

**Literature Review:
State Policy Options for Meeting the Mental
Health and Substance Abuse Needs of Deaf/Hard
of Hearing Individuals**

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Executive Summary and Matrix of Policy Options

Literature on increasing service accessibility and appropriateness for deaf/hard of hearing individuals focuses significantly on elements of the treatment approach and appropriateness of providers. Some states have begun to recognize the vital importance of the state’s role in setting policies and standards, providing governance structures, and developing service arrays. The literature review to follow explores the opportunities for state intervention to improve outcomes for deaf/hard of hearing individuals with mental health and substance abuse needs. A matrix of state policy options summarizes key areas for state intervention, with specific states listed when it has been recommended or implemented by that state.

Governance and Planning Structures:	Fiscal Policy Change	Other State Policy or Practice Change
Need for ongoing support to mental health and substance abuse system improvement		Ensure the governance structure for deaf/hard of hearing issues has capacity and direction to focus on mental health and substance abuse issues (Illinois)
Need to integrate deaf/hard of hearing issues into mental health and substance abuse		Include representatives of the deaf/hard of hearing community on the Mental Health Advisory Council (Virginia) or create a mental health coordinator position specific to deaf/hard of hearing (Massachusetts).

State Financing Options:	Fiscal Policy Change	Other State Policy or Practice Change
Ensure funding is available for increased costs associated with service delivery to this population	Medicaid waivers specific to this population may allow more comprehensive home and community-based services (Texas & Pennsylvania).	
Ensure funding is available to expand the workforce of competent interpreters and providers.	Use relay funds to develop and implement interpreter training programs (Utah & Missouri). Identify other funding sources for a long-term strategy for workforce development.	

Consumer and Family Leadership:	Fiscal Policy Change	Other State Policy or Practice Change
Engage families and consumers in service delivery and policymaking.		Provide advocacy trainings accessible to the deaf/hard of hearing and support the advocates as they develop a network of support among each other (Virginia).

Mental Health and Substance Abuse Services:	Fiscal Policy Change	Other State Policy or Practice Change
Increase deaf/hard of hearing awareness of services	Develop funding strategies for culturally appropriate psycho-education specific to this community.	Ensure service array includes prevention programs and activities specifically for families with deaf children (Missouri).

Increase competency to work with deaf/hard of hearing within existing workforce		Develop and implement strategies for training interpreters on cultural and linguistic needs of their consumers (Missouri).
Increase access to deaf/hard of hearing providers	Develop a financing mechanism to support regional teams of deaf/hard of hearing providers (social work, mental health, substance abuse, advocates/navigators, etc.) that work across catchment areas (Missouri). Mandate coverage by public/private insurers for additional costs associated with providing services to this population, including ensuring an enhanced billing code is available (Denver).	Develop targeted recruitment and training efforts to increase the number of deaf/hard of hearing providers (Missouri). Develop standards to ensure appropriate referrals are made so that deaf/hard of hearing consumers receive linguistically /culturally competent services.
Increase awareness of deaf/hard of hearing issues among providers		Develop and disseminate brochures and training materials to providers statewide (Missouri).
Increase access to interpreters who are trained & competent in mental health and substance abuse settings		Increase use of video relay interpreting to ensure access to competent interpreters. Create state standards defining a qualified interpreter in a mental health or substance abuse setting.
Need for telemedicine access within and between provider networks	Ensure all services appropriate for telemedicine can be billed as telemedicine services. Ensure provider networks have a mechanism in place for billing for providers outside catchment areas, accessed via telemedicine.	Work with providers to ensure that telemedicine equipment is standardized statewide. Include requirements in state contracts / standards requiring telemedicine equipment and plans for meeting deaf/hard of hearing needs, and monitor and provide technical support (Illinois).
Need for videophone access to treatment	Ensure all services appropriate for videophones can be billed.	Develop mechanisms for providers and consumers to access videophone equipment. Develop standards for ethical and confidential use of videophones for treatment.
Need for all deaf/hard of hearing consumers to have communication access	Identify funding options for providers and consumers to increase their access to assistive technology (e.g. amplification technology, CART, TTY/TDD, etc.).	Create standards in provider contracts related to the range of assistive technology that must be available, including during treatment and when a consumer is attempting to access treatment (Missouri).
Need for deaf/hard of hearing consumers to be aware of their rights and treatment options		Develop ASL videos explaining patient rights, diagnoses, and treatment options (Missouri).
Need to ensure deaf/hard of hearing consumers have choices in services and supports		Work with providers to engage cultural brokers or technology as a means for ensuring consumers have a choice in providers and types of services.
Need to ensure that the full range of mental		Develop standards throughout the service delivery systems that focus on

<p>health, substance abuse, and related services are linguistically and culturally competent</p>		<p>consumer choice in communication mechanism and providers.</p>
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<p>Quality Monitoring and Evaluation:</p>	<p>Fiscal Policy Change</p>	<p>Other State Policy or Practice Change</p>
<p>Need to understand if changes to the system are resulting in increased access and satisfaction with services.</p>		<p>Develop program evaluation activities in partnership with the deaf/hard of hearing communities to ensure they overcome linguistic and cultural barriers. Recognize limitation of written consumer satisfaction surveys (Missouri).</p>

Introduction and Overall Themes

Nationally, 24.6 million Americans (8.6%) are deaf or hard of hearing (Russell, 2003). Both terms, deaf/hard of hearing, can be defined in many ways. *Deaf* refers to individuals who have severe to profound hearing loss and rely primarily on visual forms of communication (such as sign language or lipreading), but when capitalized also refers to the unique culture of the Deaf community. *Hard of hearing* refers individuals who have mild to severe hearing loss and rely primarily on auditory/oral forms of communication. *Late deafened* refers to individuals who became deaf after learning to speak. Each of these three populations has unique needs, as well as some overlapping needs.

Mental health and substance abuse treatment needs among the deaf/hard of hearing are higher than among their hearing peers. For example, studies have found that deaf children's rates of emotional disturbances are from three to six times as high as those of hearing children (Glickman & Gulati, 2003). Among adults, the environmental pressures that deaf/hard of hearing individuals experience in navigating a hearing world are many, including feeling isolated, challenges in finding employment, inadequate support from their friends and family, inability to access a variety of experiences from meetings to social events, and, in general, communication barriers in all areas of life. These environmental pressures have been tied to increases in substance abuse among deaf/hard of hearing individuals (WICHE, 2006).

When deaf/hard of hearing individuals seek treatment for their mental health and substance abuse needs, they run into the same challenges as other populations: fragmented treatment systems that may not have affordable, accessible, or adequate service arrays (Mundro-Ludders, Simpatico, & Zvetina, 2004). In addition, however, most of the clinicians lack knowledge of the experience of deaf/hard of hearing individuals, including the social, cultural, biological, and developmental differences from the hearing population. The providers may not recognize their own biases or the biases in their treatment modalities. The lack of knowledge on the providers' part, combined with the communication barrier, can result in misdiagnosis, isolation, frustration, mistreatment, or even retraumatization (Glickman & Gulati, 2003).

Providers who are trained in deaf/hard of hearing issues or are themselves deaf/hard of hearing are needed throughout the country. It is about more than just having an adequate workforce in place; however, as policy issues also include the need for standards, technology access, evaluation, consumer and family involvement, and effective governance structures. Moreover, policy makers, professionals and the public must increase their knowledge of deaf/hard of hearing issues, including culture, accessibility, and policy changes in order to improve access and utilization of services (WICHE, 2006). Any policy changes must also consider that the deaf/hard of hearing community is not homogenous. Individuals who are born deaf may have a very different cultural and linguistic need from individuals who become deaf or hard of hearing later in life. Both populations, as well as deaf/hard of hearing individuals who are members of ethnic or racial minority groups, must be considered as the state moves forward with policy and practice changes.

Colorado is not the first state to see a need for planning to address the mental health and substance abuse issues of the deaf/hard of hearing. Washington, Missouri, Illinois, Alaska, Arizona, and Nevada have developed plans either focused specifically on mental health and substance abuse, or including these issues in a broader plan. Now is the time for Colorado to step forward and join these states in improving the mental health and substance abuse outcomes of deaf/hard of hearing individuals.

State Governance and Planning

Deaf/hard of hearing consumers comprise a relatively small segment of the population in Colorado and nationally. Consequently, many state mental health systems have not yet prioritized developing policies and capacity to effectively meet the needs of this population (Mundro-Ludders, Simpatico, & Zvetina, 2004). Among the states that have, two different types of governance and planning structures have emerged: deaf/hard of hearing specific governance structures and integration of deaf/hard of hearing issues into other governance and planning structures.

Deaf/Hard of Hearing Governance and Planning Structures

The National Association of the Deaf (2008) recommends the development of a deaf/hard of hearing advisory council to the State departments overseeing mental health services, with inclusion of consumers and their family members on the council. They also recommend the council be staffed by a formal position, State Coordinator, who is housed in the same department, and primarily coordinates and provides technical assistance on appropriate service delivery for this population.

Colorado has partially met these recommendations, with the Colorado Commission for the Deaf/hard of hearing, housed in the Colorado Department of Human Services. The Commission created a temporary Task Force to study mental health and substance abuse issues. Task Force members include individuals who are deaf/hard of hearing, advocacy organizations, providers and provider associations, the state Medicaid agency, and others. It does not, however, explicitly include any deaf or hard of hearing consumers of mental health and substance abuse services. Colorado also has a State Coordinator that is housed in the department and is a Task Force member and chair of the Commission.

Illinois is a particularly strong example of a lasting governance structure for deaf/hard of hearing issues. As far back as 1979, the Deaf Mental Health Task Force has sought to address barriers in the state's mental health system that limited access and care for individuals who are deaf/hard of hearing. Illinois has reported that motivated, accountable leadership has been central to their state's success in meeting the needs of a population that is historically alienated from government. The state's public and private sector partnership also prioritized clearly defined principles to guide their process (Mundro-Ludders, Simpatico, & Zvetina, 2004). Similarly, Washington defined guiding principles for their process and for their system as an important first step. Their principles include (Office of the Deaf/Hard of Hearing, Washington State, 2006):

- have compassion for clients;
- empower clients to achieve independence;
- seek equal access opportunities;
- appreciate diversity;
- respect communication choices;
- be open and accessible; be accountable to the public; and
- encourage collaborative partnerships.

Successful advisory structures like these can accomplish meaningful change. In Illinois, the Deaf Mental Health Task Force has developed service accessibility standards, a technical support and adherence monitoring system, and the beginnings of a statewide telepsychiatry

service, along with establishing new treatment and independent-living programs (Mundro-Ludders, Simpatico, & Zvetina, 2004).

Integrating Governance and Planning Structures

In addition to developing advisory councils specifically focused on deaf/hard of hearing issues, the National Association of the Deaf (2008) also recommends integrating the cultural and linguistic needs into state mental health policy. They see mental health block grant applications and other strategic plans as opportunities to address the unique access needs of this population. They also recommend an accountability system that reports back the results of efforts to improve the continuum of accessible services, with the state mental health councils being responsible for responding to these reports.

Virginia has met these recommendations by including representatives of their deaf/hard of hearing advisory group on their planning structure for the Mental Health Block Grant (Commonwealth of Virginia, Mental Health Planning Council, 2001). To avoid a lawsuit, Massachusetts went a step further and has a deaf/hard of hearing coordinator specifically in their Department of Mental Health who reports to the director. One of the coordinator's duties is to facilitate communication among the mandatory four deaf/hard of hearing competent providers in the state. Although her role isn't directly governance, her oversight function is integrated into the mental health office (Center for Public Representation, 2004).

State Level Financing Issues

All of the components of a successful mental health and substance abuse system for deaf/hard of hearing individuals discussed in this literature review require funding. While many may be able to be funded using current funding streams, it would be a mistake not to specifically explore funding strategies. Funding is required at multiple levels to successfully meet the mental health and substance abuse needs of deaf/hard of hearing individuals:

- Funding to support planning and governance
- Funding to support service delivery
- Funding to support workforce development

Funding Governance and Planning Structures

Colorado is one of the states that has used its federal relay funds to create and sustain state offices on the deaf/hard of hearing. New Mexico and Arizona have all used their relay funds to subsidize similar non-relay programs. Currently, with relay funds in place, Colorado has capacity for its governance and planning structure, the aforementioned Commission for the Deaf/hard of hearing, but not specifically in the areas of mental health and substance abuse.

Funding Direct Service Delivery

Many states are still exploring options for funding deaf/hard of hearing services. Missouri has approached the issue systemically, and plans to conduct an in-depth analysis of expenditures for deaf services throughout their department, looking for places to redeploy funds to better meet the needs (Critchfield, 2006).

Local Example, Mental Health Center of Denver: Here in Colorado, the Mental Health Center of Denver has had success in securing funding to cover the additional expenses of providing

services to deaf/hard of hearing individuals. In a study prepared by the center, they found culturally appropriate services to the deaf/hard of hearing cost approximately 20% more than for other populations. Using this study, they have been able to negotiate with public and private insurers to use an enhanced billing code to cover the costs of the specialized services.

Medicaid Waivers: At a statewide level, Texas is the only state to have a Medicaid waiver specifically for deaf/blind consumers. It allows them to provide home and community-based services meeting a range of needs, including life skills as well as more traditional mental health treatments and physical healthcare (Texas Deaf-blind Project, 2006). As is true with many Medicaid Waiver programs, it has a capped number of participants, with a waiting list of individuals who need the services, but are not able to access them. Pennsylvania is the only other state with a Medicaid waiver that specifically includes the deaf. Their waiver provides residential placements for deaf and deaf-blind individuals over 40 years old.

Funding for Workforce Development

Utah and Missouri have used their relay funds to develop and implement an interpreter training program and to recruit new interpreters. Funding for workforce development may need to come from additional sources as well, as the findings of the literature review suggest a long term strategy is needed to expand a state's deaf/hard of hearing providers of mental health and substance abuse services.

State Policy to Support Consumer & Family Leadership

Throughout the mental health and substance abuse systems, there is an emphasis on consumer and family participation in decision-making. Among the deaf/hard of hearing, consumer and family involvement at both the service level and the policy/governance level has unique barriers that must be addressed. At the service level, barriers can include:

- Consumers may not fully understand forms including consenting to their rights, making it difficult for them to be full participants in their own treatment process.
- Family members may not be fluent in sign language, creating a barrier to their involvement at the service level when a signing provider is utilized.
- Communication between family members and their children may be limited by the lack of fluency in each other's languages. Deaf children of deaf children have stronger language skills than deaf children of hearing parents, due to the language disconnect (Plessow-Wolfson, S. & Epstein, F, 2005).

Service delivery models to address the challenge of consumer and family involvement and advocacy at the service level include:

- Ensuring case managers for deaf/hard of hearing individuals are fluent in the appropriate language or communication modality, as is now required in Massachusetts (Center for Public Representation, 2004).
- Connecting family members to sign language classes, opportunities to meet with other parents of deaf children, and deaf cultural events to increase the child's sense of belonging and being loved (Glickman & Gulati, 2003).

Bridging the divide between deaf/hard of hearing individuals and their providers via a *Cultural Broker*, who advocates for the individual and is aware of the cultural strengths and influences that may affect treatment (Amaya, Bridgewater, Chaviano-Moran, Patnosh, Rhee, Sahami, SenGupta, Surh, & Torres; 2004).

- Developing grievance processes that are linguistically accessible, including having appropriate assistive technologies available.

At the policy and governance level, barriers can include:

- Meetings that are not accessible to deaf/hard of hearing consumers.
- Training and leadership opportunities to become consumer and family advocates that are not accessible to deaf/hard of hearing consumers.

To address barriers to participation by families and consumers at the governance level, advocacy training is needed specifically for this population, as Virginia's Consumer and Family Involvement Project started doing in 2001. One of the components of this project was to bring families together to develop support networks with each other. As is true with many family and consumer leadership training approaches, this peer network is a very important part of building leadership capacity.

State Policy Related to Mental Health and Substance Abuse Services

Addressing barriers to accessing and utilizing services will result in positive improvements for individuals who are deaf/hard of hearing. States that have modified their policies and programs to better meet the needs of this population have seen success. For example, in Illinois, they have increased access, with a 60% increase in the number of deaf/hard of hearing individuals identified by their mental health agencies (Mundro-Ludders, Simpatico, & Zvetina, 2004).

The barriers exist at multiple levels: seeking services, accessing services, and utilizing services. Each of level can be addressed in part through changes to state policies and practices.

Barriers to Seeking Services

Stigma issues exist within the deaf/hard of hearing community, just as with other cultures in the United States. The stigmatization of substance abuse and mental health is compounded by a mistrust of hearing providers that may exist for many deaf/hard of hearing individuals (Alvarez, Adebajo, Davidson, Jason, & Davis, 2006). Recommendations from the President's New Freedom Commission include implementing a national campaign to decrease stigma related to mental health, but unless the campaign reaches out to the deaf/hard of hearing community as a linguistic and cultural minority, it may not overcome the stigma barrier for this community.

Beyond stigma issues, deaf/hard of hearing individuals may not be aware of services that are available, if the strategies for educating the public are not accessible to this population (Alvarez, Adebajo, Davidson, Jason, & Davis, 2006). Their medical providers may also fail to be aware of the deaf/hard of hearing individuals' need for mental health or substance abuse services. Unless qualified interpreters are available for medical appointments, barriers to communication during the appointment may decrease the provider's ability to detect mental health needs, refer to appropriate services, or identify geographically accessible services for the consumer (Connolly, Rose, & Austen, 2006).

State Policies to Address Barriers to Seeking Services

Many of the strategies to address these barriers will also be of value when addressing more general service access and utilization barriers, thus workforce development and similar

strategies will be discussed later. Specific to seeking services, a couple of state policy strategies may be of use:

- Develop funding and implementation strategies for culturally appropriate psychoeducation specifically for the deaf community around mental health and substance abuse issues (Russell, 2003; Connolly, Rose, & Austen, 2006).
- Ensure that the service array available to deaf/hard of hearing consumers includes prevention programs and activities specifically with families of deaf children, to encourage the families to develop fluent communication in the home and help in identifying problems with the child's development and mental health early in life (Critchfield, 2006). This is an area that Colorado has already developed capacity, though the services are not available statewide.

Barriers to Accessing and Utilizing Services

Deaf/hard of hearing individuals can face barriers to accessing and utilizing services from the moment they first contact the service delivery agency. If the means for communication with agency staff is not accessible, the simple act of setting up an appointment may be a difficult and discouraging experience. When mental health issues are driven by or compounded by the sense of isolation from the hearing world, a linguistic barrier from the first moment of contact with an agency may discourage the consumer from continuing to seek services.

Another barrier early in the process of accessing services is the paperwork that is part of a first visit to a service delivery agency. For those deaf/hard of hearing individuals whose first and primary language is sign language, their fluency in written English may be limited. Without help from an interpreter, assistive technology, or a staff person fluent in sign language, they may not understand or be able to accurately fill out the forms.

Many barriers in accessing and utilizing services occur when there is a cultural and linguistic disconnect between the consumer and the provider. In order for treatment to be effective, the provider must accurately diagnosis the consumer's illness, develop an appropriate treatment plan, and negotiate it successfully with the consumer. With linguistic and cultural barriers between mainstream providers and many deaf/hard of hearing consumers, these initial steps may be unsuccessful (WICHE, 2006). Treatment is largely designed by hearing people for hearing people. The traditional therapeutic environment, including the trust, rapport, and awareness of individuals' issues, may not be appropriate for a deaf or hard of hearing individual (Moore & McSweeney, 2006).

When a cultural disconnect is not an issue, such as an individual who experiences deafness or other hearing impairment later in life, communication barriers may still exist. Assumptions around the ability of deaf/hard of hearing individuals to lip-read or use sign language fluently may lead to communication strategies that decrease, not increase, the effectiveness of the treatment approach. Additionally, a hearing provider may lack an understanding of the impact that losing one's hearing can have on the consumer's mental health.

Many different strategies can be used at the state policy and practice levels to address these barriers, including workforce development, implementation of technology, and development of standards to ensure appropriate services are available.

State Policies for Addressing Workforce Development

Research has shown that often the best strategy for treatment is to have a competent provider who is deaf or hard of hearing, similar to their patient. However, the barriers to developing a deaf/hard of hearing workforce in both mental health and substance abuse are significant. Beyond the normal barriers with expanding any workforce, deaf/hard of hearing individuals themselves face barriers to succeeding in higher education where the environment is designed for hearing enabled individuals (Vernon & Leigh, 2007). Thus, states that attempt to address workforce development issues must consider multiple issues over both the long and short term including:

1. The combined need for an increase in the number of deaf/hard of hearing providers along with an increase in the competence of the existing workforce to meet the needs of deaf/hard of hearing individuals.
2. What is realistic to address in the short-term, but what goals need a longer-term strategy to successfully achieve.
3. The importance of all consumers, including those who are deaf/hard of hearing, having a choice in the providers and services they access, having a continuum of appropriate services, and having access to more than just direct treatment services.

States that have developed strategies to address workforce development needs have approached it in very different ways, and recommendations from national organizations have further added to the mix of strategies. A series of complimentary strategies that Colorado may want to explore include:

1. Increase capacity for existing workforce to provide services by developing and implementing mechanisms for training staff on cultural and linguistic needs of their deaf/hard of hearing consumers (Missouri's short-term strategy).
2. Increase number of competent deaf/hard of hearing providers within the workforce through targeted workforce recruitment and training efforts (Missouri's long-term strategy).
3. Develop regional teams to provide competent services to deaf/hard of hearing, with a mix of skills and specialties on each team (Missouri's strategy).
4. Development of statewide teams, particularly in the area of crisis intervention and referral, to address the urgent and immediate needs of deaf/hard of hearing individuals and ensure they are able to access appropriate longer-term services (National Association of the Deaf, 2008).
5. Mandates that ensure public and private mental health providers ensure referrals to appropriate, specialized services for the deaf/hard of hearing, including defining what "appropriate" is for this population (National Association of the Deaf, 2008).
6. Mandate coverage by public and private insurers for the additional costs associated with providing services to deaf/hard of hearing consumers (National Association of the Deaf, 2008).

Training Providers: Many of these strategies include training of non-deaf/hard of hearing providers to increase their competence in working with these consumers. Training could include information on the unique biological, developmental, social, and cultural implications of deafness (Glickman & Gulati, 2003) as well as the mental health issues arising from developing a hearing impairment later in life. Strategies for training staff could include developing classes, workshops, conferences, and community events that are specific to mental health and substance abuse staff or more broadly engage human services professionals who deliver services to this population. The training might benefit from being coordinated with academic institutions who are already engaging in training with these providers. Regardless of how it is

provided, the training must address the need for clinicians and other health professionals to have knowledge and skills to increase their ability to work successfully with deaf/hard of hearing consumers (Connolly, Rose, & Austen, 2006).

Recruiting Deaf/Hard of Hearing Providers: The strategies also emphasize the need to expand the number of providers who are deaf/hard of hearing. In 2003, the Western Interstate Commission on Higher Education (WICHE) reported only 35 mental health providers who are deaf or hard of hearing in all 15 western states covered by the commission, 18 of which were in California (WICHE, 2006). The national lack of specialized providers from this population requires a significant effort to overcome. Providers who are deaf/hard of hearing bring a depth of experience, both professional and personal, and knowledge of the culture and language, that a hearing person cannot provide (Glickman & Gulati, 2003).

Deaf/hard of hearing individuals face barriers to higher education, thus any state wishing to increase their overall deaf/hard of hearing provider population will need to develop a strategy that includes increasing opportunities to access higher education, get professional training and mentoring, and work in direct service delivery to gain experience (Glickman & Gulati, 2003). Though mentoring can, and perhaps should, occur between hearing clinicians and deaf clinicians who are beginning in their professions (ibid.), technology might also aid in mentoring relationships between deaf clinicians placed in rural areas and those clinicians already experienced and practicing in specialized programs like the one at the Mental Health Center of Denver.

It is important to keep in mind that while a sign language competent, deaf provider may be the most appropriate provider for an individual whose first language is sign language, for someone whose first language was English, a hearing provider trained in late deafened and hard of hearing issues may be a more culturally and linguistically appropriate provider. In such circumstances, the focus may need to be on accessing the most appropriate assistive technology to increase communication, rather than accessing a provider who is deaf.

State Resources to Increase Understanding of Deaf/Hard of Hearing Needs

Along with training programs and other workforce development strategies, Missouri has defined the state role to include developing and disseminating information materials for providers and consumers. The state has committed to disseminating a brochure on the general needs of deaf/hard of hearing consumers in a wide variety of therapeutic settings, including both mental health and substance abuse treatment. The brochure includes suggested changes to make the settings more linguistically and culturally appropriate (Critchfield, 2006).

State Policies for Expanding Availability of Trained Interpreters

Training to increase the cultural competence of the current workforce will only benefit deaf/hard of hearing consumers who use sign language if their interpreters are also culturally competent. It is important to keep in mind that sign language interpreters are not only interpreting between two different languages, they are interpreting between two different modalities (signed and spoken), where the relationship between the source and the target can be highly complex. For this reason, a sign language interpreter, particularly in a medical setting, may face extreme linguistic and cultural difficulties interpreting the language used in these settings (Paijmans, Cromwell, & Austen, 2006). Additionally, interpreters who are not familiar with mental health and substance abuse settings may not be prepared for the traumatic content that can be revealed in such settings. It may be necessary to prepare the interpreter for the content of the

session, debrief the interpreter afterwards, or otherwise accommodate the interpreter's needs in such a challenging situation (National Child Traumatic Stress Network, 2004).

One possible solution is increasing the use of video relay interpreting to ensure interpreters who are familiar with and competent at interpreting in a mental health or substance abuse setting are available. Already, many interpreters are moving out of communities and into the video relay interpreting networks. Although this can decrease the availability of interpreters in community settings (Office of the Deaf/Hard of Hearing, 2006), it can increase the access to interpreters trained to work within medical settings, provided the medical setting has appropriate technology in place.

Regardless of what technology solutions may be implemented to expand access to appropriate interpreters, state policy may wish to define what a qualified interpreter is for a mental health or substance abuse setting. Connolly, Rose, & Austen (2006) define a qualified interpreter as one who has "experience in mental health work."

State Policies on Telemedicine to Increase Access to Appropriate Providers

Beyond interpreters, technology can be used to increase access to providers of all types. Telemedicine is recognized as a strategy to increase access to linguistically and culturally appropriate providers, as it can decrease the long-distance travel needed for deaf/hard of hearing individuals to access appropriate providers (Austen & McGrath, 2006). The state can play a role in creating and ensuring the quality of a statewide telemedicine network of deaf/hard of hearing providers (National Association of the Deaf, 2008). A telemedicine network is not only useful for increasing access to treatment, it can also help with the coordination of mental health services and supports of all types (Hogan, 2003).

One strategy that deaf/hard of hearing individuals have used in other states to increase their access to providers is to use videophone systems. Unlike traditional telemedicine, where the consumer visits a healthcare office where they are connected to a provider in another healthcare office, videophones allow the consumer who has the technology available at home to communicate with a linguistically appropriate provider located anywhere in the country (Vernon & Leigh, 2007).

Videophones and telemedicine are strategies that may help in addressing the barriers to developing a competent workforce in areas where the total population of deaf/hard of hearing individuals is proportionally very small. Specific state policy actions to build telemedicine and videophone capacity for this population include establishing service delivery standards around accessibility, providing technical support and monitoring to the telemedicine system, and beginning the development of the statewide system (Mundro-Ludders, Simpatico, & Zvetina, 2004).

State policy may wish to also explore how to ensure the telemedicine network can access service providers in specific regions of the state that have developed more capacity, such as the Mental Health Center of Denver, or even out of state who have unique capacity to meet the needs of this population (Russell, 2003). Finally, state policy may need to consider how to develop billing codes for services provided via telemedicine and videophones that adequately cover the expenses, as well as mechanisms for ensuring confidentiality when services are provided via these mechanisms (Mundro-Ludders, Simpatico, & Zvetina, 2004). In Illinois, where videophones are currently in use for this purpose, both insurance coverage and ethical use of the technology have been issues the state has prioritized addressing.

State Policies on Other Technology to Increase Access

Although access to deaf and hard of providers is a priority, technology can play a larger role as well. For individuals who are late deafened or hard of hearing, and do not identify with the Deaf culture or use sign language fluently, technology may aid in increasing communication between a hearing provider who is culturally appropriate for this population and a deaf or hard of hearing consumer. Assistive technology options need to be available statewide, including, but not limited to Telecommunication Devices for the Deaf (TDD/TTY), hearing aid-compatible telephones, closed-captioned televisions, open-captioned video materials, video phones, amplified telephones, captioned telephones, text messaging (Sidekick/Blackberry/PDA), instant messaging/Internet chat, email, captioning devices, live-caption services (CART, remote captioning), assistive listening devices (FM/Infrared/personal amplifiers), and telecoil-compatible listening systems. Just as consumers should have a choice of providers, so too should they have a choice of assistive technology to increase their access to providers. Missouri's state plan has specifically addressed the need for providers and consumers to have access to a range of assistive technologies, including outfitting consumers with amplification devices when appropriate (Critchfield, 2006).

Technology can also help with accessing forms and other paperwork that may be difficult for a consumer with limited written English proficiency to understand. Standardized materials that are translated into sign-language video tapes may help increase access. Videos explaining patient rights, different diagnosis, or treatment approaches that use sign language instead of being captioned only are also helpful. Within in-patient settings, assistive technology that includes visual alarms instead of auditory only alarms will aid patients in successfully interacting with their physical environment (Critchfield, 2006).

State Policies to Ensure Appropriate Service Array is Available

Although increased access to appropriate providers is a significant step forward in ensuring service accessibility, it may not ensure the full array or continuum of services are available. Deaf/hard of hearing consumers, just like their hearing-enabled peers, may need such services as case management, treatment, recovery, after-care, inpatient hospitalization, employment and housing assistance, family therapy, club houses, or other services and supports.

Missouri's state plan has emphasized the need for mental health services to be more than mental health treatment. At the statewide level, they have a plan for (Critchfield, 2006).

- Ensuring employment opportunities for consumers who are deaf/hard of hearing.
- Implementing assistive technology in inpatient settings, including flashing lights for emergencies and alerting people.

One of the areas Missouri is exploring is the development of an inpatient deaf only setting. Research has shown that deaf individuals benefit more from a deaf only setting rather than a diagnosis or need specific setting, as is more commonly used in the mental health and substance abuse arenas. The isolation of being housed with hearing consumers can add to, not decrease, the mental health needs of the deaf consumer (Critchfield, 2006) as communication with fellow patients is a therapeutic technique.

Another strategy for ensuring the full array of services is appropriate for a deaf or hard of hearing consumer is to engage a cultural broker or other consultant from the deaf/hard of hearing community (National Child Traumatic Stress Network, 2004). Although the concept of a

cultural broker is relatively new, research has shown it has improved outcomes for a variety of culturally distinct populations (Amaya et al, 2004).

State Standards to Increase Access and Utilization

Medicaid standards for addressing the needs of deaf/hard of hearing individuals do not consider many of the service delivery issues explored above since they are tied to the Rehabilitation 1973 that focuses on linguistic access. They do not, however, expand linguistic access beyond direct treatment by recognizing that access includes the initial contact with the organization, such as through TYY or an interpreter. These standards do require linguistic access when a patient is being informed of his/her rights (Center for Public Representation, 2004).

Standards by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) similarly focus more on linguistic access than whether services are provided in a manner that is culturally appropriate for the patient. However, the JCAHO standards also include a statement that (Center for Public Representation, 2004):

- “When people who speak various languages make substantial use of the organization, personnel who speak their language(s) are available.”

Unfortunately, given the proportion of individuals who are deaf or hard of hearing in the broader population, it may be rare that an organization serves as “substantial” population of deaf/hard of hearing individuals.

More comprehensive standards may be needed to ensure consistent service accessibility. As explored in each section above, useful standards may include such things as access to linguistically and cultural competent providers, access to linguistically competent materials including forms, ensuring availability of assistive technology at all stages of interaction between the provider organization and the consumer, ensuring public and private insurance will cover costs associated with providing competent services, and ensuring access to out of network providers when appropriate in network providers are unavailable.

Example standards are in place in Colorado, such as those for the Colorado Mental Health Institute at Colorado. However, the standards in this case focus on access to interpreters and communications equipment, with less emphasis on consumer choice in communication strategies or access to culturally appropriate services. Standards from the Department of Education are more specific to communication needs, with a requirement that specialized services for needs that include mental health “should have the appropriate credentials and competencies to educate children and youth who are deaf/hard of hearing, including proficiency in their primary language and communication mode” (Colorado Department of Education, 2004).

Quality Monitoring/Evaluation

Any changes made to state policies and practices must be evaluated to ensure successful implementation at the service delivery level. As is true with any service delivery system, regularly conducted program evaluations help to ensure goals are being met and true improvements are made in consumer outcomes. However, with the deaf/hard of hearing population, new and unique “language-free” measures may be needed to capture improved outcomes (Critchfield, 2006). For example, traditional consumer satisfaction surveys may be inaccessible to deaf/hard of hearing individuals who have limited English proficiency. If they are

dependent on their provider or interpreter to understand and respond to the survey, their answers may not be as open and critical as they would otherwise.

Program evaluation activities need to be designed in partnership with the deaf/hard of hearing community (Connolly, Rose, & Austen, 2006) to ensure they overcome linguistic and cultural barriers to capturing accurate and helpful information. The collaboration between researchers and the deaf/hard of hearing community may help to increase the efficient use of resources, by understanding how policies and practices do, or do not, improve outcomes.

Conclusion: Areas for Focus in the Planning Process

For a state to develop a culturally and linguistically appropriate mental health and substance abuse system for deaf/hard of hearing individuals, it must consider:

1. One size will not fit all: deaf/hard of hearing individuals differ in their communication preferences and in their cultural backgrounds. For some late deafened or hard of hearing individuals, a culturally Deaf provider may be less appropriate than a hearing provider familiar with hard of hearing issues.
2. Creative approaches will be needed to ensure consumer choice is possible: by engaging telemedicine models, regional teams, or other strategies for expanding the array of providers and service types, deaf/hard of hearing consumers may be able to select from among services and providers, just as a hearing consumer is able to do.
3. Deaf/hard of hearing individuals need to be part of designing any changes: the consumer and family advocacy movement has long argued that the mental health and substance abuse systems can only be reformed successfully with participation from those receiving services. This holds true for the deaf/hard of hearing community as well, as research supports that their voices are needed to ensure services are appropriate and helpful (Vernon & Leigh, 2007).

A successful state system is about more than having a deaf provider in each provider network. As the literature demonstrates, it is about a comprehensive approach to state policy and clinical practice that respects the unique needs of deaf/hard of hearing consumers.

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