



Cultural Diversity Series:

**Meeting the Mental Health Needs
of Persons Who Are Deaf**

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Prepared by:

A. Barry Critchfield, Ph.D.

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Preface

*There is a significant Deaf Culture in the United States,
one that is often invisible and misunderstood but that nevertheless is
as vibrant and substantial as that of any other minority group.*

This report on meeting the mental health needs of persons who are deaf is the latest publication in the National Technical Assistance Center for State Mental Health Planning's (NTAC's) *Cultural Diversity Series*, which explores the mental health needs of an increasingly diverse nation. This report makes it clear that policymakers, planners, providers, and practitioners must work closely with members of the Deaf Community to fashion programs and strategies that meet their needs and that demonstrate a responsiveness to the issues of the Deaf Culture. (Following the convention suggested by Padden and Humphries (1988), I use the lower-case term "deaf" when referring to noncultural matters, such as the audiological condition of deafness, and the uppercase "Deaf" when referring to cultural matters, such as "Deaf Culture" and "Deaf Community.")

Until relatively recently, people who are deaf with mental illness have been a silent minority, despite the fact that they experience mental disorders at the same, or in some cases a greater, rate than the general public. It is thus important for public mental health systems to recognize fully the presence and needs of consumers who are deaf and to provide services and supports that meet their needs.

Each report in NTAC's *Cultural Diversity Series* provides a synopsis of a particular population's mental health needs, relevant cultural characteristics and traditions, perceptions about mental illness, and preferences for services and supports. Each report also describes several mental health programs that have successfully tailored their services to the needs of consumers in this population and provides a comprehensive resource section with recommended readings and organizational resources. Ultimately, the goal of the *Cultural Diversity Series* is to assist state mental health agencies in moving toward public mental health service delivery systems that are appropriate and accessible to all consumers.

Other reports in NTAC's *Cultural Diversity Series* address the mental health needs of African Americans (1999); American Indians and Native Alaskans (to be published in 2002); Asian and Pacific Islander Americans (2002); Latinos (2001); and persons who are gay, lesbian, bisexual, or transgendered (1999).

Acknowledgments

Persons who are deaf and who also have a serious mental illness or serious emotional disturbance face many barriers in their efforts to receive effective, comprehensive public mental health services tailored to their needs. One of the leaders in the ongoing effort to enhance the quality and availability of public mental health services to persons who are deaf is A. Barry Critchfield, Ph.D., director of the South Carolina Department of Mental Health's Program of Services to Deaf and Hard of Hearing People, and author of this report. We want to express our gratitude to Dr. Critchfield for contributing his knowledge, expertise, and commitment to this issue and this project.

The National Technical Assistance Center for State Mental Health Planning (NTAC) would also like to express thanks to individuals who provided their consultation and expertise during the development of the report, including Steve Hamerding, M.A., director, Missouri Office of Deaf and Linguistic Support Services, Missouri Department of Mental Health; Randall R. Myers, Ph.D., L.C.S.W., state coordinator, Services to People Who Are Deaf, Hard of Hearing, Late Deafened, and DeafBlind, Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services; Robert Q. Pollard, Jr., Ph.D., associate professor of psychiatry (psychology), and director, Deaf Wellness Center, University of Rochester School of Medicine; Meryl C. S. Troop, director, Deaf Services and Multicultural Diversity, Maine Department of Behavioral and Developmental Services; and Roger C. Williams, L.M.S.W., C.T., director of clinical services, South Carolina Program of Services to Deaf and Hard of Hearing People. Special thanks also go to Gail P. Hutchings, M.P.A., former deputy director of the National Association of State Mental Health Program Directors (NASMHPD), for initiating and supporting this project.

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We are especially grateful to the Center for Mental Health Services' Division of State and Community Systems Development and its director, Joyce T. Berry, Ph.D., J.D., for supporting and facilitating our efforts on this and numerous other projects to improve the provision of public mental health services throughout the nation.

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—*Kevin Ann Huckshorn, R.N., M.S.N., I.C.A.D.C., Director,
NASMHPD Office of Technical Assistance*

Introduction to the *Cultural Diversity Series*

The fundamental precepts of cultural competence include respecting and valuing differences among consumers, assuming responsibility to address these differences, and assessing the mental health system's success in addressing cultural differences.

As the 21st century gets under way, state mental health agencies face the growing challenge of accommodating an increasingly diverse and evolving constituency. The call to provide appropriate and accessible mental health services to all consumers—regardless of color, ethnicity, national origin, language, race, religion, age, disability, gender, sexual orientation, or socioeconomic standing—challenges state mental health agencies to develop effective, culturally competent, and linguistically appropriate services and treatment methods. As the U.S. population changes dramatically, so does the public mental health system consumer base. Immigration is now the nation's major source of population growth. More than 1 in 4 Americans (27 percent) are non-White and/or Latino. The U.S. Bureau of the Census (May 1996) projects that by the year 2050, nearly 1 in 2 Americans (47 percent) will be non-White and/or Latino. Mental health staff may be unprepared for differences in language and worldview, and even less prepared, for example, to support a gay, inpatient consumer facing prejudice from other staff or residents or to provide crisis intervention to a consumer who is deaf or has another disability. However, local and/or federal statutes may require appropriate service provision to these persons.

The *Cultural Diversity Series* attempts to provide basic information and guidelines regarding the needs of a variety of ethnic and nonethnic minorities. Each of these technical assistance reports provides a synopsis of the particular population's mental health needs, relevant cultural characteristics and traditions, perceptions about mental illness, and preferences for services and supports. Each report also describes several mental health programs that have successfully tailored their services to meet the needs of diverse consumers and contains a comprehensive resource section with recommended readings and organizational resources.

The goal of the *Cultural Diversity Series* is to assist state mental health agencies in moving toward mental health service delivery systems that are appropriate and accessible to all consumers. This report explores ways to develop culturally competent, public mental health systems and services for persons who are deaf. A future report will focus on meeting the mental health needs of American Indians and Native Alaskans. The following reports in this series are available from the National Technical Assistance Center for State Mental Health Planning (NTAC): *Creating Culturally Competent Systems of Care for Latinos: Perspectives from an Expert Panel*; *Meeting the Mental Health Needs of African Americans*; *Meeting the Mental Health Needs of Gay, Lesbian, Bisexual, and*

Disturbing Service Utilization Trends

Despite their growing numbers, members of ethnic and racial groups are often underserved or inappropriately served by the public mental health system. Research suggests that various ethnic groups underutilize mental health services, either by dropping out of services or by entering services at much later stages in their illness, thereby creating a need for more costly services (Lefley, 1990; Munoz & Endo, 1982). For example, studies have found that although African Americans, Native Americans, and Latinos/Hispanics in most states underutilize community-based services, they are significantly overrepresented in state inpatient facilities (Aponte, 1994).

In anticipation of increased future service demands by growing ethnic minority populations, state mental health agencies are increasingly examining their accessibility to both ethnic and nonethnic minorities. State mental health agencies may be able to reduce the use of costly inpatient services by engaging ethnic minorities during earlier stages of their mental illnesses. More important, by providing culturally competent, community-based services to all minorities, mental health decisionmakers can minimize human distress.

Cross-Cultural Mental Health Services and Barriers to Service Delivery

Cross, Bazron, Dennis, and Isaacs (1989) view culture as encompassing “the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious or social group.” Cross-cultural mental health service delivery occurs whenever two or more of the participants are culturally different. Thus, Atkinson, Morten, and Sue (1998) point out that cross-cultural service delivery occurs, for example, in “a counseling dyad consisting of a low-aculturated Mexican American client and a high-aculturated Mexican American counselor.” Similarly, a married, heterosexual service provider brings a vastly different world view and set of experiences to the counseling relationship than a single client who is lesbian. Policymakers and service providers are coming to understand that cultural diversity must be broadly defined to accommodate wide variations among consumers.

Cultural differences exist on many levels, including help-seeking behaviors, language and communication styles, symptom patterns and expressions, nontraditional healing practices, and the role and desirability of medical intervention (Comas-Diaz & Griffith, 1988; Gaw, 1993). Members of ethnic and nonethnic minorities may be underserved by the public mental health system for varied and complex reasons. Some commonly cited factors include the following:

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- ◆ the stigma of mental illness and the varying ways that members of different ethnic minority groups may define mental health and mental illness;
 - ◆ lack of culturally appropriate services to accommodate the needs and beliefs of diverse consumers;
 - ◆ consumer fears of experiencing discrimination in the treatment setting;
 - ◆ mental health providers' lack of awareness or knowledge regarding culturally appropriate policies and practices;
 - ◆ language barriers increased by the growing numbers of both consumers and providers whose native language is not English;
 - ◆ communication barriers based on differences in verbal and nonverbal styles that may lead some minority consumers to feel they have given very clear messages to providers who have not understood the communication;
 - ◆ lack of familiarity with Western or mainstream mental health services;
 - ◆ fear of exposure or discomfort about disclosing sexual orientation or gender identity concerns to service providers; and
 - ◆ systemic barriers, such as funding sources that place strict limits on reimbursable services.

Cultural Competence

Developing cultural competence within a mental health system is a dynamic and evolutionary process. The fundamental precepts of cultural competence include respecting and valuing differences among consumers, assuming responsibility to address these differences, and assessing the mental health system's success in addressing cultural differences. A culturally competent approach to services requires that agencies examine and potentially transform each component of mental health services, including assessment, treatment, and evaluation (Miller, Peck, Shuman, & Yrn-Calenti, 1995). The authors identify six stages of developing cultural competence:

- Stage 1: Sees other cultures as inferior: seeks to destroy other cultures.
- Stage 2: Cultural incapacity: adopts paternalistic posture toward so-called inferior people.
- Stage 3: Cultural incapacity: seeks to assimilate differences, ignore strengths.

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- Stage 4: Cultural precompetence: realizes weaknesses and makes commitment to improve.
 - Stage 5: Culturally competent: respectful, accepting, self-monitoring.
 - Stage 6: Takes advocacy and educational role.

Developing respect for differences and cultivating successful approaches to diversity requires increased awareness—of one’s self; of unstated, institutional, cultural norms; and of the history, culture, and needs of diverse consumers. To increase cultural competence, mental health service providers need to develop an awareness of their own racial and cultural heritage; to understand how that heritage influences their understanding and biases about normality/abnormality and the process of mental health service delivery; and to understand the significant impact of differences both in language and in verbal and nonverbal styles on the process of communication (Atkinson et al., 1998). Mental health systems typically operate on unstated Western principles—such as, for example, the primacy of the individual over the group, a focus on competition and achievement, separation of the mind and body, and devaluation of altered states of consciousness—which may be at odds with the underlying values and beliefs of some ethnic and racial populations. Without awareness of this dynamic, mental health providers may impose this Western framework on minority consumers.

The populations that are the subject of these reports have all experienced and/or are experiencing some form of social inequity that is directly relevant to their status as underserved groups. Exploring and sometimes challenging the assumptions and biases held by stakeholders and the wider community is a crucial step toward achieving a culturally competent system. These attitudes have a direct impact on the functioning of minorities, their mental health needs, and their willingness to seek services. Similarly, cultural assumptions affect the mental health system, its practitioners, and its ability to engage minorities.

Some mental health systems and providers seeking to increase cultural awareness may inadvertently rely on overgeneralizations that ignore subgroup and individual variation, thus belying the basic value of cultural competence. To be truly culturally competent, mental health systems must be aware of significant differences in lifestyle and worldview among diverse populations, while valuing and responding to the distinct needs of each client. Rather than relying on stereotypes about groups, administrators, and practitioners need to be aware of their own cultural assumptions and to ask consumers how *they* understand their problems and what *they* need.

These reports are designed to help key decisionmakers wrestle with the challenges facing public mental health systems, while effectively addressing the need for individualized, culturally competent services for ethnic and nonethnic minorities.

A closer look at: Refugees

People seeking refuge in the United States come from all ethnic and racial backgrounds, and they often have great difficulty obtaining traditional mental health services. These individuals have often experienced severe stress, resulting from continuous threat to life or freedom, traumatic flight, death of family members or friends, torture and imprisonment, living in concentration or refugee camps, uncertainty and lack of control over relocation, and inability to return to their homeland (Garcia-Peltoniemi, 1991). Their mental health may be jeopardized by multiple losses (of country, family, status) and other major disruptions (e.g., unemployment) that often accompany resettlement in a new country. A proportional number can be expected to be sexual minorities, deaf, or disabled, and the meaning and impact of these attributes will vary widely by culture.

Unfortunately, definitive prevalence rates of mental illness among refugees are elusive. The few studies available reveal that depression, anxiety, and posttraumatic stress disorder are reported at disproportionately higher rates in refugee populations. In addition, a small percentage of refugees experience schizophrenia or brief reactive psychoses marked by delusional content strongly related to culture that may require prolonged, intensive intervention (Garcia-Peltoniemi, 1991). Typically, state mental health agencies have contact with refugees during times of crises through crisis counseling services or inpatient treatment. Successful strategies to engage refugees prior to the eruption of crises include the following:

- ◆ networking with and through the refugee community;
- ◆ conducting home visits;
- ◆ linking with physical health services;
- ◆ using bicultural professional and paraprofessional staff; and,
- ◆ making outreach efforts that focus on helping refugees meet basic needs, such as housing and income.

Such services are accepted more easily when linked with resettlement agencies (e.g., religious-based organizations, private organizations, state agencies, or ethnic organizations that assist individual refugees upon arrival), and mutual assistance associations in which former refugees and immigrants help their own people. The Center for Mental Health Services' Office of Refugee Mental Health serves as a bridge between the mental health and refugee communities, providing consultation and training to states and refugee organizations.

A closer look at: Non-English-Speaking Consumers

The challenge of developing culturally competent mental health services is complicated by the vast number of languages that are spoken in the United States. Mental health providers may have difficulty reaching, communicating with, and treating non-English-speaking and/or deaf consumers, who exist within all communities.

Ideally, bilingual mental health professionals will be available to engage and provide treatment to people whose primary language is other than English. However, the need for academically trained, multilingual, and multicultural mental health professionals far exceeds the number now available. While increasing the numbers of these professionals is essential, other models of services are also in use, including the following:

Bilingual Paraprofessionals. While they may not have formal clinical training, bilingual workers serve many valuable functions, including translator, paraprofessional counselor, culture broker, outreach worker, community educator, community advocate, and trainer of service providers about the refugee's culture (Egli, 1987). Ultimately, the goal may be to encourage bilingual workers to obtain further academic training in mental health to increase the supply of bilingual and bicultural psychiatrists, psychologists, social workers, and other mental health professionals. It should be noted that persons who can communicate in both American Sign Language and a spoken language are considered bilingual.

Interpreters. Using interpreters for assessments and treatment is a less desirable route, but one that many systems rely upon given the shortage of bilingual mental health professionals. As Adkins (1990) noted, "A facility with language does not make a person an effective interpreter unless there has been adequate training, agreement on interpretation system, and building of rapport between the mental health professional and interpreter." Thus, relying on family members to serve as interpreters is considered inadequate and inappropriate.

Executive Summary

This report summarizes the relevant research and writing in the fields of deafness and mental illness, identifies problems and barriers in the public mental health service delivery system, and recommends specific interventions and systemic alterations to improve mental health services and programs for persons who are deaf and also have behavioral health problems.

Mental health policymakers and planners need to take *culture* into account when dealing with people who are deaf and thus develop services that are sensitive to the needs, wishes, and goals of the Deaf Community. This involves much more than simply hiring interpreters. How, then, do policymakers and planners know the needs, wishes, and goals of individuals who are deaf? Of all the resources available to mental health policymakers, planners, and providers, none is more important than the Deaf Community itself. Involving individuals who are deaf, at every step in planning and development, is essential for the delivery of high-quality mental health services and supports to this population.

Prevalence and Definitions

Speaking at the First World Conference on Mental Health and Deafness in Washington, DC, in 1998, Bernard Arons, M.D., director of the federal Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, noted how far behind the United States has fallen in providing mental health services to individuals who are deaf. According to Arons, several states do not even have mental health services for those who are deaf.

The need for mental health services for the Deaf Community, however, is clear from the statistics. The individuals on whom this report focuses, those whose hearing loss occurred in childhood and who rely primarily on visual rather than auditory signals for communicating (rather than those who are hard of hearing or older adults who have lost their hearing late in their lives), make up anywhere from 0.55 percent to 0.88 percent of the general population.

Public mental health systems by and large have done a poor job of responding to this population's needs despite the fact that its needs are the same as, or at times greater than, those of the general public. Until now, the mental health systems have assumed that interventions, techniques, and services that work for consumers in the general population are equally effective for consumers who are deaf.

Deaf Culture, Experiences, and Attitude

Clearly, public mental health systems must learn from the wider Deaf Culture, deaf social patterns, and Deaf Community needs. Having a mental illness can be a greater barrier to successful functioning in society than being deaf is for persons who have been without hearing since birth and have learned to communicate effectively using American Sign Language (ASL). Mental health workers can learn from

the Deaf Community that people who have been deaf since childhood may be able to communicate fluently in ASL, but may not be able to communicate in English because they have never learned it. This is not an indication either of lack of intelligence or of mental health problems.

Many public mental health systems and providers, however, cannot communicate in ASL and have little or no training and experience in working with consumers who are deaf. That lack of communication and experience makes actually addressing the individual's mental illness very difficult.

Mental health systems must recognize that many consider ASL to be the heart and soul of the Deaf Community. ASL is not English, but rather a separate language with its own rules and conventions and with no written form. Despite the fact that ASL is difficult for adults to learn to use fluently, mental health workers must deliver services in the manner preferred by consumers who are deaf.

Because of the shortage of trained mental health professionals who possess fluent two-way communication abilities in ASL, sign language interpreters continue to be a very important element of service delivery in the mental health field. Although interpreters can provide an all-important communication bridge between consumers who are deaf and clinicians who are not, using an interpreter is, in many cases, not the most effective means of communication.

Only in the past 30 years have many organizations for persons who are deaf begun to challenge existing societal barriers and demand accommodations that enable persons who are deaf to participate fully in the social and economic life of the nation.

Another issue that causes problems for individuals who are deaf and need the mental health system is the education they have received from childhood. The education of children who are deaf is seriously lacking. Although people who are deaf perform normally on I.Q. tests, the average reading level of high school graduates who are deaf is below the fourth grade. Again, communication is an issue: Teachers working with students who are deaf often lack the sign language proficiency and specialized training required to communicate adequately. Strategies that could solve this problem are being considered. Public mental health systems, clinicians, and other public mental health professionals, however, need to be aware of the significant English-language deficits and concomitant general information gaps among many mental health consumers who became deaf before learning a language (prelingual deafness).

State Mental Health Systems and the Deaf Community

Every person who is deaf should have access to a signing therapist or counselor within his or her local mental health catchment area. That is a long-term goal, but today state mental health systems that provide effective services and accommodations to all consumers who are deaf are

rare. Although there are many excellent local and regional programs throughout the nation, only a few states provide effective services systemwide.

An initial obstacle to such effective mental health care is the disbursement of funding. The emphasis in most states is on inpatient settings, which are very expensive. A better emphasis is on more cost-effective, community-based alternatives that would serve more people who are deaf.

Having each locality draw on statewide resources rather than fund a full complement of specially trained staff and facilities on its own can make funding feasible for services to persons who are deaf. It is generally agreed that one mental health case manager is needed for every 400,000 adults in the general public and that one additional mental health professional is sufficient to serve children and families within the same population (Trotter, B., 1999).

Mental Health Services for Persons Who Are Deaf

Many states have mounted legal challenges based on federal laws, including the Americans with Disabilities Act of 1990 (ADA), the Rehabilitation Act of 1973, and the Civil Rights Act of 1964, in order to compel mental health systems to provide accessible services to consumers who are deaf and to Deaf Communities. In states where public mental health agencies contract with private providers for outpatient services, all contracts must include language that guarantees access to services by people who are deaf. Alliances with agencies that have traditionally served persons who are deaf help to establish entry points to mental health systems that are available readily to members of the Deaf Community.

For a number of reasons, children who are deaf are particularly vulnerable to developing emotional difficulties. Communication difficulties between parents who can hear and children who are deaf are often apparent throughout the developmental period. The most effective children's services appear to be school-based services in which mental health professionals offer ongoing counseling, therapy, and advocacy in the school environment and provide a link to the home. This report encourages the use of deaf therapeutic foster homes, which has been successful (Hamerdinger & Murphy, 2000). Each state mental health system needs specialists who work with children and adolescents who are deaf and their families as well as treatment programs designed specifically for children who are deaf and who have emotional disturbances.

The same racial, ethnic, religious, sexual orientation, and other differences and issues that exist in society at large are present within the Deaf Community, and these differences may have an impact on the delivery of mental health services. Persons who are deaf and also members of a racial, ethnic, or other minority group often feel a "dual identity" and may believe they have to choose which of these identities is primary in order to obtain needed services. Providing effective mental health services, however, requires attention to all aspects of a person's cultural identity (both minority group status and

deafness). Issues of cultural diversity and deafness-related

matters are important areas for state mental health systems to emphasize in training service providers.

There is a serious and widespread shortage of mental health professionals trained to work with consumers who are deaf in a number of fields, including psychiatry, social work, nursing, counseling, case management, and therapeutic recreation. Despite the lack of educational institutions throughout the country that prepare mental health professionals to work with consumers who are deaf, state mental health systems have an obligation to seek out and hire competent personnel who can deliver effective services to this population. A few states have begun to fund small-scale training programs to try to meet this need.

One means of addressing the scarcity of trained professionals is through technology, including the use of video conferencing to provide direct services to consumers in remote regions of the state. Services that can be delivered using this technology range from psychiatric medication assessment, treatment planning, and case coordination to individual and family therapy, emergency interventions, and forensic services. Two-way pagers are emerging in deaf communities as a vital communication link and an effective means of service delivery and support among mental health professionals.

All recipients of mental health services have a right to make choices about where and how they live. Many consumers who are deaf may prefer to live with or near other persons who are deaf, whether or not these persons are mental health consumers, so they can look to one another for emotional and intellectual support as well as for information.

Recommendations

Based on its findings in these areas, the report makes the following recommendations:

- ◆ Establish the position of state coordinator or director of deaf services within each state mental health agency, consistent with the position description outlined in this report.
- ◆ Establish regional adult mental health services in most community catchment areas that serve multiple mental health centers, and employ sign-fluent, culturally competent staff members using a team approach.
- ◆ Establish acute care inpatient treatment programs with sign-fluent staff to serve both psychiatric and substance-abuse clients.
- ◆ Create a residential treatment program for children who are deaf, perhaps in conjunction with an existing program for children who can hear.

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- ◆ Initiate a special effort to reach out to people of color and members of racial and ethnic minorities who are deaf.
 - ◆ Manage mental health interpreting services under a single statewide contract that is coordinated by the state mental health agency.
 - ◆ Establish a statewide emergency telephone TTY crisis line to answer emergency calls from people who are deaf 24 hours a day, 7 days a week, 12 months a year.
 - ◆ Require all contracts with service-delivery agencies to include provisions that prohibit discrimination in serving people who are deaf.
 - ◆ Develop accessible housing for people who are deaf with mental illness.
 - ◆ Provide training grants or scholarships to students interested in pursuing careers in mental health and deafness.
 - ◆ Establish a statewide multiethnic advisory panel to oversee the ongoing development of services for persons who are deaf.

Conclusion

This report will generate questions as well as answers for state mental health providers as they plan services for persons who are deaf with serious mental illness. Existing research and successful mental health programs for people who are deaf can serve as resources and models for states that want to begin a mental health program for individuals who are deaf. Information about research and programs, however, has yet to be widely disseminated throughout the general mental health community. Many successful programs have been discontinued because of a lack of funding. This report includes information on two model programs and a list of suggested readings from which architects of mental health programs are encouraged to learn. Today, many persons who are deaf with serious mental illness throughout the nation are unserved or underserved, a situation that should not be allowed to continue in the new century.

Introduction

*To be nobody but yourself, in a world which is doing its best to make you everybody else,
means to fight the hardest battle which any human being can fight, and never stop fighting.*
—e.e. cummings

There is a significant Deaf Culture in the United States, one that is often invisible and misunderstood but that nevertheless is as vibrant and substantial as that of any other minority group. An increasing number of people who are deaf view themselves as members of a cultural and linguistic minority rather than as individuals afflicted with a handicap they must minimize or overcome. An appreciation of this statement must guide the architects of human services if they are to develop effective programs and strategies that truly assist and support persons who are deaf and facilitate their participation in the high-tech economy of the 21st century. In the introduction to their seminal work *Deaf in America: Voices from a Culture*, Padden and Humphries (1988) make the following observation:

The traditional way of writing about Deaf people is to focus on the fact of their condition—that they do not hear—and to interpret all other aspects of their lives as a consequence of this fact.... In contrast to the long history of writings that treat them as medical cases, or as people with “disabilities,” who “compensate” for their deafness by using sign language, we want to portray the lives they live, their art and performances, their everyday talk, their shared myths, and the lessons they teach one another. We have always felt that the attention given to the physical condition of not hearing has obscured far more interesting facets of Deaf people’s lives. (p. 1)

This report summarizes the relevant research and writing in the fields of deafness and mental illness, identifies problems and barriers in the public mental health service delivery system, and recommends specific interventions and systemic alterations to improve mental health services and programs for persons who are deaf and who also have behavioral health problems. The report does not attempt to provide a rigid blueprint for states to follow in implementing programs for this population; instead, it draws on a wide range of research and examples of successful models to offer strategies that states can use to improve services to this seriously underserved group of mental health services recipients.

Delivering effective mental health services to persons who are deaf is a complex issue. It involves much more than simply hiring sign language interpreters. Indeed, interpreters sometimes can be a significant impediment in the mental health treatment environment—either because they do not accurately reflect the content or nuances of a therapeutic encounter or because they inhibit the full flow of information and emotion. Mental health policymakers and planners need to take into account the *culture* in which

people who are deaf live, and they must develop services that are sensitive to the needs, wishes, and goals of the Deaf Community. That will require creativity and flexibility on the part of the entire mental health service delivery system.

Mental health policymakers, planners, and providers need to draw on the Deaf Community as a resource to develop effective programs for this population. This report suggests strategies for tapping into the resources of the Deaf Community to support state mental health agencies as they take on this challenge.

Prevalence and Definitions

Approximately 24.6 million Americans have some degree of hearing loss (8.6 percent of the total U.S. population age 3 and older; Holt & Hotta, 1994). The vast majority of these individuals are persons who are hard of hearing or older adults who have lost their hearing late in their lives. This report focuses on individuals with hearing impairments who rely primarily on visual rather than auditory input for communicating with others and whose hearing loss occurred in childhood rather than later in life. Prevalence rates for this population are thought to range from 0.55 percent to 0.88 percent of the general population, according to the National Center for Health Statistics 1990 and 1991 National Health Interview Surveys.

Many terms are used to refer to individuals who have difficulty hearing. The word “deaf” by federal definition means a hearing loss that adversely affects educational performance and is so severe that the child “or adult” is impaired in processing linguistic (communication) information through hearing, with or without amplification (hearing aids). The term “hard of hearing” means a hearing loss, whether permanent or fluctuating, that adversely affects a child’s “or adult’s” educational performance but which allows the child “or adult” access to some degree of communication with or without amplification.”(Easterbrooks, 1997; Individuals with Disabilities Education Act, 1990.)

Individuals who are deaf, like other individuals, are subject to a wide range of mental illnesses. They experience Axis I mental health disorders at virtually the same rate as the general population (Altshuler, 1978; Grinker, 1969; Rainer, Altshuler, Kallmann, & Deming, 1963; Robinson, 1978; Vernon, 1978, 1980). For Axis II disorders and childhood behavior problems, the prevalence rates in the deaf population are significantly higher than for the population as a whole (Gentile & McCarthy, 1973; Graham & Rutter, 1968; Schlesinger & Meadow, 1972; Williams, 1970). The federal Rehabilitation Services Administration (1977) notes, “In 1977, an estimated 43,000 deaf persons were in need of mental health services, and the incidence of emotional disturbance among deaf children was three to six times greater than among their hearing counterparts.” (See also Robinson, 1978).

By and large, public mental health systems have done a poor job of responding to the needs of people who are deaf, assuming that interventions, techniques, and services that work for persons in the general population are equally effective for consumers who are deaf. Ironically, this approach is often justified on the basis of not wanting to discriminate based on disability. Experience has shown, however, that truly effective services must be tailored to the special needs of people who are deaf. The lack of such specialized services means that many persons who are deaf with mental illness never receive adequate mental health services or any services at all. Steinberg (1991) describes the situation:

Given the paucity of resources accessible to hearing-impaired persons at this time, it is likely that more than 90 percent of this population's mental health needs remain unserved. Even today, deaf adolescents and adults remain isolated in state hospitals, without means of communication, often misdiagnosed and inappropriately treated. However, the majority of mentally ill deaf persons are not hospitalized. They live in the community but do not receive the mental health services needed to achieve productive and independent function. (p. 381)

Speaking at the First World Conference on Mental Health and Deafness in Washington, DC, in 1998, Bernard Arons, M.D., director of the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, commented, "America is one to three *decades* behind where we should be in providing public mental health services to deaf people. As a matter of fact, I just read that the other day in an article published in 1988...so I guess we must be *two to four* decades behind by now. There are still several states that have no such services at all."

Despite a growing awareness among the nation's public mental health systems of the need to provide culturally competent services to members of a wide range of ethnic and cultural groups, the culture of deafness is often overlooked. Yet American Sign Language (ASL), the primary means of communication for many in the Deaf Community, is the third most commonly used language in the United States after English and Spanish. Unlike members of many linguistic groups who become assimilated into mainstream American society by learning to speak English, people who are deaf cannot learn to hear, which makes it difficult for them to become proficient in spoken English. Nonetheless, their assimilation often is blocked by the requirement that they communicate in English.

Although the scope of this report does not permit a comprehensive discussion of all the issues surrounding the topics of deafness and mental illness, the report offers an overview of the complexities and challenges associated with implementing new services for a population that is virtually invisible to many state mental health systems and service providers. The goal is to summarize relevant material and to issue a clarion call to state mental health policymakers, planners, and other stakeholders to begin to address the needs of this population.

Deaf Advocacy

As a cohesive, politically powerful advocacy group, the Deaf Community has been late in arriving. Although organizations of and for people who are deaf have a long history in the United States, these organizations served primarily to shelter people from an often uncomprehending and sometimes hostile society or to help them assimilate invisibly into the larger community. Only in the past 30 years have many organizations for persons who are deaf begun to challenge societal barriers and demand accommodations that enable persons who are deaf to participate fully in the social and economic life of the nation. Relatively recent events such as the “Deaf President Now!” campaign at Gallaudet University in 1988 have empowered people who are deaf and convinced them they can accomplish much politically when they speak as one (Jankowski, 1997). There has also been extensive collaboration among professionals who work with people who are deaf to improve educational or rehabilitative services for their clients.

In many ways, people who are deaf with mental illness have been a *silent minority*. They seldom complain to “hearing” systems, although their needs are just as real and as great as those of other persons with serious mental illness. Effective mental health services thus have been developed more slowly for this population than for members of many other cultural and ethnic groups.

State mental health officials are likely to wonder whether providing special services for consumers who are deaf would require a substantial increase in spending. In many cases, however, more effective deployment of existing resources is needed rather than greater expenditures. Many state mental health systems already devote substantial resources to serving consumers who are deaf, but they are serving relatively few, in less than appropriate inpatient settings. They could effectively serve far more consumers by redirecting a portion of those resources to community-based programs.

In fiscal year 1991, South Carolina spent approximately \$1.7 million to house 22 people who are deaf in state psychiatric facilities. In fiscal year 2001, by refocusing more of its resources on community-based services, South Carolina spent \$887,000 to serve 411 clients primarily in outpatient settings. This approach not only represents a more effective use of tax dollars, but also has enabled the state to avoid potentially significant legal expenses in defending the mental health system against lawsuits targeting treatment practices that may have resulted in inappropriate use of inpatient services (*Bailey v. Sawyer*, 1999; South Carolina Educational Television Network, 2000; see also South Carolina Department of Mental Health Model Program).

A variety of federal laws require public mental health systems to provide effective services to consumers who are deaf: The U.S. Constitution, the Americans with Disabilities Act (ADA), and Section 504 of the Federal Rehabilitation Act of 1973 all require states to offer the same mental health services to all people who are deaf or hard of hearing as they offer to other citizens. In addition, the U.S. Constitution requires adequate mental health care for people who are deaf or hard of hearing and

who are in the custody of a state (Lee & Kearney, 1995).

Since enactment of the Rehabilitation Act of 1973, federal law has required state governments, including state mental health agencies, to provide equal access to their services for people with disabilities, including those who are deaf. Although certain building modifications, ranging from wheelchair ramps to restroom accommodations, were implemented relatively quickly following enactment of this law, service modifications for consumers who are deaf have been much longer in coming. Even now, few state mental health systems provide full access to services for consumers who are deaf. This report provides state mental health officials with an understanding of what constitutes equal access to services under the law for persons who are deaf with a mental illness.

For a comprehensive analysis of the legal basis for providing accessible mental health services to individuals who are deaf, see Lee and Kearney (1995).

Deaf Culture, Experience, and Attitudes

Public mental health systems must reflect an awareness of Deaf Culture, deaf social patterns, and Deaf Community needs, which are rarely fully understood by existing societal institutions. Mental illness represents a much more significant barrier to successful functioning in society than deafness. For persons deaf since birth who have learned to communicate effectively using ASL, the inability to hear may be among the least of their inconveniences, if they consider it one at all. Yet, deafness often presents a barrier to communication for mental health workers, unfamiliar with the deaf culture and community, and they may find it difficult to adequately address the person's mental illness. Effective mental health services need to focus on mental health, not on deafness. Mental health providers need to accept a person's hearing loss to the degree that it becomes invisible to the treatment process.

Specialized services and accommodations for persons who experience a severe hearing loss later in life tend to be significantly different from those needed by persons who experience prelingual deafness. It is important for mental health providers to respect consumers' desired modes of communication, i.e., speech/lipreading, sign language, written notes, or some other mechanism; such as computer, fax, or TTY (telecommunications device for the deaf). A person whose hearing loss occurred after acquiring language is likely to retain the ability to speak quite intelligibly and may appear to be less affected by hearing loss than a person with prelingual deafness. Fluency in English may often result in a more effective diagnosis for a person who is deaf, while a lack of fluency may hinder the diagnostic process. Persons with prelingual deafness—even individuals with undergraduate and advanced degrees—experience greater difficulty in communicating with mental health providers because they are less likely to have strong English fluency.

Higgins (1980) comments that as a social group, people who are deaf often have functioned as an “inferiorized” minority, similar to many other minority groups. The parents of people who are deaf, however, are often hearing, which reduces the opportunity for the social learning and values dissemination that most minority groups receive from parents. People who are deaf, therefore, often look toward peers and other social counterparts who are deaf for societal learning (Holt, Traxler, & Allen, 1997). That is probably why adults who are deaf are not evenly distributed throughout the U.S. population, but are in “Deaf Centers” that typically arise in larger cities where there is a critical mass of persons to support deaf churches, clubs, and social agencies. In addition, most states have residential schools for students who are deaf, and those schools may become the hub for a local Deaf Community. Examples of such Deaf Centers include Fremont, California; Rochester, New York; and St. Augustine, Florida.

American Sign Language

ASL, the primary language of the Deaf Community, is a linguistically rich and complex system with its own grammatical and syntactical rules. The visual and gestural language is inextricably bound to the development and the very fabric of Deaf Culture (Rutherford, 1988).

Several aspects of ASL are relevant to the mental health professional who may be called on to interview a client who is deaf, regardless of whether an interpreter is present. Movements of a signer's eyes, face, and head help form signs, act as adverbs and adjectives, and serve as grammatical signals (Baker-Shenk, 1985). For example, a subtle twitching of the nose signifies "yeah-I-know," and a furrowed brow may represent a question (Steinberg, 1991).

Mental health systems seeking to provide services to people who are deaf need to demonstrate respect for ASL and deliver services to consumers in a way that they will understand. It is a difficult language, however, for adults to learn to use fluently. Although a person may learn to express himself or herself quite comfortably by taking language courses in ASL, understanding a native signer's language and, more important, understanding the cultural milieu from which the signer has emerged, takes many years of dedicated, full-time effort. Relatively few mental health professionals have developed fluent, two-way communication abilities in ASL. Thus, there is a continuing need for sign language interpreters in the public mental health system.

ASL is not English, but rather a separate language with its own rules and conventions. A person with prelingual deafness may be, as mentioned, functionally illiterate in English. This lack of English fluency adds to the difficulty of communicating with a hearing clinician, which often results in a misdiagnosis of a mental illness based on the individual's written English. Because there is no written form of ASL, attempting to communicate with consumers who are deaf using notes, lipreading, or even TTY may be fraught with problems because any of these strategies requires fluency in English. The following anecdote, presented by a participant at a town hall meeting on mental health issues held in Birmingham, Alabama, sponsored by the Alabama Association of the Deaf, illustrates the misunderstandings that can occur when a consumer who is deaf seeks to communicate with hearing mental health providers who do not know ASL or understand Deaf Culture:

John [a pseudonym] was sent to the mental health center by his Vocational Rehabilitation counselor. Although the mental health center was informed of his deafness, no interpreter was provided. His intake was handled by a competent social worker who wrote notes back and forth with John on a notepad. To her question, "What brings you here today?" John responded, "Where interrupt, damn!" He appeared quite agitated, making numerous unintelligible verbalizations. Later, John stood up and walked to the door, intending to leave, but was detained by the security officer on duty. He was then involuntarily admitted to an inpatient unit with a working diagnosis of Explosive Personality, R/O Paranoia, NOS. During

his hospitalization, he wrote numerous notes such as, “Why interrupt none” and “Please to phone TTY my deaf.” He signed a waiver, consenting to treatment with an atypical antipsychotic medication, and after several days he became much less agitated, preferring to sit in his room or the day room, not interacting with other people. Finally, after seven weeks of hospitalization (and two court hearings), an interpreter was provided. He was released within a few hours of the interpreter’s arrival. (Personal communication, November 4, 2000)

Had a competent interpreter or mental health professional trained in deafness been available, the emergency-room staff would have understood that John all along had been requesting a sign language interpreter and seeking to make a TTY telephone call. Following his discharge, John simply disappeared from the public mental health service system. His lack of follow-through with mental health services in all probability was influenced by this unfortunate experience. In addition, it is unlikely that he would see the value in filing a formal complaint. Recipients of mental health services who are deaf must have the opportunity to communicate with clinicians using the language in which they are most adept. For many persons who are deaf, that language is ASL. If a clinician with fluent sign language facility is not available, a qualified interpreter must be present.

Deaf Community Views of Mental Health Advocacy Groups

The Deaf Community often finds traditional mental health advocacy organizations to be inaccessible. These organizations, of course, are not intentionally hostile, but, like much of the rest of society, they are generally unaware of the needs of consumers who are deaf and the accommodations necessary to include them within their advocacy efforts. People who are deaf thus often are unaware of these advocacy organizations or do not seek them out for membership. Instead, people who are deaf with mental illness often have only discussed with each other and with the “deafness establishment” their concerns regarding the lack of effective, accommodating services. Thus both communities—deaf and hearing—have contributed to the paucity of services available for persons who are deaf in public mental health systems.

Cultural Diversity in the Deaf Community

The same racial, ethnic, religious, sexual orientation, and other differences that exist in society at large are present within the Deaf Community, and these differences may have an impact on the delivery of public mental health services. Higgins (1980) notes that persons who are deaf and are also members of a minority group often feel a “dual identity” and may believe they have to choose which of these identities is primary in order to obtain needed services. Providing effective mental health services, however, requires attention to all aspects of a person’s cultural identity.

State Mental Health Systems and the Deaf Community

State mental health systems that provide effective services and accommodations to all consumers who are deaf are rare (Arons, 1998). Although there are many excellent local and regional programs throughout the nation (e.g., Chicago; Johnson County, Kansas; Minneapolis/St. Paul; Northern Virginia; Portland, Maine; Rochester, New York; and the San Francisco Bay Area), only a few states provide effective services systemwide. The long-term goal is for every person who is deaf to have access to a signing therapist or counselor within his or her local mental health catchment area.

The fact that some state mental health systems have implemented effective services for persons who are deaf regardless of where they reside in the state indicates that such services are possible with dedicated planning, effective resource allocation, and committed leadership. At the same time, the lack of qualified, trained professionals nationwide necessitates that this be a long-term rather than immediate goal.

Few state systems provide the necessary accommodations for people who are deaf to participate fully in their services, and as a result the Deaf Community generally regards public mental health systems as “unfriendly.” Mental health agencies—recognizing that the goal of providing effective services to the Deaf Community is long-term—need to make a concerted effort to reach out to the Deaf Community. Nash and Nash (1981) note that a clinician’s level of comfort with Deaf Culture and language are often more important to a consumer who is deaf than professional reputation, academic training, or other objective measures of professional expertise:

Some professionals do establish rapport with...[people who are deaf]...However, it is important to recognize that an individual’s professional standing is irrelevant to this process....He or she must [also] demonstrate competence in...deaf [culture]..., which, most importantly, means knowing [American Sign Language] and using [the language] as...used by members of the local Deaf Community. Only then can one’s professional status be reinterpreted by...deaf [people] as helpful for the purpose of mediating between deaf and hearing worlds. (p. 74)

State Mental Health Resources

Although a number of states already spend substantial sums on mental health services for persons who are deaf, these funds are often used to maintain a small number of consumers in inappropriate, high-cost inpatient settings instead of more cost-effective, community-based alternatives that would provide more services to more consumers. If funds used for unnecessary inpatient services were redirected to community agencies, many consumers who are deaf could receive more appropriate services and supports in less restrictive environments.

Refocusing Resources

The first step for state mental health officials to take to refocus resources is to conduct a thorough survey of existing inpatient facilities to determine the number of patients who are deaf receiving services. It is not enough to review computerized hospital records, because these records do not always identify individuals who are deaf. It is also important for sign-fluent staff members to visit facilities and interview treatment staff and residents. The author of this report is aware of several instances in which facilities reported that they had no patients who were deaf; however, a brief tour of living areas and interviews with nursing staff revealed a number of patients who were deaf. Deafness is sometimes overlooked or misinterpreted as an indicator of serious mental illness.

A second step is to review services provided to children who are deaf. Children who are deaf evidence serious emotional difficulties at a rate significantly greater than children who hear; yet the services they receive often are tailored for children who hear. Sometimes practitioners and interpreters trained to work with children who are deaf are available; sometimes they are not. Many children who are deaf are served in extremely costly, private, residential treatment programs. Funds devoted to these types of programs could be used to develop and support cost-effective, nonresidential programs located closer to children's homes, family support systems, and communities.

Resource Allocation

While there is a need to place greater emphasis on community-based programs for consumers who are deaf, it is still essential to offer them inpatient services. Each state mental health system must maintain an appropriate level of inpatient services to meet the needs of consumers who are deaf. Effective community-based programs must be in place prior to transferring consumers who are deaf from inpatient facilities to communities. As with hearing consumers, moving consumers who are deaf from inpatient settings back to the community can be disastrous unless effective community-based services and supports are in place.

As noted previously, mental health services for people who are deaf should be viewed as a regular cost of service delivery. When computing the state mental health funding formula, these additional costs need to be factored in so that a small fraction of general reimbursements covers the costs of providing services for people who are deaf.

State Leadership and Advocacy

The question of whether the full array of public mental health services should be managed at the state or local levels is beyond the scope of this report. In planning and implementing programs

for consumers who are deaf, however, public mental health officials need to consider a number of factors that support strong state leadership, including the following:

- ◆ At any given time, there are relatively few people who are deaf with mental illness in any locality. Despite this low incidence, providing effective mental health services for persons who are deaf is a resource-intensive undertaking.
- ◆ There is a serious, nationwide shortage of mental health professionals who have the training and experience to work with consumers who are deaf. This shortage extends to qualified sign language interpreters, especially those with specialized training in mental health settings.
- ◆ The recommended service ratio of one mental health case manager trained to work with consumers who are deaf for every 400,000 adults in the general population and one additional mental health professional to serve children and families within the same population (Trotter, B., 1999) is likely to require cooperation among historically “competing” entities to serve larger populations or geographic regions.
- ◆ Providing services to persons who are deaf with mental illness can be economically feasible if each locality draws on statewide resources rather than funding a full complement of specially trained staff and facilities. Mental health providers need to share resources, including psychologists, psychiatrists, and sign language interpreters.

Advocacy Needs

Few consumers who are deaf wield political pressure, and, as a result, programs for individuals who are deaf have been eliminated in favor of programs for groups with more political clout. Any innovative program using highly specialized personnel needs good leadership to insulate it from such pressures and to allow professionals the flexibility they need to develop and maintain programs. To help overcome these barriers, mental health advocacy organizations and the Deaf Community need to work together. Advocacy organizations can provide access to their meetings through interpreters, amplification systems for persons who are hard of hearing, and other technological aids such as captioning. These organizations can actively encourage consumers who are deaf to serve as members of their boards and other governing bodies and to contribute to the formulation and oversight of state mental health plans regarding consumers who are deaf. Mental health advocacy groups need to provide people who are deaf the same level of participation as they do other recipients of mental health services.

Contractual Advocacy

In states where public mental health agencies contract with private providers for outpatient services, all contracts should include language that guarantees access to services by people who are deaf.

Combining resources by multiple-contract agencies may prove to be more cost-effective than having each agency attempt to develop services for a tiny population of potential consumers. This can be accomplished through memoranda of agreement among providers.

A high proportion of mental health services are delivered through contracts with private providers and these contracts must include nondiscrimination language. In the case of consumers who are deaf, the following provisions may be included:

- ◆ All services must be provided in the client's preferred language (ADA requirement).
- ◆ All videotapes, televisions, etc., used by consumers must be closed-caption compatible.
- ◆ All alarm systems and alerting devices must meet the American Standards Association standards for visual signaling.
- ◆ Telephone systems must be TTY and hearing aid accessible.
- ◆ Providers must respond to consumer complaints regarding access to services by persons who are deaf in a timely and respectful manner. Providers must be fully accessible to service recipients.

Equal Access to Services

For effective advocacy, state leadership should be aware of the legal requirements in place for providing equal access to mental health services for consumers who are deaf (also see Disability Rights Litigation, p.18). The following is an overview of these requirements:

- ◆ All state residents who are deaf have access to the full continuum of public mental health services, regardless of where they live.
- ◆ Direct care staff are sign-fluent and culturally competent in ASL and deafness. Providers must recruit and employ staff who have the ability to function within the Deaf Community, both linguistically and culturally. This requires more than simply offering elementary sign language courses to new or current staff. The Deaf Community will identify potential staff members so service providers can make an effort to hire qualified individuals who are deaf as well as people who can hear but who have close ties to the Deaf Community (e.g., children of parents who are deaf, parents of children who are deaf, siblings of individuals who are deaf).
- ◆ Interpreters are trained in mental health techniques, vocabulary, and systems issues. It should not be assumed that certification means an interpreter is competent to function in mental health settings. Interpreters need to be oriented to the mental health treatment process, to

learn a mental health vocabulary, and to become acclimated to the full range of mental health settings.

- ◆ There is an effective forum for feedback that enables consumers to provide information to administrators and advocates. Consumers who are deaf need opportunities to provide honest assessments of the mental health services they are receiving. Holding community meetings, enabling members of the Deaf Community to interact with representatives of community agencies, and establishing a statewide advisory panel for consumers who are deaf enables members of the Deaf Community to give feedback on existing services and shape future ones. Suggestion boxes, letters to the editor, or telephone hotlines are likely to be less useful, primarily because of the lack of English proficiency among many in the Deaf Community.
- ◆ Children, adolescents, and their families are part of the service delivery continuum. Many of the mental health problems experienced by children who are deaf are related to family and communication issues in the home. To address these issues, state mental health systems need to ensure that a full range of culturally appropriate services are available to families with one or more children who are deaf. However, family members should not serve as interpreters in the treatment setting.
- ◆ Services are available for clients with co-occurring mental illness and substance abuse/addiction disorders. Substance abuse rates are extraordinarily high among persons who are deaf and have mental health problems (McCrone, 1994). The phenomenon of self-medication can be particularly problematic in the Deaf Community, which has little, if any, access to public mental health services. Recovery from both mental illness and substance abuse is an important concern and deaf consumers need access to the same services for co-occurring disorders that are available to people who can hear.
- ◆ Services are available for persons with multiple disabilities. Developmental disabilities are the most prevalent of co-occurring disabilities among persons who are deaf (Dew, 1999). In states and localities without well-coordinated services, persons who are deaf and who also have developmental disabilities, visual impairment, or physical limitations are likely to be bounced from one system to another without ever receiving adequate services from any agency. Services to this population go far beyond the capabilities of any individual social service agency. Comprehensive, well-coordinated treatment services, under the direction of a single case-management entity, are required.
- ◆ An accessible inpatient unit is available to provide crisis intervention and short-term mental health services. When a person who is deaf experiences a mental health crisis that results in hospitalization, services must be provided in a facility with sign-fluent staff members or qualified interpreters. Informed consent is as much a right for people who are deaf as it is for other

consumers. If a medication is to be used, the consumer needs to clearly understand the potential side effects. Some side effects, such as tremors and involuntary facial movements, may be particularly debilitating for a person who communicates using ASL because of the role of hands and facial expression in sign language communication.

- ◆ All inpatient and residential treatment facilities that house consumers who are deaf are equipped with appropriate visual alerting devices. These facilities need to have devices to connect with fire alarms, door knocks, telephone rings, and other emergency and communication mechanisms. Televisions must be closed-caption accessible and telephone TTY devices must be available. If videotapes or films are part of the treatment process, they must be accessible, either through captioning or the use of interpreters.
- ◆ Housing options are available that support Deaf Community values and preferences. Hearing people take daily communication with other people for granted, and it might not occur to them how isolated a person who is deaf may feel living in a neighborhood or apartment complex where everyone else can hear. Housing options such as group homes, group apartment projects, and other congregate living arrangements are among the appropriate housing options for persons who are deaf with serious mental illness. For children who are deaf with serious emotional disturbances, short- or long-term placement with a foster family who is deaf may be appropriate.
- ◆ Practices are in place that ensure the confidentiality of consumers who are deaf. In addition to normal confidentiality issues that arise in any mental health setting, special confidentiality issues arise with consumers who are deaf. Although clinicians and consumers understand the importance of confidentiality, this may not be true of untrained sign language interpreters who have not received special instruction in working in mental health settings. It is important to ensure that interpreters and other staffers understand and abide by the confidentiality mandates of the mental health setting. Practitioners can provide services in settings that are not exclusively oriented to mental health—for example, at public health offices. The codes of ethics that govern the activities of certified interpreters require them to honor the confidentiality of persons for whom they provide services. In many localities, persons who are deaf constitute a small community within a community, making it difficult to maintain privacy. For example, several consumers who are deaf may participate in the same group-therapy session, or an interpreter may belong to the same religious or community organization as a consumer who is deaf. Although there may be no easy solutions to such situations, it is important for mental health administrators and planners to be aware of these potential problems.

State Directors of Deaf Services

Perhaps the most effective system modification to make in improving statewide management of services

is hiring a qualified statewide director of deaf services whose sole responsibility is to oversee the establishment, coordination, and development of statewide services for members of the Deaf Community. Identifying, interviewing, and selecting candidates is likely to involve creating steering committees, holding regular stakeholder meetings, and having frequent communication with the Deaf Community and with state and local mental health administrators. Qualified individuals who are deaf should be strongly considered for such positions. In several states, persons who are deaf hold the position of director of deaf services. Regardless of their hearing status, candidates for this position should be fluent in ASL and be able to relate closely with members of the Deaf Community to serve as a liaison between the state mental health system and consumers who are deaf. Fluency in ASL may be determined by a score of 4 or 5 on the National Association of the Deaf Interpreter Assessment Program; a score of “superior” or better on the Sign Communication Proficiency Interview; certification by the Registry of Interpreters for the deaf at a C.I. (Certificate of Interpreting) or C.T. (Certificate of Transliteration) level; or an independent evaluation of communication skills by members of the state’s Deaf Community, ensuring that the applicant can communicate fluently.

The state director’s primary responsibilities may include the following:

- ◆ Coordinate and evaluate through ongoing communication with the Deaf Community a statewide program of community-based outpatient and inpatient services for people who are deaf with mental illness, mental retardation, and/or substance abuse problems. Perform needs assessments and continuing analyses of policies, procedures, and services to ensure that programs meet the evolving needs of this client group, based on specific outcome measures set up with help from the Deaf Community. Manage a comprehensive budget to support the development and ongoing operation of the program and monitor appropriate reimbursement for services provided through Medicaid and other third-party sources.
- ◆ Manage the development and implementation of complex initiatives, such as culturally affirmative housing and employment programs, that involve several levels of government and a variety of agencies to ensure they are appropriate to the needs of people who are deaf with mental illness, mental retardation, and/or substance abuse problems.
- ◆ Supervise an ongoing program of staff development and in-service training to ensure that staff at all levels in the state mental health system are knowledgeable to the extent necessary for their specific jobs about Deaf Culture and treatment issues associated with working with individuals who are deaf.
- ◆ Supervise and consult with staff members working with consumers who are deaf and their immediate clinical supervisors.
- ◆ Negotiate and monitor the development of contracts for specialized services needed by the Deaf

Community, including interpreter services and specialized aids to enhance the quality of life for consumers who are deaf in keeping with the mandates of the ADA and other federal disability rights legislation.

- ◆ Develop internal policies and procedures addressing topics such as provision and funding of interpreters, testing of TTY equipment, maintenance and publication of TTY-accessible telephone numbers, captioning of video materials, development of communication data fields that capture language preference, and TTY-accessible telephone numbers for all client and provider databases.

Educational Needs

The state mental health systems must also consider the education that has been given to children who are deaf. The level of education received by consumers who are deaf will make a difference in how well mental health providers communicate with them. State mental health providers, then, should be aware that the education of children who are deaf has been viewed by many in the field as a series of academic and pedagogic failures. Although people who are deaf demonstrate a normal performance range on I.Q. tests, the average reading level of high school graduates who are deaf is below fourth grade (Braden, 1994; Holt, Traxler, & Allen, 1997). One of the main problems is that teachers working with students who are deaf often lack the sign language proficiency and specialized training required to adequately communicate.

One strategy being tried in some education settings is to provide instruction using a bilingual/bicultural model in which English is treated as a second language for deaf students, much as it may be taught to students whose first language is Japanese or Spanish. In this case, teachers use ASL to provide English-language instruction to persons who are deaf, building on their already developed or developing ASL fluency. Although this approach appears promising, research on the methodology is far from conclusive.

The lack of education for children who are deaf, especially the significant English-language deficits experienced by many mental health clients who have prelingual deafness, has important implications for how mental health practitioners communicate with them. For example, relying on written messages, TTY conversations, or captioned television is of little value if the consumer does not understand English. The state mental health system must find ways to partner with state systems of education to effectively communicate with consumers who are deaf.

Mental Health Services for Persons Who Are Deaf

Mental health services for persons who are deaf lag behind those for the hearing population in both availability and quality. Researchers have estimated that “between two and fifteen percent of those deaf persons in need of mental health services can obtain them” (Heller, Langholz, & Acree, 1986; Steinberg, 1991 p. 281). An estimated 40,000 deaf Americans experience serious psychopathology (Pollard, 1996), but only a tiny percentage of them are receiving appropriate services and treatment in either community or inpatient settings. Some in the field estimate that the quality and quantity of mental health services for people who are deaf lag as much as 10 to 30 years behind services for people who are hearing (Moses, 1990).

In preparing to improve mental health services for persons who are deaf and to address their unmet mental health needs, it is important to consider the following questions:

- ◆ What are reasonable and acceptable standards of “accessible and appropriate” mental health services for people who are deaf?
- ◆ What are reasonable and acceptable standards of multicultural and multilingual competencies among mental health professionals interested in serving people who are deaf?
- ◆ What types of effective strategies and programs can be implemented to help attract a larger number of people who are deaf as well as people from other minority backgrounds, both deaf and hearing, for professional careers in the mental health field?
- ◆ How can interpreter-preparation programs be assisted in expanding preservice and in-service training opportunities for interpreters interested in working in mental health settings?
- ◆ In what ways can the delivery of mental health services be enhanced to meet the needs of diverse groups of people of racial or ethnic minority backgrounds who are deaf? (Prominent among these diverse groups are those who are African American, Hispanic, or Asian.)

Until concerted efforts are made to answer these questions, as well as others, the quality of mental health services for people who are deaf will continue to lag far behind services for the larger hearing population. For a more extensive summary of the unmet mental health needs in the deaf population, see Anderson and Thornton (1993). According to the authors, “The challenge for the future is to vigorously advocate at the local, state, and national levels for the highest quality of mental health services and programs as is reasonably possible.” (p. 228)

Disability Rights Litigation

To compel mental health systems to provide services that are accessible to consumers who are deaf, deaf communities in many states have resorted to legal challenges based on federal laws, including the ADA of 1990, the Rehabilitation Act of 1973, and the Civil Rights Act of 1964.

Nancy Doe v. Wilzack, filed by the National Association of the Deaf in 1986, won recognition that psychiatric patients who are deaf deserve more than just medication when hospitalized. This and other pre-ADA lawsuits called attention to long-neglected rights of consumers who are deaf and spawned numerous specialized treatment programs across the country (Willigan & King, 1992).

Recent ADA rulings, such as *Cruz v. North Central Bronx Hospital* and *People v. Mid-Hudson Medical Group* (1995) in New York state, have underscored the rights of patients who are deaf to be provided with interpreter services in inpatient and outpatient medical and psychiatric settings. Most dramatically, the U. S. District Court in Florida ruled in *Tugg v. Towey* (1994) that simply providing mental health services through sign language interpreters does not constitute equivalent services to the ones hearing people receive and thus violates the ADA. The court mandated that the agency in question hire clinicians “with sign language ability, who possess the training, education or experience and an understanding of the mental health needs of the Deaf Community.” As welcome as this recognition is, the dearth of professionals who have such qualifications makes it doubtful that mental health agencies across the country can comply with such mandates in the near future (Pollard, 1996).

Mental Health Professional Training and Education

Human resources and personnel training pose significant barriers to the development of appropriate services for people who are deaf. There is a serious and widespread shortage of professionals who are trained in deafness in a number of mental health fields, including psychiatry, social work, nursing, counseling, case management, and therapeutic recreation. Only a few educational institutions throughout the country prepare mental health professionals to work with consumers who are deaf. For example, each year Gallaudet University in Washington, DC, graduates a small number of social workers, counselors, and psychologists trained in deafness. A handful of other graduate programs train a few students who have a particular interest or aptitude in working with consumers who are deaf. The need for mental health professionals who are trained in deafness, however, far outstrips their availability and likely will continue to for decades. Nonetheless, state mental health systems have an obligation to identify and hire competent personnel who can deliver effective services to consumers who are deaf.

New Approaches to Training

To establish new and innovative approaches to education and training requires creativity and learning from other programs. One proposal under consideration in South Carolina is for a collaborative effort

among a number of higher education institutions in a distance-learning model. The goal is to develop a unique teaching and research environment that brings together diverse resources in a field that has traditionally been highly segmented, both in terms of geography and communication. One possible approach incorporates a certification in deafness within existing degree programs, enabling students in a variety of mental health-related professions to specialize in serving consumers who are deaf. Another strategy enables persons with training or experience in deafness, such as sign language interpreters and family members of deaf persons, to develop appropriate professional skills in the mental health arena through scholarships and trainee programs. Offering postdoctoral fellowships for professionals interested in enhancing their knowledge and skill level in working with consumers who are deaf and understanding Deaf Culture is another innovative approach.

Members of the Deaf Community need to be included in discussions and planning activities for training mental health professionals to work with them. Forums such as town hall meetings, workshops, and social events can provide an opportunity for them to interact with mental health and education officials to discuss plans for improving training opportunities.

Training for Cultural Diversity

Mental health service providers also need to be well trained in issues of cultural diversity among persons who are deaf. Of utmost importance is the service provider's acceptance of each consumer's culture of origin and willingness to bond with that culture in a manner that will allow the support systems already in place to be of additional assistance to the consumer who is deaf (Corbett, 1995). This points to the importance of having a culturally sensitive and diverse staff to meet the needs of all consumers. Anderson and McGee (1996) identified a number of factors that lead to success in post-secondary education among minority students who are deaf, including persistence in achieving goals, a strong sense of pride, and effective advocacy skills on the part of both the individual who is deaf and concerned family members.

Advances in Technology

Pollard (1996) points out that there is a paucity of trained professionals capable of directly serving persons who are deaf with psychiatric disabilities and that this condition is likely to persist into the foreseeable future. One means of addressing this problem is through the use of technology. Since 1995, the South Carolina Department of Mental Health has had positive results using video conferencing to provide direct services to consumers in remote regions of the state. The results include significant savings in travel costs and time, faster access by consumers and clinicians to mental health professionals with sign language fluency, more appropriate emergency intervention capabilities, better and more frequent contacts between staff and consumers, and safe and secure communication using a dedicated integrated services digital network (ISDN) telephone service. Two-way pagers also are emerging in deaf communities as a vital communication link and an effective means of service delivery and support

among professionals.

Services that can be delivered using this technology range from psychiatric medication assessment, treatment planning, and case coordination to individual and family therapy, emergency interventions, and forensic services. Not all of these services, however, are reimbursable through third-party payers when provided using this technology. As technology improves, and if third-party payments become available for a wider range of telemedicine services, it is likely that other states will follow this example and use newer technology as it is developed, thus spreading scarce professional resources across much wider geographic and population areas.

Statewide Deafness Advisory Panels

A statewide deafness advisory panel is very useful in establishing mental health services for persons who are deaf. Panel members may be drawn from some or all of the following entities: state mental health agency, state commission for deaf and hard of hearing, state vocational rehabilitation agency, state school(s) for children who are deaf, state department of education (special education), state association(s) of the deaf, state National Alliance for the Mentally Ill affiliates, state SHARE (Self-Help Association Regarding Emotions) organization, interpreter organizations and training programs, and other interested organizations, including agencies that provide mental health services to people who are deaf.

The advisory panel can be established by legislative mandate or as an ad hoc group sponsored by the state mental health agency. Initial efforts will likely be directed to such activities as needs assessments, funding, state plan development, recruiting, and training. Each state's individual needs will help determine the panel's priorities and directions. In virtually all states, much work needs to be done, and the resources are available to accomplish this work if planned and managed carefully.

The advisory panel should serve as a subcommittee to the state mental health planning council, with at least one member serving on both entities. That allows for more direct input by the Deaf Community into the state mental health planning process and for a more influential voice from consumers who are deaf. Establishing this subcommittee is recommended rather than simply including a member who is deaf on the planning council. This recommendation is not meant to preclude other persons who are deaf in addition to the representative of the advisory panel subcommittee from serving on the mental health planning council.

Developing Funding and Service Structure

While each state and locality must respond to local conditions and needs, it is usually not feasible to duplicate specialized services to the deaf population in each catchment area of a particular entity. Rather, it is recommended that consideration be given to regionalizing services and allowing service

providers to operate within multiple catchment areas, through contracts or memoranda of agreement, thus increasing the cooperation between agencies and allowing the most effective use of professional expertise. Experience has shown that one mental health case manager who is trained to work with consumers who are deaf can serve a population of 400,000 adults in the general public, and one additional mental health professional is sufficient to serve children and families within the same population (Trotter, B., 1999).

Depending on local public transportation availability, it may be most effective to allow staff mobility to work in multiple mental health sites, rather than expect clients to travel to a central service office. Resources to fund these services may be found in long-term inpatient units where people who are deaf are served (some unnecessarily), in residential treatment programs where children who are deaf may be placed (especially if those children are being served out-of-state), and in general Medicaid revenues. Each state will likely identify unique funding sources. People who are deaf generally qualify for Medicaid services based solely on their deafness, and eligibility for reimbursement based on a particular mental illness diagnosis is not generally required. Medicaid may thus be a significant financial base for the development of these services.

Ensuring Service Access

In some mental health systems, although the services exist, established entry points may not be readily available to members of the Deaf Community. To correct this situation, public mental health service providers need to initiate alliances with agencies that have traditionally served persons who are deaf, such as vocational rehabilitation, Deaf Community services, and specialized educational institutions, including residential schools for the deaf. These agencies can then be asked to refer persons who are deaf to the mental health system. If the entire burden of seeking access remains with the consumer, the consumer is less likely to take advantage of mental health services.

To engender trust and confidence, representatives of mental health service providers need to reach out to the Deaf Community by attending social events, religious functions, sporting activities, and other events in which persons who are deaf participate. In addition, mental health central authorities might sponsor conferences and workshops to educate the Deaf Community about the benefits and purposes of behavioral health care. At an administrative level, providers need to include leaders who are deaf in task forces, committees, and focus groups designed to improve services to consumers who are deaf. Once it becomes clear that the public mental health system is making a commitment to change, confidence will spread throughout the deaf constituencies.

Sign Language Interpreters

Until enough mental health providers are fluent in ASL, it is vital for mental health systems to provide sign language interpreters for people who are deaf. Sign language interpreters, however, can be at once

the most helpful and the most detrimental aspects of the mental health service delivery continuum for people who are deaf. A well-trained interpreter can help mental health professionals understand the world view and inner difficulties of a person who is deaf.

The interpreter can also assist the person who is deaf to develop a greater awareness of mental health treatment and program options.

There are important potential disadvantages that may not readily be apparent to either consumers or mental health professionals. Effective communication involves innuendo and emotions; in many cases, an interpreter only provides the illusion of effective communication. A hearing clinician asks a consumer who is deaf certain questions, hears responses through the interpreter, and assumes communication is occurring. A consumer who is deaf understands everything the interpreter signs, sees the interpreter voicing the response to the clinician, and assumes that communication is occurring. Often overlooked by both clinician and consumer is the unavoidable involvement of the interpreter in the interaction. The interpreter may serve as both a vehicle and a filter for communication, unconsciously shielding both parties from information or emotions that may be uncomfortable to the interpreter but perhaps vital to the encounter.

This editing is a natural human process, not necessarily a by-product of poor training or questionable ethics. The interpreter's own life experiences, educational level, values, and attitudes influence the communication process. Clinicians would be wise to carefully monitor the interpreting process. A video camera can be used to record an interpreter's performance and then "back-translated" to the clinician using another interpreter. The outcome may be quite surprising to both the clinician and the consumer.

It is good practice, therefore, for providers to use only certified interpreters. There are two national certifying bodies in the United States for ASL interpreters: the Registry of Interpreters for the Deaf and the National Association of the Deaf's Interpreter Assessment Program. In addition, some states have their own interpreter assessment programs. Currently, there is no recognized national certification specifically for mental health interpreters, but efforts are under way to develop criteria and certification licensure procedures for this sub-specialty.

Mental health providers often find that it is more effective to contract with one agency to provide a full continuum of sign language interpreting services than to attempt to identify individual interpreters on an as-needed basis or to develop "in-house" interpreting capabilities. In most communities, sign language interpreters are not needed frequently enough to justify establishing full-time staff positions. If individual case managers or service providers have to arrange for interpreters on an ad hoc basis, the likelihood of service interruptions and professional errors increases.

Interpreting services usually are not billable as a separate, third-party service category. Under the provisions of the ADA, however, the cost of services provided by an agency can be slightly increased for all patients served to cover the cost of interpreter services. The ADA vests the financial responsibility for providing interpreters with the service provider, not the consumer who is deaf. Providing interpreting services for consumers who are deaf is a legitimate service-

delivery cost and needs to be built into an agency's funding formula. In some states, at least a portion of the interpreting costs are reimbursable by Medicaid.

Despite their potential drawbacks, interpreters are likely to continue to be one of the main modes of service delivery in the mental health field for persons who are deaf. Professional training programs are not gearing up to increase the number of fluently signing, trained case managers, social workers, counselors, psychologists, and psychiatrists who are needed today, let alone over the next several decades.

In general, family members should not serve as interpreters in mental health settings, regardless of their skill level or willingness to do so. In some cases, a person's mental health problems—whether the individual is hearing or deaf—are enmeshed with family dynamics, and another family member cannot be expected to speak objectively, especially in what can be an emotionally charged atmosphere of a mental health encounter. In stating this general principle, it must be acknowledged that obtaining the services of a qualified interpreter who is not a family member may not always be possible, particularly in emergency situations. Under such circumstances, the involvement of a non-family interpreter should be sought as soon as reasonably possible.

Inpatient Services

In addition to communicating effectively with consumers who are deaf, mental health providers in each state must have links to inpatient treatment facilities that are accessible to patients who are deaf. In many states, some efforts have been made to make a program or unit accessible. To be considered fully accessible, programs need to include, at a minimum, the following:

- ◆ Admission policies and procedures that do not discriminate, intentionally or otherwise, against persons who are deaf. For example, admission offices need TTY telephone access and interpreters need to be available (on-call) on a 24-hour, 7-day basis. There also should be a means of communicating that includes visually identifying both parties; in other words, an audio intercom-type system is not helpful when a patient who is deaf is being admitted.
- ◆ Treatment units that are accessible. Visual alerting devices are required by law for fire, smoke, and carbon monoxide detectors. Patients also need special devices—door knock indicators, telephone ringers, and non-auditory wake-up alarms, such as flashing lights or bed vibrators. All televisions for patient use, as well as videotapes or films used in treatment, should be closed-captioned. If inpatients generally have access to telephones, a TTY should be available for patients who are deaf; if not, pay phones should have TTY capability. Interpreters should be readily available, and all staff members including nurses should have training in sign language. Ideally, video materials for audiences who are deaf should use ASL and have performers and narrators who are deaf. Some mental health materials are available in this form and may be purchased through a variety of Internet

and other sources.

- ◆ Assessment procedures that are nondiscriminatory. Qualified examiners should always be used, preferably those who are fluent in ASL. Given the fact that such professionals are rare and expensive, qualified interpreters must be used. (For a discussion of interpreter qualifications, see the earlier Sign Language Interpreters section.) Language-based assessments or tests that require reading should not be used with persons who are deaf. For example, the Minnesota Multiphasic Personality Inventory (MMPI) is not appropriate. For a thorough explanation of testing and consumers who are deaf, see Vernon and Andrews (1990).
- ◆ Nondiscriminatory treatment. All staff providing treatment services to consumers who are deaf should be sign fluent (*Tugg v. Towey*, 1994). Given the fact that the number of sign-fluent therapists is limited, interpreters will be used for the majority of inpatient treatment. In group treatment settings, special accommodations need to be made for interpreters, recognizing that their presence significantly alters the treatment process for everyone involved. Some excellent resource material is available in the fields of interpreting and mental health (see DeMateo, Veltri, & Lee, 1985). Consent forms should be translated by a qualified interpreter using sign language. If videotapes or other materials are used, they also need to be made accessible.
- ◆ Proper medication monitoring for patients. Medication side effects that might be considered less problematic for individuals who can hear, such as hand or finger tremors and facial tics, may have a significant negative impact on a person's ability to communicate the grammatical and other nuances of ASL. These side effects must be clearly communicated to patients who are deaf.
- ◆ Full inclusion in the treatment planning process. Again, either sign-fluent staff members or qualified interpreters are required.
- ◆ Outside consultation from expert sources. Outside consultation is a standard of good health care, and professionals serving consumers who are deaf should be willing to ask for assistance from experts in the field.
- ◆ Proper and complete discharge planning. The greatest stumbling block to effective programming for consumers who are deaf is often the lack of community resources to support them once they have been discharged from treatment. Housing needs to be "deaf friendly" and accessible. Furthermore, treatment personnel in the community need to be fluent in ASL and fully involved in the placement process so that services are not interrupted.

Due to the high cost and resource requirements for making inpatient facilities fully accessible to deaf persons, not every treatment unit and facility in a state needs to be made accessible. Prior program and treatment considerations, such as county of residence, diagnostic category, and gender, should be

eliminated for patients who are deaf when considering inpatient placement. A single treatment unit, highly specialized and fully accessible, may be sufficient to serve the deaf population of an entire state, regardless of individual residence or diagnosis. Policies and practices can be altered to accommodate patients who are deaf, but these changes require forethought and strategic implementation. States with large populations may need more than one treatment unit.

In states where all (or many) inpatient services are provided by the private sector, the state mental health system still has an obligation to ensure accessible inpatient treatment for consumers. Contracts and agreements between public and private entities must reflect an awareness that services to people will occur in a nondiscriminatory manner. In addition, private providers are equally bound by the provisions of the ADA.

Length of stay in inpatient units is a significant consideration. People who are deaf, on average, require longer stays than people who can hear. Reasons for this are numerous—related to educational, language, and programming deficits. Medication side effects may be more pronounced or have a greater negative impact on some patients who are deaf. There is little literature available to guide professionals in predicting recidivism, cooperation with treatment recommendations, or other “distinctively deaf” variables when examining inpatient stays.

Housing Services

Consumers who are deaf, as with other recipients of mental health services, should have a right to make choices about where and how they live. It is important for mental health providers to understand that many consumers who are deaf prefer to live with or near other persons who are deaf for emotional and intellectual support as well as for information. They also need treatment personnel in the community to be fluent in ASL and fully involved in the placement process so that mental health services are not interrupted.

Being surrounded by others who can communicate fluently (both expressively and receptively) in ASL is a highly significant variable when considering what factors enable a person who is deaf to feel comfortable in a living situation. Placing a single consumer who is deaf in a large apartment complex with hearing people may appear to be including them in society but, in fact, may be the most isolating alternative available. If a person has no one with whom they can communicate, the world can quickly begin to feel ominous and isolating, and symptoms of mental illness may return or be exacerbated. Most important, physical inclusion with communication isolation does not represent the least restrictive environment.

This is not to say that all people who are deaf and have a mental illness will make the same choices—some may prefer a group home environment, others may opt for apartment living with other persons who are deaf or with available staff nearby, and still others may prefer to live on their own, with

minimal or no staff support. Taking into account these linguistic and cultural concerns, however, persons who are deaf should have the same range of available housing options as other members of society. In addition, it is essential that housing for consumers who

are deaf conform to ADA standards for access and include visual doorbell and door knock indicators, alarm systems, smoke detectors, and telephone service.

Adult Issues of Trauma, Violence and Abuse

As previously mentioned, one of the primary issues affecting mental health service provision to deaf persons is the lack of adequately competent sign language interpreters. Most hearing people know little about the subtleties of American Sign Language and even less about what constitutes sufficient interpretation. Sign language interpreters vary greatly in skill level and in experience working in mental health settings. In many cases, an interpreter who is well skilled at interpreting a deaf persons sign language into verbal language may not be nearly as competent in the reverse skill. The lack of readily available and qualified sign language interpreters in emergency mental health service sites, settings where they are most needed to address acute mental health emergencies, creates significant obstacles to effective treatment. Without an understanding of mental health assessment questions and the signs and symptoms of mental illness, the interpreter may not interpret signed or spoken thoughts precisely, rendering the assessment either incorrect or greatly weakened.

A person who is deaf is always at risk for either miscommunication or, at worse, coercion and manipulation by mental health providers. Situations may arise where a deaf person with a mental illness receives treatment based on interpretations of their behavior. As such, behaviors that arise from anger and frustration at being misunderstood or not listened to can easily arise to the clinician interpreting that the consumer is dangerous. As a result, the clinician may respond by using strategies designed to contain and control the situation to prevent the situation from escalating into a violent encounter. There are multiple instances of deaf persons with mental illness being put into restraint or seclusion, primarily because the clinician misinterpreted behaviors that were the result of anger and frustration at not being understood. Most devastating is the very real and final restriction on communication that being “tied down” places on a deaf persons ability to communicate. One person characterized it by stating, “Being tied down in restraints to a deaf person is what being tied and gagged is to a speaking person.” K. A. Huckshorn, R.N., M.S.N., I.C.A.D.C. (personal communication, January 30, 2002, at the Third Technical Report Meeting on Seclusion and Restraint, Special Focus: Persons Who are Deaf or Hard of Hearing)

The same issues that occur in mental health settings also routinely occur in some schools, residential treatment settings and in the criminal justice system. The resulting effects on deaf persons with mental illness are the experience of repeated misunderstanding, violence, and re-traumatization creating fear, suspicion, and real anger. This is not an atmosphere that breeds compliance with follow-up treatment or voluntary engagement with the mental health system.

Services for Children and Families

For a number of reasons, children who are deaf are particularly vulnerable to developing emotional difficulties. Mindel and Vernon (1970) note that approximately 92 percent of children who are deaf are born to parents who can hear and that communication difficulties between parent and child often are apparent throughout the developmental periods. It is estimated that only 15 percent of parents develop the sign language communication skills necessary to carry on meaningful conversations with their children, beyond simple commands and queries. Meaningful communication with siblings and extended family members is also rare or nonexistent.

The school environment also can be problematic and a source of emotional distress for children with hearing impairments. Children who are deaf and attend school in local school districts often remain in self-contained classrooms with the same classmates, teachers, and support staff for years at a time. Interaction with peers who can hear may occur only during lunch breaks or at school-wide events, where there is little chance for developing friendships. For children who attend state residential schools for the deaf, a different set of problems, no less debilitating, often develops. These children may live apart from their families five days a week and never fully experience regular family interactions.

The most effective children's services appear to be school-based services in which mental health professionals provide ongoing counseling, therapy, and advocacy in the school environment. If serious family problems arise, counselors can visit the homes of children and assist parents and siblings to better understand the dynamics of deafness and provide a more nurturing and supportive environment. Such services are being provided in some localities, but the public mental health system must be responsible for them. Residential schools for children who are deaf often provide similar supportive programs and services. To ensure high-quality services, a close working relationship should exist between the state school(s) for the deaf and the state mental health agency. (See also Educational Needs section.)

The problems of children's services are numerous and profound. The solutions are complex and painstaking to implement, but they are possible. Cost-effective, outcome-oriented, practical programs that address the needs of children and adolescents who are deaf and their families are vital. Each state needs specialists who work with children and adolescents who are deaf and their families. In more populated regions, full-time staff can focus their services on this population; where numbers dictate otherwise, regional children's services may be more cost-effective. Good programs that are well implemented could have a positive impact that will be felt for generations and will help avoid a negative impact on future social service and correctional systems.

Treatment programs for emotionally disturbed children who are deaf need to be available, whether in concert with programs for children who can hear, in concert with the state schools for the deaf, or as separate entities. As with other service areas, these treatment programs need to be fully accessible in terms of communication and access to information, recognizing the language development lags that

children who are deaf often experience.

Childhood Trauma and Abuse

Children who are deaf are thought to be targeted by sex offenders because these children may be perceived as unlikely to report the offense. Many youth who are deaf also appear to be susceptible to pressure to experiment with drugs and alcohol in an attempt to find an identity within negative peer groups (Lala, 1995). When assessing needs and providing clinical interventions, mental health practitioners as well as administrators and planners need to understand these potential issues.

Research shows that rates of physical and sexual abuse among children who are deaf are extraordinarily high compared with the general population (Elder, 1993). While, as in the general population, no hard data are available, estimates range from abuse rates two to three times those experienced by people without disabilities. Sullivan, Vernon, and Scanlon (1987) reported that in the clinical population they studied, 53.4 percent of children who are hearing impaired reported having been the victims of sexual abuse. Obviously, these data are skewed considering the only children they saw were already diagnosed with an emotional or behavioral disorder, which was likely related in some way to the abuse they reported. The percentage is nonetheless very high.

There may be multiple reasons for this unusually high rate of victimization. Some professionals relate it directly to the lack of early communication between parent and child, and the child's search for intimacy in any possible way to fill the resulting developmental disruption (Critchfield, 1983). Other researchers have postulated that potential abusers may perceive children who are deaf as "ideal" victims, naively supposing them to be unable to report the abuse (Critchfield, 1983; Elder, 1993). The general lack of social knowledge among children who are deaf also contributes to their lack of understanding of what constitutes acceptable and unacceptable behavior in others (Sullivan, Scanlon, Brookhouser, & Schulte, 1992). The truth is likely a combination of several of these factors.

Developing Services for Children Who Are Deaf

When considering the development of services to a deaf population (and especially to children who are deaf), planners must take into account the likelihood that their clinical personnel will be dealing with the victims and survivors of sexual trauma. It is likely that a therapist's caseload will reflect a large number of seriously traumatized consumers. Therapists should expect extended periods of treatment and treatment complications. In addition, there may be a need for better education and information in preventative efforts to do as much as possible to reduce the rate and severity of the childhood problems that may manifest themselves in the lives of adults. Direct-service personnel for children who are deaf and have been traumatized need frequent and quality clinical supervision, regardless of their experience, because of the emotionally and physically exhausting treatment they will deliver. Mutual staff support and frequent professional/social support activities are essential.

Recommendations

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- ◆ Establish a Director of Deaf Services position within each state mental health agency's central office, consistent with the position description outlined earlier in this report.
 - ◆ Establish, in most community catchment areas, regional adult mental health services serving multiple mental health centers and employing sign-fluent, culturally competent staff members in a team approach. Each team might be composed of a social worker, counselor, case manager, children's specialist, and an addictions specialist. The recommended service ratio is one mental health case manager for each 400,000 adults in the general population and one additional mental health professional to serve children and families within the same population (Trotter, B., 1999).
 - ◆ Establish acute-care inpatient treatment programs with sign-fluent staff to serve both psychiatric and substance abuse clients. States where such programs have succeeded have found that long-term psychiatric inpatient care is rarely required, except in forensic cases and some cases involving organic dysfunction for which medication and extensive staff support are inadequate in community settings.
 - ◆ Implement an individualized aggression risk assessment that both identifies potential triggers as well as effective interventions. Implement policy that strongly discourages the use of seclusion or restraints, especially with the Deaf population. Ensure that staff clearly understand the issues related to the use of seclusion and restraint on a person who is deaf.
 - ◆ Establish regional children's mental health services as a component of the teams described above. These specialists would serve primarily in mainstream educational programs and with the families of children and adolescents.
 - ◆ Establish a residential treatment program for children who are deaf, perhaps in conjunction with an existing program for hearing children. Critical to the success of such a program is the inclusion of sign-fluent staff and competent clinicians. In terms of less restrictive alternatives, therapeutic foster care using well-trained host families has shown tremendous potential for reducing inappropriate behavior and enhancing the quality of life for children who are deaf and have emotional difficulties.
 - ◆ Make a special effort to reach out to people of color who are deaf, who tend to be over-represented in mental health populations in general. The Deaf Community is no different from other groups in this regard. The National Black Deaf Advocates (NBDA) has been an excellent resource in helping to bridge the cultural and linguistic gaps that often exist between African Americans and other people who are deaf. In addition, national organizations exist for people who are deaf from a number of other racial and ethnic backgrounds, including Native

Americans, Asian Americans, and Hispanic/Latino Americans. Consumers and potential staff members should be identified within these “dual minority” groups. Involving representatives of racial and other minority groups in the planning process at an early stage sends a message of inclusion and awareness that previously may have been absent on the part of public mental health systems.

- ◆ Manage mental health interpreting services through a single statewide contract, coordinated through the central office of the state mental health agency. A single toll-free telephone number can be established enabling all community and facility-based programs to have access to interpreters as needed.
- ◆ Establish a statewide emergency telephone TTY crisis line to answer emergency calls from people who are deaf 24 hours a day, 7 days a week, 12 months a year. This can be done quite inexpensively using state-of-the-art pagers and computer referrals. Regional staff members can serve as call recipients on a rotating basis, thus allowing people who are deaf and in crisis immediate access to culturally competent resources, especially for after-hours emergencies. The technology to establish such a service is readily available and cost-effective in preventing unnecessary hospitalizations.
- ◆ Require that all contracts with service delivery agencies include provisions that prohibit discrimination in serving people who are deaf. While virtually all government contracts include nondiscrimination language, in the case of services to consumers who are deaf, these requirements need to be more clearly spelled out, in terms of specific requirements to meet their needs. Specifics are included throughout this report. Community mental health centers can satisfy the requirements of access to their services through subcontracts with regional service programs.
- ◆ Once the state mental health agency has committed itself to a particular model of service delivery, develop standards of care to ensure compliance with the laws and safe, humane, and effective services for consumers who are deaf. Once services are in place, it is realistic (indeed mandatory) that standards be promulgated, through the involvement of consumers, focus groups, service providers, and mental health administrators.
- ◆ Develop accessible housing for people who are deaf with mental illness. In each state, regional housing programs should include access to a group home specifically and exclusively for residents who are deaf. In addition, make less structured housing options available for persons requiring a lesser degree of support—such as supported apartments, fully independent apartments, and family settings where appropriate.
- ◆ Provide training grants or scholarships to students interested in pursuing careers in mental health

and deafness. Each state should identify at least one institution that is interested in establishing a formal training program and work cooperatively with that institution to offer courses and training opportunities to provide a steady stream of qualified personnel to the mental health system. It is possible that a training objective may be achieved through the development of coalitions among states using available technology to train diverse professionals in the intricacies of deafness-related service delivery.

- ◆ Establish a statewide multicultural advisory panel to oversee the ongoing development of services for persons who are deaf. This should be a standing committee, with membership representing all stakeholders in a geographic region, especially consumers of mental health services who are deaf. This committee should have direct influence on the development of the state mental health plan so that consumers who are deaf are not overlooked.

Conclusion

Much remains to be done. Readers of this report are likely to emerge with as many questions as definitive answers for state mental health systems as they plan services for persons who are deaf with serious mental illness. Readers can learn more about this topic by referring to the publications and organizations included in the resource section as well as to those cited in the text of this report. Since the 1960s, a tremendous amount of research has been conducted and numerous successful programs have been established, but comprehensive information regarding research and effective programs has yet to be widely disseminated in the public mental health community. Many successful programs have been funded, implemented, and then discontinued because of the loss of outside financial support. The fact that these programs no longer exist cries out for the reestablishment and regeneration of efforts for permanent programs that are fully incorporated into each state's mental health structure. Today, people who are deaf with serious mental illness are present and unserved, or underserved, throughout the nation. This neglect should not be allowed to continue in the United States in the 21st century.

Model Program:
South Carolina Department of Mental Health
Program of Services to Persons Who Are Deaf or Hard of Hearing

Program Overview

Since 1989, the South Carolina Department of Mental Health has funded a unique program of services for persons with mental illness who are deaf or hard of hearing. Working within the department's existing structure, officials developed new strategies to meet the needs of this underserved community. These new approaches required a reassessment of the department's regional configuration as well as of the relationship between local community mental health centers and the state central office. Fundamental to the development of this initiative is the core belief that public mental health services should be delivered in the preferred language of consumers who are deaf and in a milieu that is sensitive to Deaf Community values.

Key components of the program include mobile, community-based counselors who are responsive to consumer needs, residential alternatives that affirm the values of Deaf Culture by enabling recipients of public mental health services to live in close proximity to other persons who are deaf, and a small inpatient treatment unit that complements and supports the community-based programs. Regional services include a traditional continuum of mental health care enhanced by the use of state-of-the-art technology that affords greater efficiency in the delivery of services. These technical innovations include the use of video conferencing, a statewide crisis-line, and laptop computers that enable regional counselors to have access to central databases and supervision assistance through modems and direct-line connections to the larger mental health computer network. Two-way pagers assist professionals in the field who are deaf in the same way that cellular telephones benefit field personnel who can hear.

A staff of about 35 mental health professionals deliver a comprehensive array of high-quality mental health services using American Sign Language (ASL) for persons who are deaf or hard of hearing throughout South Carolina. Although staff members are based in local mental health centers around the state, they travel throughout a region to provide services to consumers who are deaf or hard of hearing.

Culturally Competent Initiatives and Strategies

One of the most significant innovations in the South Carolina Department of Mental Health's Program of Services to Persons Who Are Deaf or Hard of Hearing has been the identification of highly trained and dedicated practitioners who provide services to persons who are deaf in their preferred language and cultural milieu. In many ways, the services provided to consumers with hearing problems are the same as those afforded to other consumers. The primary difference is in the mode of communication. For many persons who are deaf, ASL is the preferred method

of communicating, and all staff members in this program are fluent in its use. Fourteen of the 35 staff members are deaf.

Vital to the delivery of effective mental health services is the participation of two psychiatrists who use sign language communication to manage medications for clients throughout the state. They use video conferencing to link with mental health centers around the state using desktop video connections. The clinicians routinely conduct one-on-one interviews with consumers who are deaf (both adults and children), managing their medications, intervening in emergencies, and assisting in treatment planning without necessitating travel to remote locations. Thus, patients who are deaf have direct communication access to their doctor without the need to use an interpreter.

Regardless of where they live in the state, people with mental illness who are deaf or hard of hearing have access to counseling, case management, social work, and other services conducted in a language that is accessible to them. Regional mental health professionals travel throughout the state, providing services to consumers in mental health centers, homes, places of work and worship, and other appropriate and culturally affirming settings.

The program also offers a wide range of supported housing alternatives that enable consumers who are deaf to live in close proximity to each other, providing numerous opportunities for communicating and developing friendships with other persons who are deaf. Supported employment efforts have resulted in a significant number of people who are deaf with mental illnesses returning to work or finding employment for the first time in their lives. Substance abuse services are also available to adult and youth consumers who are deaf and need them.

Collaborative Efforts

The state deaf services program has strong ties to and support from the state's Deaf Community, dating back to the original plans to establish the program in 1985. In preparation for initiating the statewide program, state and local mental health service providers established and fostered effective linkages with this vital community resource and engaged in substantive discussions about the proposed program's operation, structure, goals, and principles. With the support of the statewide deaf services program, public mental health services providers are able to offer accessible mental health services to persons who are deaf or hard of hearing in an efficient manner throughout their geographic region. Without that support, each mental health center would have been required to develop and provide services to a deaf population whom most staff do not have the training or experience to serve.

In South Carolina, a significant level of collaboration exists between the state mental health agency and numerous other entities, including educational programs for children who are deaf, the state vocational rehabilitation agency, the South Carolina Association of the Deaf, the Commission for the Blind, the state agency serving people with Developmental Disabilities and

Special Needs, the state Department on Alcohol and Other Drug Abuse Services, and the Governor's Offices of Children's Services.

In addition, state mental health administrators frequently receive requests for consultation in developing services for consumers who are deaf from other state mental health systems. To date, South Carolina mental health system staff have provided direct consultation to 16 states and made more than 100 presentations at national, state, and regional conferences regarding its model for providing public mental health services to people who are deaf or hard of hearing. In cooperation with South Carolina Educational Television, the state deaf services program developed a videotape explaining how its services operate. Indeed, at least three states have implemented mental health services for persons who are deaf based on the South Carolina model, which can be replicated, with modifications, in any statewide or regional public mental health system.

Recently, state Department of Mental Health officials and several South Carolina universities discussed a proposal to involve institutions of higher education throughout the country in establishing a collaborative, multistate network that provides training to professionals in a variety of mental health disciplines with a specialization in providing services to persons who are deaf and hard of hearing.

Evaluation Efforts and Results

In South Carolina, the average daily inpatient census of consumers who are deaf has dropped from a peak of 22 in 1993 to the current average of 1.2. The average length of stay for persons who are deaf with mental illnesses in inpatient settings decreased from more than 20 years to approximately 15 days during that same period. Simultaneously, the number of consumers that the state mental health system serves has steadily increased. The significant reduction in inpatient census and length of stay combined with substantial growth in the number of consumers served provides a clear indication that the program is meeting its goal of providing appropriate, community-based mental health services to members of the Deaf Community.

In addition, fewer state funds are spent today to serve a far larger population of consumers who are deaf than were spent in past years to place a relatively small number of consumers who are deaf in inappropriate and expensive inpatient settings. In 1991, the South Carolina Department of Mental Health spent more than \$1.7 million to provide mental health services for fewer than 30 consumers who are deaf (primarily in inpatient settings); today, the state mental health system serves more than 400 persons who are deaf in community settings at a much lower overall cost, when factoring in Medicaid revenue as well as block grant funds. These consumers receive significantly better services in far less restrictive settings. Some of the persons once confined to inpatient facilities now hold competitive jobs, live independently, and function as productive and contributing members of society.

Funding

In fiscal year 2002, the cost of the entire state mental health program for persons who are deaf or hard of hearing is about \$1.3 million. This amount includes \$1.1 million in general revenue funds from the South Carolina Department of Mental Health as well as \$200,000 in Center for Mental Health Services (CMHS) state block grant funds designated specifically to establish five new positions to expand services for children and adolescents who are deaf and their families. These gross expenditures do not reflect the nearly \$450,000 in reimbursements from Medicaid, private insurers, and other third-party payers.

Contact Information

A. Barry Critchfield, Ph.D.
Director of Services to Deaf and Hard of Hearing People
South Carolina Department of Mental Health
P.O. Box 485
(2414 Bull Street)
Columbia, South Carolina 29202
(803) 898-8301
(803) 898-8874 (TTY)

Model Program:
Thresholds Bridge Program for the Deaf
Chicago, Illinois

Program Overview

Thresholds Bridge Program for the Deaf, established in 1984, serves consumers who are deaf with a broad range of psychiatric disabilities in the Chicago metropolitan area. The program provides comprehensive mental health services for adults who are deaf, including residential, outreach, and vocational rehabilitation programs. The Bridge Program has been successful in integrating inpatient, outpatient, residential, and advocacy services in a manner tailored to address the special needs of persons who are deaf. The program, which serves 150 to 200 consumers who are deaf each year, is one of several specialty programs operated by its parent agency, Thresholds, whose mission includes developing and expanding services to help meet the mental health needs of consumers and to improve the quality of life of a wide range of persons with serious mental illness.

Thresholds' specialty programs also include the Mother's Program, the Young Adult Program, the Older Adult Program, and, most recently, the Jail Program. Each of these programs serves populations that often are neglected by other mental health systems. The Thresholds Jail Program recently received the American Psychiatric Association's highest honor, the Gold Achievement Award for innovative service provision and excellence in service delivery. The Bridge Program received a significant achievement award from the American Psychiatric Association in 1991 for its rehabilitative services to adults who are deaf and who have a mental illness. Altogether, Thresholds serves more than 5,000 consumers each year and employs 1,000 staff with an annual budget of more than \$40 million.

Residential Programming

The Bridge Program operates three supervised residences. Each structure is a 10-bed therapeutic group home located in an apartment building purchased by the program and supervised by teams of house managers, all of whom are fluent in American Sign Language (ASL). Each building is equipped with communication and safety devices including telecommunication devices for the deaf (TTY) and visual fire alarms and doorbells. The original residence, purchased in 1984, was supplemented in 1988 by a second residence with less intense supervision designed for people who are nearly ready to live on their own in the community.

The original residence's intensity of supervision is between that of the second residence and a third one purchased in 1991, which serves people who are deaf who have experienced long-term hospitalization in a state psychiatric facility. This is the most intensely supervised residence (24 hours per day, 365 days per year) and provides up to 16 hours of programming per day. Consumers who are deaf and who have been hospitalized for extended periods often come to the program extremely dependent on

routinized, externally controlled environments. Many are so dependent on external controls that free time can be stressful. In recognition of this fact, community-based services continue to provide structured programming; however, members also have the freedom to make choices about all aspects of their lives, often for the first time.

The Bridge Program's unique approach is designed to offer a continuum of services to consumers who are deaf depending on their needs. For example, in the less intensely supervised residences, staff are on duty for part of each day and members may come and go as they please. Some consumers travel independently to and from work, home visits, and others activities. As members reach their rehabilitation goals, they are encouraged to move to a less restrictive residence and, eventually, to an apartment in the community. Consumers who make this transition from group to independent living receive services from the Bridge Program's Assertive Community Treatment Team.

Assertive Community Treatment

An assertive community treatment (ACT) team serves a clinically diverse group of about 60 consumers who are deaf, including persons who previously resided in one of the program's supervised residences and who are able to live independently with ongoing staff support. The program is designed to prevent unnecessary hospitalization and is based on the highly regarded ACT model initiated in Madison, Wisconsin. Each of the program's nine outreach workers makes an average of 15 home visits per week to consumers participating in this program. Outreach workers help program participants with a wide variety of tasks, including performing routine housekeeping chores, paying bills and communicating with physicians or potential employers who may have little or no experience with persons who are deaf or the Deaf Culture. Often, the outreach workers simply carry on a friendly chat, in sign language, in the consumer's living room. This flexible, hands-on approach makes it possible to match services rendered to the particular needs of each individual.

Vocational Rehabilitation

A team of vocational rehabilitation experts each year serves 30 to 50 clients who are deaf and who have a mental illness. This service, the newest addition to the Bridge Program, was made possible by a grant from the Illinois Office of Rehabilitation Services in response to a pressing need for expanded vocational rehabilitation services. Although ACT team staff had provided this service previously, it became clear that there was a need for experts in the field of vocational rehabilitation, as more consumers entered the program with extremely limited work skills. This behaviorally grounded program, focusing on prevocational skills, has been successful in helping many consumers make the transition from sheltered workshops to competitive employment. Staff members provide vocational learning opportunities for consumers such as a weekly job club, field trips to employment sites where other people who are deaf work, resume-writing workshops, and interview-skill development. Staff often assist program members in interacting

with the state vocational rehabilitation system and may provide job coaching once an individual finds employment.

Culturally Competent Initiatives or Strategies

With rare exceptions, community mental health programs, even the most progressive ones, are designed for consumers who are hearing. As a result, persons who are deaf with serious mental illness often encounter numerous, seemingly insurmountable barriers to receiving effective services. Persons who are deaf and seek help from mental health programs designed for hearing consumers may risk being ignored, misunderstood, misdiagnosed, or cared for by mental health professionals who have little or no knowledge of deafness.

The Thresholds Bridge Program was carefully designed to address these and other major concerns: the need for mental health workers who are fluent in ASL and familiar with issues related to deafness and Deaf Culture; the need for both high and low levels of program structure for members of this exceedingly heterogeneous population; and the need for a wide variety of program components, including assertive outreach and service coordination, supervised and supported housing, vocational and social rehabilitation, and the other elements of a comprehensive community support system.

Modeled after a Thresholds' intervention for frequent hospital users that received the Significant Achievement Award from Hospital and Community Psychiatry in 1991, the Bridge Program has become a focal point—within Thresholds, throughout Illinois, and even nationally—for efforts to make all major mental health services and programs fully accessible to consumers who are deaf. Because of its cost-effective yet comprehensive design, the program provides a model for other agencies seeking to maximize accessibility to persons who are deaf.

Leadership at the national level began in 1989 when the Bridge Program co-sponsored, with the National Health Care Foundation for the Deaf, the first National Conference on Community-Based Alternatives for Deaf Persons with Mental Illness in Washington, DC. This highly successful and long overdue gathering was jointly funded by the National Institute of Mental Health and the National Institute on Disability and Rehabilitation Research. Since that time, with the support of many leading mental health programs for the deaf, the conference has become known as “Breakout: Innovations in Psychosocial Rehabilitation and Deafness.” The director of the Thresholds Bridge Program has served as the conference chair for three of the five conferences held to date, and the program is well represented at each conference by presenters, organizers, and participants.

At the Deaf Culture Workshop held during Thresholds' annual Staff Development Day, experts on deafness from the Bridge Program lecture on Deaf Culture, sign language, effective use of interpreters, and other relevant topics to promote deaf awareness throughout the agency. Thresholds employs a Manager of Interpreting Services (a new position) who teaches ASL to agency staff and members, provides staff training and psychiatric consultation, and convenes other consumer and staff meetings

and appointments. Having a designated agency-wide interpreter has helped integrate services for consumers who are deaf by creating easier access to programming available throughout Thresholds. For example, consumers who are deaf now are able to attend the computer class Thresholds offer to its members.

Collaborative Efforts

From the outset, the Bridge Program's managers have received invaluable advice from leaders of the Deaf Community as well as from other advocates for people who are deaf. Staff members from other Thresholds programs are involved in an ongoing initiative to achieve at least a basic proficiency in sign language and familiarity with Deaf Culture. As noted, agencywide training activities improve, promote, and stimulate accessibility both for members who are deaf and staff. Moreover, the overall quality of services improves when a larger community of people can communicate with program participants who are deaf.

An important feature of the program is its close collaboration with Chicago-Read Mental Health Center, a state psychiatric hospital that operates an inpatient unit for patients who are deaf. Most referrals to the Bridge Program come from this unit, and, when necessary, most re-admissions take place there. Staff members from the Bridge Program attend weekly meetings at the unit and visit informally with current or prospective service recipients.

Program staff also collaborate closely with Addiction Recovery for the Deaf (ARD), a Chicago-based substance abuse treatment program for persons who are deaf. Both programs have experience in serving clients simultaneously and have developed a system to maintain continuity of care. For some consumers who are deaf, the Bridge Program, ARD, and the Chicago-Read Mental Health Center coordinate with each other to ensure a smooth transition from one program to the other, with the Bridge Program taking responsibility for the difficult transition back into the community after hospitalizations or substance abuse treatment.

Finally, a Bridge Program staff member represents Thresholds as a member of the Illinois Office of Mental Health's State-Wide Advisory Committee for deaf and hard of hearing services, attending quarterly meetings with deaf service providers. A teleconferencing format allows full accessibility for deaf services providers from around the state. This is a tight-knit group, with some participants having worked together for up to 15 years. The committee was responsible for the creation of the position of Illinois' State-Wide Coordinator of Deaf/Hard of Hearing Services as well as an additional position that focuses on the mental health needs of people living in metropolitan Chicago.

Evaluation Efforts

Thresholds consistently evaluates its programs and activities, and it disseminates the findings through training, consultations, publications, and conference presentations. Upon entering the program, a typical

consumer has been hospitalized an average of six times and has spent more than three years in an outpatient setting. Many members lived with relatives before entering the program (42 percent) or in sheltered settings (38 percent), and 90 percent were unemployed. During their tenure in the program (average 2.9 years), 43 percent avoid rehospitalization altogether, 63 percent are employed, and 45 percent live in independent apartments. Among members who have spent at least 12 months in the program, Global Assessment Scale scores have improved significantly between intake and follow-up, moving members to the next higher category of functioning. Many members also experience a significant decrease in symptoms as measured by the Brief Psychiatric Rating Scale and demonstrate significantly improved independent living skills.

Funding

The Bridge Program has grown substantially since 1984 with grant support from the Illinois Office of Mental Health and the Illinois Office of Rehabilitation Services. The program currently serves 110 consumers who are deaf, has an annual budget of \$2 million, and employs a staff that includes 35 full-time and 29 part-time workers.

Contact Information

Heather K. Horton
Program Director
Thresholds Bridge Program for the Deaf
4734 South Ellis
Chicago, Illinois 60615
(773) 924-9833
Fax: (773) 924-8983
Pager: (312) 689-4481
Email: hkhorton@midway.uchicago.edu

References

- Adkins, M.A. (1990). Role of bilingual/bicultural service providers in the delivery of mental health services. In W.H. Holtman & T.H. Bornemann (Eds.), *Mental health of immigrants and refugees—Proceedings of a conference sponsored by the Hogg Foundation and World Federation for Mental Health*. Austin, TX: Hogg Foundation for Mental Health.
- Altshuler, K. Z. (1978). Toward a psychology of deafness. *Journal of Communication Disorders*, *11*, 159–169.
- Anderson, G., & McGee, S. (1996). Helping minority individuals navigate through successful school and work transitions. In M. Kolvitz (Ed.), *Challenge of change: Beyond the horizon*. Knoxville, TN: University of Tennessee.
- Anderson, G., & Thornton, M. (1993). Unresolved issues in the provision of mental health services to people who are deaf. In O. M. Welch (Ed.), *Research and practice in deafness: Issues and questions in education, psychology and vocational service provision* (p. 228). Springfield, IL: Charles C. Thomas.
- Aponte, H.J. (1994). *Bread & spirit. Therapy with the new poor: Diversity of race, culture and values*. New York: W.W. Norton.
- Arons, B. (1998). Support services for deaf people in the American mental health system. *Proceedings of the First World Conference on Mental Health and Deafness*. Washington, DC: Gallaudet University Press. Available: www.mentalhealth.org/newsroom/speeches/October22gallaudet.htm
- Atkinson, D.R., Morten, G., & Sue, D.W. (1998). Racial/ethnic minorities and cross-cultural counseling. In Atkinson, et al. (Eds.), *Counseling American minorities* (p. 17). New York: McGraw-Hill.
- Bailey v. Sawyer*. (1999). Civil Action 99-A-1231, United States District Court (M.D. Ala. 1999).
- Baker-Shenk, C. (1985). The facial behavior of deaf signers: Evidence of a complex language. *American Annals of the Deaf*, *130*, 297–304.
- Braden, J.P. (1994). *Deafness, deprivation, and IQ*. New York, Plenum Press.
- Bradford, J., Ryan, C., & Rothblum, E.D. (1994). National lesbian health care survey: Implications for mental health care. *Journal of Consulting and Clinical Psychology*, *62*, 228–242.

Comas-Diaz, L., & Griffith, E.E. (Eds.). (1988). *Clinical guidelines in cross-cultural mental health*. New York: Wiley.

Corbett, C. (1995). Culturally competent mental health services. In R.R. Myers (Ed.), *Standards of care for the delivery of mental health services to deaf and hard of hearing persons*. Silver Spring, MD: National Association of the Deaf, Mental Health/Deaf and Hard of Hearing Services. (This book may be ordered from the National Association of the Deaf, Silver Spring, MD, at (301) 587-4873.)

Critchfield, A.B. (1983). Deafness and intimacy: A developmental perspective. In Petersen, E. W. (Ed.), *New directions in mental health and deafness in Indiana*. Little Rock, Arkansas: University of Arkansas Press.

Cross, T.L., Bazron, B.J., Dennis, K.W., & Isaacs., M.R. (1989). *Toward a culturally competent system of care: A monograph on effective services for minority children who are seriously emotionally disturbed*. Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center.

De Mateo, A., Veltri, D., & Lee, S.M. (1985). *The role of the sign language interpreter in psychotherapy*. Presentation at the Ninth Annual Registry of Interpreters for the Deaf Convention.

Dew, D. (Ed.). (1999). *Serving individuals who are low-functioning deaf: 25th Institute on Rehabilitation Issues, 1999*. Washington, DC: The George Washington University. See also University of Arkansas Rehabilitation Research and Training Center (RT-31) [WWW document]. URL www.uark.edu/depts/rehabres/publications.html

Easterbrooks, S. (1997). Educating children who are deaf or hard of hearing: Overview. *ERIC Digest #E549* [WWW document]. URL www.ed.gov (From this Web site, do search for title of article.)

Egli, E. (1987). *The role of bilingual workers without professional mental health training in mental health services for refugees*. Minneapolis, MN: Department of Psychology, University of Minnesota.

Elder, M. (1993). Deaf survivors of sexual abuse: A look at the issues. *Moving Forward*, 2(5), [WWW document]. URL <http://movingforward.org/v2n5-cover.html>

Garcia-Peltoniemi, R.E. (1991). Clinical manifestations of psychopathology. In J. Westermeyer, C.L. Williams, & A.N. Nguyen (Eds.), *Mental health services for refugees*. Washington, DC: U.S. Government Printing Office.

Gaw, A.C. (Ed.). (1993). *Culture, ethnicity and mental illness*. Washington, DC: American Psychiatric Press.

Gay, Lesbian, Bisexual and Transgender Health Access Project. (1997). *Health concerns of the gay, lesbian, bisexual, and transgender community*. (2nd Ed.). Boston: Massachusetts Department of Public Health.

Gentile, A., & McCarthy, B. (1973). *Additional handicapping conditions among hearing impaired students, United States, 1971-1972*. Washington, DC: Gallaudet College, Office of Demographic Studies.

Graham, P., & Rutter, M. (1968). Organic brain dysfunction and child psychiatric disorder. *British Medical Journal*, 3, 695–700.

Grinker, R. R., Sr. (Ed.). (1969). *Psychiatric diagnosis, therapy, and research of the psychotic deaf*. Final Report, Grant No. R. D. 2407 S. Social and Rehabilitation Service, Department of Health, Education and Welfare. (Available from Dr. Grinker, Michael Reese Hospital, 2959 S. Ellis Ave., Chicago, IL 60612).

Heller, B.W., Langholz, D.J., & Acree, M. (1986). Effective psychotherapy with deaf persons: Therapist and client characteristics. In D. Watson, B. Anderson, & M. Taft-Wilson (Eds.), *Integrating human resources, technology and systems in deafness* (pp. 46-74). (Monograph No. 13) Silver Spring, MD: American Deafness and Rehabilitation Association.

Higgins, P.C. (1980). *Outsiders in a hearing world: A sociology of deafness*. Beverly Hills, CA: Sage.

Hamerdinger, S., and Murphy, D. (2000). Using the deaf community as an alternative treatment approach: Developing deaf treatment foster homes. *JADARA*, Vol. 33 No. 2, 26-41.

Holt, J.A., Traxler, C.B., & Allen, T.E. (1997). *Interpreting the scores: A users guide to the 9th edition of the Stanford Achievement Test for educators of deaf and hard of hearing students* (Tech. Rep. 97-1). Washington, DC: Gallaudet University, Gallaudet Research Institute.

Holt, J.A., and Hotta, S.A. (1994). *Demographic aspects of hearing impairment: Questions and Answers* (3rd edition). Washington, DC.: Gallaudet University Center for Assessment and Demographic Studies.

Individuals with Disabilities Education Act (IDEA) of 1990, Pub. L. No. 101-476.

Jankowski, K. (1997). *Deaf empowerment: emergence, struggle and rhetoric*. Washington, DC:

Gallaudet University Press.

Lala, Jr., F. (1995). Substance abuse among deaf people: A discussion. In M. Garretson (Ed.), *Deafness: Life and culture II*. Silver Spring, MD: National Association of the Deaf.

Lee, R., & Kearney, M.K. (1995). Setting the legal context: What is the meaning of equal access to mental health services. In R.R. Myers (Ed.), *The standards of care for the delivery of mental health services to deaf and hard of hearing persons*. Silver Spring, MD: National Association of the Deaf, Mental Health/Deaf and Hard of Hearing Services. (Order from the National Association of the Deaf, Silver Spring, MD, at (301) 587-4873.)

Lefley, H.P. (1990). Culture and chronic mental illness. *Hospital and Community Psychiatry*, *41*(3), 277–286.

McCrone, W. (1994, Fall). A two-year report card on Title I of the Americans with Disabilities Act: Implications for rehabilitation counseling with deaf people. *Journal of the American Deafness and Rehabilitation Association*, *28*(2), 1–20.

Miller, C.E., Peck, L., Shuman, J., & Yrn-Calenti, C. (1995). *Building bridges: Tools for developing an organization's cultural competence*. Tucson, AZ: La Frontera.

Mindel, E., & Vernon, M. (1970). *They grow in silence—The deaf child and his family*. Silver Spring, MD: National Association of the Deaf.

Moses, C. (1990). Where do we stand? Trends in society affect mental health programs. *Gallaudet Today*, *20*(3), 2–5.

Munoz, F.U., & Endo, R. (Eds.). (1982). *Perspectives on minority group mental health*. Washington, DC: University Press of America.

Nash, J., & Nash, A., (1981). *Deafness in society*. Lexington, MA: Lexington Books.

Padden, C., & Humphries, T. (1988). *Deaf in America*. Cambridge, MA: Harvard University Press, p. 1. See also Padden, C. (1980). The Deaf Community and the culture of deaf people. In C. Baker & R. Battison (Eds.), *Sign language and the Deaf Community*. Silver Spring, MD: National Association of the Deaf., p. 90.

Pollard, R. (1996, April). Professional psychology and deaf people: The emergence of a discipline. *American Psychologist*, 392.

Rainer, J. D., Altshuler, K. Z., Kallmann, F. J., & Deming, W. E. (1963). *Family and mental health*

problems in a deaf population. New York: New York State Psychiatric Institute.

Rehabilitation Services Administration. (1977). *Third Annual Conference on Deafness*. Washington, DC: U.S. Department of Health, Education and Welfare (U.S. Department of Health and Human Services).

Robinson, L. (1978). *Sound minds in a soundless world* (DHEW Publication No. ADM 77-560). Washington, DC: U.S. Government Printing Office.

Rutherford, S. (1988). The culture of American deaf people. *Sign Language Studies*, 59, 129–147. See also Woodward, J. (1982). *How you gonna get to heaven if you can't talk with Jesus: On depathologizing deafness*. Silver Spring, MD: TJ Publishers.

Schlesinger, H. S., and Meadow, K. R. (1972). *Sound and sign: Childhood deafness and mental health*. Berkeley, CA: University of California Press.

South Carolina Educational Television Network. (2000). *Breaking the barriers: Mental health services for the deaf* (Video). Columbia, SC: South Carolina Department of Mental Health.

Steinberg, A. (1991). Issues in providing mental health services to hearing-impaired persons. *Hospital and Community Psychiatry*, 42(4), 380–389.

Sullivan, P. M., Scanlon, J., Brookhouser, P. E., & Schulte, L. E. (1992). The effects of psychotherapy on behavior problems of sexually abused deaf children. *Child Abuse and Neglect* 16, 297–307.

Sullivan, P.M., Vernon, M., & Scanlon, J. (1987). Sexual abuse of deaf youth. *American Annals of the Deaf* 132, 256–62.

Trotter, B. [president] (1999). Proceedings of Council of State Directors of Mental Health Services to Deaf and Hard of Hearing People, 1999. Jefferson City, MO: Missouri Department of Mental Health.

Tugg v. Towey, 864 F. Supp. 1201 (S.D. Fla., 1994).

Tugg v. Towey, No. 94-1063, 5 *National Disability Law Rep.* 999-1005, July 19, 1994.

U.S. Bureau of the Census. (1996, May). *Resident population of the United States: Middle series projection, 1996-2000, by sex, race and Hispanic origin, with median age*. Washington, DC: Population Division, U.S. Bureau of the Census.

Vernon, M. (1978). Deafness and mental health: Some theoretical views. *Gallaudet Today*, 9, 9–13.

Vernon, M. (1980). Perspectives of deafness and mental health. *Journal of Rehabilitation of the Deaf*, 13, 9–14.

Vernon, M., & Andrews, J. (1990). *The psychology of deafness: Understanding deaf and hard-of-hearing people*. White Plains, NY: Longman Division, Addison-Wesley.

Williams, C. E. (1970). Some psychiatric observations on a group of maladjusted deaf children. *Journal of Child Psychology and Psychiatry*, 11, 1–18.

Willigan, B.A., & King, S.J. (1992). *Mental health services for deaf people*. Washington, DC: Gallaudet University Press (Gallaudet University, American Deafness and Rehabilitation Association, and University of California, San Francisco, Center on Deafness).

Suggested Readings on Cultural Competency

The following list of articles, reports, books, and other publications provides further resources for those who would like to expand their understanding of cultural competency and public mental health services. These publications address a wide range of ethnic and cultural minority groups.

NTAC *Cultural Diversity Series* (current volumes):

McCarn, S. R. (1999). *Meeting the mental health needs of gay, lesbian, bisexual and transgender persons*. Alexandria, VA: National Technical Assistance Center for State Mental Health Planning.

National Technical Assistance Center for State Mental Health Planning. (2001). *Creating culturally competent mental health systems for Latinos: Perspectives from an expert panel*. Alexandria, VA: Author.

National Technical Assistance Center for State Mental Health Planning. (1998). *Meeting the mental health needs of African Americans*. Alexandria, VA: Author.

National Technical Assistance Center for State Mental Health Planning. (2000). *Examples from the field: Programmatic efforts to improve cultural competence in mental health services*. Alexandria, VA: Author.

National Technical Assistance Center for State Mental Health Planning. (2002). *Meeting the mental health needs of Asian and Pacific Islander Americans*. Alexandria, VA: Author.

***Cultural Diversity Series* (volumes in development):**

Meeting the mental health needs of American Indians and Alaskan natives.

Other Suggested Readings:

American Counseling Association. *Journal of Multicultural Counseling and Development*.

Arredondo, P., Toporek, R., & Brown, S., et al. (1996). *Operationalization of multicultural counseling competencies*. Alexandria, VA: Association of Multicultural Counseling and Development.

Atkinson, D., & Hackett, G. (1997). *Counseling diverse populations*. New York, NY: McGraw Hill College Division.

Atkinson, D., Morten, G., and Sue, D. (1998). *Counseling American minorities: A cross-cultural perspective, 5th edition*. New York, NY: McGraw-Hill.

Bernal, G., Bonilla, J., & Belido, C. (1995). Ecological validity and cultural sensitivity for outcome research: Issues for the cultural adaptation and development of psychosocial treatments with Hispanics. *Journal of Abnormal Child Psychology* 23, 67–82.

Center for Mental Health Services. (2000). *Cultural competence standards in managed mental health care services: Four underserved/underrepresented racial/ethnic groups*. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. [WWW document]. URL www.mentalhealth.org/publications/allpubs/SMA00-3457.

Center for Mental Health Services, Refugee Mental Health Branch. (1994). *Lessons learned from regional workgroup meetings on programs for Vietnamese former political prisoners*. Rockville, MD: Author.

Daugherty, D. & Stanhope, V. (Eds.). (1998). *Pathways to tolerance: Student diversity*. Bethesda, MD: National Association of School Psychologists.

Davis, K. (1997). *Exploring the intersection between cultural competency and managed behavioral health care: Implications for state and county mental health agencies*. Alexandria, VA: National Technical Assistance Center for State Mental Health Planning.

Droby, R. M. (2000). *With the wind and the waves: A guide for non-native mental health professionals working within Alaska native communities*. Nome, AK: Norton Sound Health Corporation.

Escobar, J., Hoyos-Nervi, C., & Gara, M. (2000). Immigration and mental health: Mexican Americans in the United States. *Harvard Review of Psychiatry* 8, 64–72.

Gay, Lesbian, Bisexual and Transgender Health Access Project. (1999). *Community Standards of Practice for Provision of Quality Health Care Services for Gay, Lesbian, Bisexual and Transgendered Clients*. Boston, MA: Massachusetts Department of Mental Health.

Glickman, N., & Harvey, M. (1996). *Culturally affirmative psychotherapy with deaf persons*. Mahwah, NJ: Lawrence Erlbaum Associates.

Hindley, P., & Kitson, N. (Eds.). (2000). *Mental Health and Deafness*. London: Whurr Publishers.

Isaacs, M., & Benjamin, M. (1991). *Towards a culturally competent system of care: Volume II*. Washington, DC: Center for Child Health and Mental Health Policy, Georgetown University Child Development Center.

Isaacs, M., & Benjamin, M. (1998). *Towards a culturally competent system of care: Volume III*. Washington, DC: Center for Child Health and Mental Health Policy, Georgetown University Child Development Center.

Isaacs Shockley, M. (1997). *State of the states: Responses to cultural competence and diversity in child mental health*. Washington, DC: National Technical Assistance Center for Children's Mental Health.

Lee, E. (Ed.) (1997). *Working with Asian Americans: A guide for clinicians*. New York: Guilford Press.

Lee, L.C. & Zane, N.W.S. (Eds.) (1998). *Handbook of Asian American Psychology*. Thousand Oaks, CA: Sage Publications.

Lopez, S., & Hernandez, P. (1986). How culture is considered in the evaluation of mental health patients. *Journal of Nervous and Mental Disease* 174, 598–606.

Lynch, E., & Hanson, M. (1998). *Developing cross-cultural competence: A guide for working with children and their families*. Baltimore, MD: Paul H. Brookes Publishing Co.

Miller, C., Peck, L., Shuman, J., & Yrn-Calenti, C. (1995). *Building bridges: Tools for developing an organization's cultural competence*. Tucson, AZ: La Frontera.

Munoz, R., & Sanchez, M. (1997). *Developing culturally competent systems of care for state mental health services*. Boulder, CO: Western Interstate Commission for Higher Education.

New York State Office of Mental Health. (1998). *Cultural competence performance measures for managed behavioral healthcare programs*. Albany, NY: Author.

Office of Refugee Resettlement. (1991). *Promoting mental health services for refugees: A handbook on model practices*. Washington, DC: U.S. Department of Health and Human Services, Family Support Administration.

Ohio Department of Mental Health Office of Consumer Services, Outcomes Management Group, Ltd., and Innovative Consultants International, Inc. (1998). *Cultural competence in mental health: A study of nine mental health programs in Ohio*. Columbus, OH: State Printing.

Phillips, D., Leff, H., Kaniasty, E., Carter, M., Paret, M., Conley, T., & Manisha, S. (1999). *Culture, race and ethnicity(c/r/e) in performance measurement: A compendium of resources*. Cambridge, MA: The Evaluation Center @HSRI.

Pollard, R.Q. (1998). *Psychopathology*. In Marschark, M., and Clark, D. (Eds.), *Psychological perspective on deafness* (Vol. 2) pp. 171–197. Mahwah, NJ: Lawrence Erlbaum, Inc.

Ponterotto, J. (1995). *Handbook of Multicultural Counseling*. Thousand Oaks, CA: Sage Publications.

Ponterotto, J., & Pedersen, P. (1993). *Preventing prejudice: A guide for counselors and educators (Multi-Cultural Aspects of Counseling, Vol. 2)*. Thousand Oaks, CA: Sage Publications.

Roizner, M. (1996). *A practical guide for the assessment of cultural competence in children's mental health organizations*. Boston, MA: Judge Baker Children's Center, Technical Assistance Center for the Evaluation of Children's Mental Health Systems.

Ryan, C., & Futterman, D. (1998). *Lesbian and gay youth: Care and counseling*. New York: Columbia University Press.

Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (2000). *Creating a vision for the 21st century: Proceedings of the National Congress for Hispanic Mental Health*. Rockville, MD: Author.

Sue, D., Ivey, A., Pederson, P., et al. (1996). *A Theory of Multicultural Counseling and Therapy*. Baltimore, MD: Brooks/Cole Publishing Co.

Sue, D., & Sue, D. (1999). *Counseling the culturally different: Theory and practice*. New York: John Wiley and Sons.

Sue, S. (1983). *The mental health of Asian Americans*. San Francisco, CA: Jossey-Bass Publishers.

Sue, S., Fujino, D., Hu, L., & Takeuchi, D. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology* 59:533–540.

Transgender Education Network. (1998). *Determining barriers to treatment for transsexuals and transgenders in substance abuse programs*. Boston: JRI Health.

Uba, L. (1994). *Asian Americans: Personality patterns, identity, and mental health*. New York: The Guilford Press.

U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity—A supplement to mental health: A report of the surgeon general*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Vera, M., Alegria, M., Freeman, D., Robles R., Pescosolido, B., & Pena, M. (1998). Help seeking for mental health care among poor Puerto Ricans: Problem recognition, service use, and type of provider. *Medical Care* 36(7), 1047–1056.

White, J., & Parham, T. (1990). *The psychology of blacks: An African American perspective*. Upper Saddle River, NJ: Prentice Hall.

Organizational Resources

Action Council for Cross-Cultural Mental Health and Human Services, Inc.

The Action Council
P.O. Box 1695
Columbia, SC 29202
(803) 898-8619
Fax: (803) 898-8624
Contact: Dolores Macey

The Action Council for Cross-Cultural Mental Health and Human Services, Inc., is a voluntary organization dedicated to enhancing the involvement of citizens who are minorities in the management, delivery, and use of mental health and human services. The Action Council is a dues-collecting, membership organization that provides programmatic and policy consultation and training for managers and decisionmakers and promotes education in understanding diverse cultures. The Action Council sponsors an annual conference in conjunction with the South Carolina Department of Mental Health and other organizations.

African American Family Services

2616 Nicollet Avenue South
Minneapolis, MN 55408
(612) 871-7878
Fax: (612) 871-2567
www.aafs.net
Contact: Tasselean Parker

The mission of African American Family Services is to help the African American individual, family, and community reach a greater sense of well-being through the delivery of community-based, culturally specific chemical health, mental health, and family preservation services.

AIDS Mental Health Training Program (AMHTP)

UCLA Center for Health Promotion and Disease Prevention
Center for Health Sciences, Room 61-236
10833 LeConte Avenue, Box 951772
Los Angeles, CA 90095-1772
(310) 794-7130
Fax: (310) 206-5717
www.medsch.ucla.edu/aidsinst/education/edprograms/index.html
Contact: Thomas Donohoe



The AMHTP at UCLA is funded by the Center for Mental Health Services and offers HIV knowledge- and skill-based training tailored to mental health providers and health educators who work with people with serious mental illness. AMHTP training programs provide extensive information about HIV and AIDS, as well as experiential training to practice prevention and intervention skills. AMHTP trainings are provided in English and Spanish and address the unique challenges of communicating about and treating HIV-related concerns among mental health service consumers.

American Counseling Association

Association for Multicultural Counseling and Development (AMCD)

P.O. Box 2256

Sacramento, CA 95812-2256

(916) 424-8959

Fax: (916) 424-3985

www.counseling.org/multi_diversity

Contact: Dr. Marcelett Henry

Established in 1972 under the American Counseling Association, the AMCD works to develop an efficient and effective system of organizational management, enhance existing professional standards, and promote and expand culturally competent research and knowledge.

American Psychiatric Association (APA)

Committee on Gay, Lesbian and Bisexual Issues

1400 K Street, NW

Washington, DC 20005

(202) 682-6097

Fax: (202) 682-6837

Contact: Janice Taylor

The APA Committee on Gay, Lesbian and Bisexual Issues is charged to investigate problems and issues that affect the mental health of the gay, lesbian, and bisexual populations—such as discrimination and stigmatization—develop teaching programs to help correct the inadequate training of psychiatrists about homosexual issues; and promote the education of the APA membership and the general public about homosexuality.

American Psychological Association (APA)

Division 44

Society for the Psychological Study of Lesbian,

Gay and Bisexual Issues

729 Boylston Street, 4th Floor

Boston, MA 02116

(617) 262-0315

www.apa.org/about/division/div44.html

Contact: Douglas M. Deville, Psy.D.

The APA Division 44, addressing gay, lesbian, and bisexual concerns, focuses on the diversity of human sexual orientations by supporting research, promoting relevant education, and addressing professional and public policy. It has committees and task forces on accreditation, bisexuality, education, public policy, youth and families, ethnic/racial diversity issues, and science and research. Division 44 publishes a newsletter three times a year and a program describing Division 44's activities for distribution at the annual APA convention.

American Psychological Association

Division 22

Rehabilitation Psychology

Division 22 Administrative Office

750 First Street, NE

Washington, DC 20002-4242

(202) 336-6013

Fax: (202) 218-3599

www.apa.org/divisions/div22

Contact: Dawn Ehde, Ph.D., Membership Chair

The APA Division 22 focuses on the psychological aspects of disability and rehabilitation, providing public information about these issues and promoting high standards and effective practices for professional psychologists in this field. The division publishes a quarterly journal, *Rehabilitation Psychology*, and a quarterly newsletter, *Rehabilitation Psychology News*. Members are involved in clinical service, research, teaching, and administration.

American Psychological Association (APA)

Office of Ethnic Minority Affairs (OEMA)

750 First Street, NE

Washington, DC 20002-4242

(202) 336-5500

Fax: (202) 336-6040

www.apa.org/pi/oema

Contact: Alberto Figueroa

The APA OEMA promotes scientific understanding of the influences of culture and ethnicity on behavior, encourages increased public knowledge of the special psychological resources and mental health needs of communities of color, and increases the number and participation of ethnic minority psychologists in the discipline and the APA. In support of these objectives, OEMA's activities include maintaining and editing the *Directory of Ethnic Minority Professionals in Psychology*, operating a

minority job bank, and publishing *Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations*.

Asian and Pacific Islander American Health Forum

942 Market Street, Suite 200
San Francisco, CA 94102
(415) 954-9955
Fax: (415) 944-9999
www.apiaf.org
Contact: Tessie Guillermo

Washington, DC Area:
440 First St. NW, Suite 430
Washington, DC 20001
(202) 624-0007
Fax: (202) 624-9488

A national advocacy, policy, and research organization dedicated to improving the health of Asian and Pacific Islander Americans. The Health Forum offers publications and fact sheets on all aspects of Asian and Pacific Islander health including mental health. The Forum also maintains a closed and moderated mailing list as an information and referral point for individuals and organizations that provide alcohol, substance abuse, and mental health services.

Association of Asian Pacific Community Health Organizations (AAPCHO)

439 23rd Street
Oakland, CA 94612
(510) 272-9536
Fax: (510) 272-0817
www.aapcho.org
Contact: Jeffery B. Caballero, M.P.H.

The AAPCHO is a national association representing community health organizations dedicated to promoting advocacy, collaboration, and leadership that improves the health status and access of Asian Americans, Native Hawaiians, and Pacific Islanders within the United States, its territories, and freely associated states, primarily through member community health clinics. Formed in 1987, AAPCHO advocates for policies and programs that will improve the provision of health care services that are community driven, financially affordable, linguistically accessible, and culturally appropriate. As a unified voice of its membership, AAPCHO shares its collective knowledge and experiences with policymakers at the national, state, and local levels.

Center for Hispanic Mental Health Research

Graduate School of Social Service
Fordham University
113 West 60th Street
New York, NY 19923-7484
(212) 636-7085
Fax: (212) 636-7079

Contact: Luis Zayas, Ph.D., Director

Established in 1999 with a grant from the National Institute of Mental Health, the Center for Hispanic Mental Health Research at Fordham University's Graduate School of Social Service conducts applied research focusing on Hispanic populations to generate new knowledge leading to improved mental health services for this growing segment of the U.S. population. Among the center's primary objectives are to conduct epidemiological research identifying the mental health needs of diverse Hispanic groups; conduct studies to find ways that standard assessment, treatment and prevention strategies can be modified to enhance mental health outcomes for Hispanics; conduct psychotherapeutic intervention studies that test the efficacy of new culturally competent psychosocial services; and disseminate information about research findings through a variety of publications and other forums. In addition, the center is dedicated to increasing the number of researchers, both faculty and students, in the field of mental health. The center's research activities focus on mental health issues that particularly affect Hispanics in the northeastern United States but that also have implications for Hispanic and Latino populations throughout the nation.

Deaf Wellness Center

University of Rochester School of Medicine

Department of Psychiatry

601 Elmwood Avenue

Rochester, New York 14642

(585) 275-3544 (Voice or TTY)

Fax: (585) 273-1117

www.urmc.rochester.edu/smd/psych/Education/psychology/predoc/psycho_deaf.htm

Contact: Robert Q Pollard, Jr., Ph.D., Director

The Deaf Wellness Center, in addition to providing outpatient services to persons who are deaf or hard of hearing in the Rochester, New York, area, serves primarily as a training center for professionals pursuing careers in mental health and deafness. The center trains deaf and sign-proficient hearing individuals for leadership and unusual dedication to excellence in the mental health professions, and it promotes and contributes to such training in other health care professions. The center's primary training objective is to prepare professionals who are deaf for careers of scholarship and clinical service excellence. The center also trains hearing individuals who work with professionals or consumers who are deaf, fostering their comprehension of and respect for people who are deaf and sign language and their ability to work with people who are deaf in an effective and mutually enriching manner. Training content is informed by the latest relevant research and addresses the spectrum of biological, psychological, social, linguistic, and cultural factors that have an impact on the lives of persons who are deaf.

European Society for Mental Health and Deafness (ESMHD)

"Daylesford," Stokeinteignhead, Devon, TQ12 4QD

United Kingdom

+44 1626 873332

Fax: +44 1626 873332

bob.clowes@esmhd.org

www.esmhd.org/intro-page.html

Contact: Bob Clowes, Executive Director

Much of the current state-of-the-art research and clinical initiatives in the area of mental health and deafness is occurring outside the United States. Prominent among worldwide organizations is the ESMHD, an international nongovernmental organization that promotes the mental health of persons in Europe who are deaf. In the view of this organization, mental health encompasses the promotion of healthy emotional, psychological, and social development and the prevention and treatment of mental illness and other disorders. ESMHD's primary focus is on people who were born deaf or for whom deafness occurred in early childhood and whose first or preferred language is sign language. The organization is also interested, however, in the mental health of all persons who are deaf, whatever the age of onset or degree of deafness. ESMHD's goals include encouraging (1) the provision of mental health practices appropriate to the needs of people who are deaf; (2) access to specialized mental health services for persons who are deaf with mental health problems; (3) specialized habilitation or rehabilitation services for people who are deaf and have been deprived of opportunities for the development or maintenance of life skills; (4) research into mental health and deafness; (5) opportunities for people who are deaf to provide mental health services for other people who are deaf; (6) the development of networks of interested people in each country; (7) information collection and dissemination on the mental health care of people who are deaf; (8) respect for the language and culture of people who are deaf; and (9) exchange of ideas and support among individuals and organizations with an interest in mental health and deafness. ESMHD publications are available from Forest Bookshop, 8 St John St, Coleford, Gloucestershire, GL16 8AR United Kingdom.

Gay, Lesbian, Bisexual and Transgender (GLBT) Health Access Project

Justice Research Institute Health

100 Boylston Street, Suite # 815

Boston, MA 02116

(617) 988-2605

Fax: (617) 988-8708

www.glbthealth.org

Contact: Mary Clark, Director

The GLBT Health Access Project, in partnership with the Massachusetts Department of Public Health, works to foster the development of comprehensive, culturally appropriate health promotion policies and health care services for gay, lesbian, bisexual, and transgender people through a variety of venues including community education, policy development, advocacy, direct service, and prevention programs. GLBT Health Access recently published "Community Standards of Practice for the Provision of Quality Health Care Services for Gay, Lesbian, Bisexual and Transgender Clients." These Community Standards offer detailed guidelines for making health and mental health services accessible and culturally appropriate for persons who are gay, lesbian, bisexual, or transgender. Training and technical assistance regarding the use of

these guidelines is provided to service settings throughout Massachusetts through the Fenway Community Health Center.

**Georgetown University Child Development Center
National Technical Assistance Center for Children's Mental Health**

3307 M Street, NW, Suite 401

Washington, DC 20007

(202) 687-5000

Fax: (202) 687-1954

www.gucdc.georgetown.edu

Contact: Joan Dodge, Ph.D.

The mission of the Georgetown University Child Development Center is to improve the quality of life for children with special needs and their families. Products and services include information packets; issue briefs and monographs on children and adolescents with serious emotional disturbances; conferences and training institutes on planning, delivery and financing of services, and increasing cultural competence in mental health service delivery; consultation on systems change and services development and delivery; and agency and organizational collaboration.

**Multi-Ethnic Behavioral Health Resource
and Training Center**

17 S. High Street, Suite 500

Columbus, OH 43215

(614) 228-2220

Fax: (614) 228-2285

www.mebhc.com

Contact: Marty Miller

The Training Center provides advocacy and training on cultural diversity and mental health issues relevant to the needs of African American, Asian, Hispanic, and Native American residents of Ohio.

National Alliance for Hispanic Health

1501 16th Street, NW

Washington, DC 20036

(202) 387-5000

Fax: (202) 265-8027

www.hispanichealth.org

Contact: Jane Delgado, President

The National Alliance for Hispanic health is the oldest and largest network of health and human service providers, servicing more than 10 million Hispanic consumers throughout the United States. Since

1973, the National Alliance for Hispanic Health has grown from a small coalition of visionary mental health providers to a large, dynamic, and strong group of organizations and individuals whose mission is to inform and mobilize consumers; support health and human service providers in the delivery of quality care; improve the science base for accurate decisionmaking; promote appropriate use of technology; and ensure accountability and advocate in behalf of Hispanics.

**National Asian American and Pacific Islander (NAAPIMHA)
Mental Health Association**

565 South High Street
Denver, CO 80209
(303) 298-7910
Fax: (720) 223-2381
www.NAAPIMHA.org
Contact: D.J. Ida, Ph.D.

The NAAPIMHA's mission is to promote the mental health and well-being of Asian Americans and Pacific Islanders. NAAPIMHA advocates in behalf of Asian American and Pacific Islander mental health issues as well as serves as a forum for effective collaboration and networking between stakeholders of community-based organizations, consumers, family members, service providers, program developers, evaluators, and policymakers representing the various ethnic and regional differences. NAAPIMHA focuses on the following areas, recognizing that cultural competency will be reflected at all levels: (1) enhanced collection of appropriate and accurate data; (2) identification of current best practices and service models; (3) increased capacity building that includes providing technical assistance and training of service providers, both professional and paraprofessional; (4) conducting research and evaluation; and (5) engaging consumers and families.

**National Asian Pacific American Families
Against Substance Abuse (NAPAFASA)**

340 East Second Street, Suite 409
Los Angeles, CA 90012
(213) 625-5795
Fax: (213) 625-5796
www.napafasa.org

NAPAFASA is a private, nonprofit, 501(c)(3) membership organization dedicated to addressing mental health and substance abuse concerns of Asian and Pacific Islander populations on the continental U.S., Hawaii, the six Pacific Island jurisdictions, and elsewhere. Founded in 1988, NAPAFASA involves service providers, families, and youth in efforts to reach Asian and Pacific Islander communities to promote health and social justice and to reduce substance abuse and related problems.

**National Association of Social Workers (NASW)
National Committee on Lesbian, Gay
and Bisexual Issues (NCLGB)**

750 First Street, NE, Suite 700

Washington, DC 20002-4241

(202) 408-8600

Fax: (202) 336-8310

www.socialworkers.org

Contact: Evelyn P. Tomaszewski, ACSW

NCLGB works to promote the development of knowledge, theory, and practice as related to gay, lesbian, and bisexual issues; to identify ways to eliminate homophobic social work practices and policies (e.g., so-called reparative therapies); and to assist the association and the larger profession in developing lesbian-, gay-, and bisexual-affirming policies, procedures, and programs. NASW supports curriculum content that affirms lesbian, gay, and bisexual people; encourages implementation of relevant continuing education; strives for full representation of lesbian, gay, and bisexual people at all levels of leadership and employment in social work; and advocates for and encourages efforts to end violence and discrimination toward gay, lesbian, and bisexual people.

**National Center for American Indian and
Alaskan Native Mental Health Research**

University of Colorado Health Sciences Center

Department of Psychiatry

4455 East Twelfth Avenue

Campus Box A011-13

Denver, CO 80220

(303) 315-9232

Fax: (303) 315-9579

www.uchsc.edu/sm/ai/ncaianmhr/

Contact: Spero Manson, Ph.D., Director

Funded by the National Institute of Mental Health, the National Center for American Indian and Alaskan Native Mental Health Research focuses on research, research training, information dissemination, and technical assistance for American Indian and Alaskan Native populations. The center has developed a computerized bibliography on Indian and Alaskan Native mental health and a resource directory that inventories individuals, programs, and agencies with expertise in mental health research, service, and education specific to Indian and Alaskan Native communities.

National Council of La Raza (La Raza)

111-19th Street, NW, Suite 1000

Washington, DC 20036

(202) 785-1670
Fax: (202) 776-1792
www.nclr.org
Contact: Helen Coronado

La Raza is a private, nonprofit organization established in 1968 to reduce poverty and discrimination and improve opportunities for Hispanic Americans. La Raza works toward this goal primarily through capacity-building assistance to support and strengthen Hispanic community-based organizations; promoting applied research, policy analysis, and advocacy to provide a Hispanic perspective on issues such as education, housing, and health; and encouraging the adoption of programs and policies that equitably serve Hispanics.

National Latino Behavioral Health Association (NLBHA)

P.O. Box 387
Berthoud, CO 80513
(970) 532-7210
Fax: (970) 532-7209
Contact: Marie Sanchez, B.S.W.

The roots for the NLBHA began on March 2000 as more than 100 prominent Hispanic community leaders and key partners met at a historical National Congress for Hispanic Mental Health convened by the Substance Abuse and Mental Health Services Administration (SAMHSA). A national agenda and an action plan to improve mental health services for the Latino community were crafted at the Congress. As part of its mission, NLBHA will use the agenda and action plan as guideposts in improving the mental health and substance abuse needs of the Latino population.

National MultiCultural Institute (NMCI)

3000 Connecticut Avenue, NW, Suite 438
Washington, DC 20008-2556
(202) 483-0700
Fax: (202) 483-5233
www.nmci.org
Contact: Elizabeth P. Salett

A nonprofit organization located in Washington, DC, NMCI offers organizational consulting and training—including diversity training and organizational development initiatives—sponsors multicultural conferences, produces educational resource materials, and provides multicultural counseling and referral services.

National Research Center on Asian American Mental Health (NRCAAMH)

Department of Psychology—University of California at Davis

One Shields Avenue
Davis, CA 95616-8686
(530) 752-1400
Fax: (530) 752-3747
<http://psychology.ucdavis.edu/asianamerican/>
Contact: Stanley Sue, Ph.D.; Nolan Zane, Ph.D.

The NRCAAMH was established in 1988 with a grant from the National Institute of Mental Health. NRCAAMH prides itself on being a national and multidisciplinary leader in Asian American and Pacific Islander mental health research. NRCAAMH was founded in response to the need for programmatic research addressing the mental health concerns of Asian Americans and Pacific Islanders. The center seeks to contribute theoretical and applied research that has an impact on mental health policy and service delivery for Asian Americans and Pacific Islanders.

Office of Minority Health Resource Center

P.O. Box 37337
Washington, DC 20013-7337
(800) 444-6472
Fax: (301) 230-7198
TTY: (301) 230-7199
www.omhrc.gov/omhrc/index.htm
Contact: Jose Tarcisio M. Carneiro, M.P.A., Ed.D.

The Minority Health Resource Center is a national resource and referral service for minority health issues that provides information on funding sources and community programs. The center's newsletter, *Closing the Gap*, is available free of charge. A customized database searches health resources for African American, Asian American, Pacific Islander, Latino, and Native American populations.

The Program for Research on Black Americans (PRBA)

5062 Institute for Social Research
P.O. Box 1248
Ann Arbor, MI 48106-1248
(734) 763-0045
Fax: (734) 763-0044
www.isr.umich.edu/rcgd/prba
Contact: Susan Frazier-Kouassi, Ph.D.

PRBA, historically characterized by its vision and innovation, has undertaken a number of important studies focusing on the mental health of African Americans. In 1998, PRBA received funding from the National Institute of Mental Health to create the African American Mental Health Research Program (AAMHRP). The overall objectives of AAMHRP are to introduce a new period of growth and

implement a consolidation of the intellectual, scholarly, research, and

training capabilities of the PRBA in studying mental health problems and serious mental disorders among African American populations.

TransGender Education Network (TEN)

JRI Health, TEN

100 Boylston Street, Suite 860

Boston, MA 02116

(617) 988-2605, ext. 211

Fax: (617) 988-2629

www.jri.org/ten.html

Contact: Daviko Marcel, Program Director

TEN is an HIV prevention and health promotion initiative aimed at Greater Boston's transgender community. The project works in three ways: it provides education for medical and human service providers, outlining the health and social service needs of transgendered persons; it sponsors community-building events for the transgender community to foster self-esteem and an awareness of each person's right to medically and culturally appropriate health and social services; and it has outreach that links transgendered persons to the services and resources they need.

**Western Interstate Commission on
Higher Education (WICHE)
Mental Health Program**

P.O. Box 9752

Boulder, CO 80301-9752

(303) 541-0250

Fax: (303) 541-0291

www.wiche.edu/mentalhealth/

Contact: Jim Stockdill, Ph.D.

WICHE is a public interstate agency established to promote and facilitate resource sharing, collaboration, and cooperative planning among the western states for higher education and work-force needs. Member and affiliate states are Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Utah, Washington, and Wyoming. WICHE has been involved, through contracts with the Substance Abuse and Mental Health Services Administration (SAMHSA), in important national efforts to improve cultural competence in mental health care services and was instrumental in efforts to generate standards of care for culturally competent mental health care service provision to members of underserved/underrepresented racial ethnic groups.