Work Services in the K-12 Education System

Kota Takayama

Abstract

This article focuses on Deaf and Hard of Hearing college students' experiences with school social work services. This study surveyed 136 Deaf and hard of hearing college students about their experiences with school social work services, their concerns about social workers' competencies, and service delivery. The results of the study imply that school-based social work services should be culturally relevant and school social workers culturally competent. Furthermore, the results indicated that respondents ranked services they felt most comfortable asking about and which aspects of service delivery they felt were most important.

From Isolation to Communication: Connecting Adults Who Have Hearing Loss With Their Communication Partners

Stephen D. Roberts and Nancy A. Delich

Abstract

As Baby Boomers enter the late adulthood stage of life, hearing loss continues to be one of the most prevalent, chronic, and isolating conditions facing older adults today. Research has focused on the negative consequences of hearing loss on the health and the person's well-being, but it is equally important to recognize that hearing loss also leads to communication loss. The resulting social isolation and the collateral effects of hearing loss on the communication partner are the focus of this mixed-method study that explored the hearing loss-related quality of life for both parties. Five overarching themes emerged from the analysis, presenting salient features of the hearing loss-related quality of life for both participants. Moreover, self-reported assessments revealed that communication partners significantly underrated their spouses' social/situational effects of hearing loss compared to their spouses' ratings. The findings showed how the participants' quality of life had been shaped by the challenges of communication as exacerbated by hearing loss. The participants remarked that the interview process served to increase their awareness of needed communication strategies to reduce social, emotional, psychological, and communication isolation, and improve quality of life for both parties.

For previous JADARA issues, please go to

www.repository.wcsu.edu/jadara

JADARA has a Facebook page! Follow us!

www.facebook.com/ADARAJournal

Important Information on Membership Renewal Dues:

ADARA changed the annual membership renewal date from **April 1 to July 1**. For members who did not pay their membership dues back in April 2020 will need to renew as soon as possible to continue receiving the *ADARA Update* newsletter and have access to the newest JADARA issues. Expect an e-mail notification from MemberPlanet.com regarding your July 1st renewal or join today if you are not a member yet. If you have already paid your renewal dues back in April 2020, your membership has been extended to July 1, 2021, or July 1, 2022 if you paid the two-year membership. Effective now, ADARA is no longer offering the 2-year membership beyond July 1, 2020. Please note that if you decide not to renew your ADARA membership, this newsletter will be your last. Thank you.



ADARA

ADARA Membership is now online! Click the link to become a member or to renew your membership:

[Online Membership Application](#)

ADARA Social Media Channels

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