

**Promising Practices of Statewide Mental Health Models
Serving Consumers who are Deaf: How to Advocate
for Your Model in Your Home State**

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Abstract

This article provides comprehensive information on how to develop a successful statewide mental health model serving consumers who are Deaf. The article also covers three different statewide models currently in operation in Minnesota, South Carolina, and Alabama, including information about how each program was implemented. The successes, similarities, and differences of each model are analyzed and the information on how to establish and advocate for a statewide mental health model in your home state is discussed.

Keywords: deaf, mental health, promising practices, state models, advocacy

Mental health services provided to consumers who are Deaf in communities throughout America vary widely in quantity and quality depending on which state or city in which the consumer lives. Some places have specialized programs but most commonly consumers who are Deaf are a vastly underserved minority within the larger behavioral health systems. For this article, "Deaf" with an uppercase D is described as a hearing loss severe enough that a signed language or writing is the primary means of communication (Padden & Humphries, 1988).

These consumers often experience difficulties in receiving appropriate specialized and culturally affirmative mental health services. As a first solution, consumers who are Deaf are often encouraged to lip-read and speak for themselves to avoid the "trouble" or expense of getting an interpreter. Most people from this population cannot communicate well through lip reading or in written English. In addition, many mental health providers and other service professionals are likely to lack awareness of the language barriers that consumers who are Deaf face, or misunderstand

them in ways that can have a potentially deleterious effect. A body of research studies and documentations showed that consumers who are Deaf with mental health issues are less likely to be appropriately diagnosed or treated, because many mental health clinicians are not properly trained to work with them (Haskins, 2004; Mathos, Kilbourne, Myers, & Post, 2009; Pollard, 1994).

Culturally affirmative mental health services in larger behavioral health systems should become widely available for consumers who are Deaf to ensure that they receive appropriate treatment. Glickman (2003) distinguished between culturally affirmative and mere accessible treatment; he described "accessible" treatment as providing reasonable accommodations to consumers who are Deaf, such as using qualified American Sign Language (ASL) interpreters. ASL interpreters are responsible for translating spoken English to ASL and vice versa. Other examples of accessible treatment include using Deaf Interpreters (DIs), or written communication during the therapy sessions. Deaf Interpreters specialize in use of gesture, props, drawings and other tools to enhance communication when consumers who are Deaf have minimal or no understanding of ASL. Culturally affirmative mental health treatment for persons who are deaf (also known as "Deaf-friendly" treatment) is understood as receiving services from ASL-fluent clinicians trained to work specifically with clients who are deaf (Glickman, 2003, 2009) and may supplement their communication with the auxiliary aids mentioned above.

The term "mental health services" will be used as inclusive of the identification, assessment, diagnosis, and treatment of Deaf individuals with mental health needs (National Association of the Deaf, 2003). The term also includes the delivery of both public and private mental health services for inpatient or outpatient care by mental health providers.

Obstruction of Nation's Mental Health Treatment System

While very few disabled consumers are well served by the nation's mental health system, consumers who are deaf have been identified as the most underserved of any disability group (Basil, 2000). In addition, Leigh, Powers, Vash, & Nettles (2004) reported that lack of funding for services and disability-related expertise were identified to be the major barriers in obtaining appropriate psychological services. Moreover, very few insurance networks provide direct outreach to Deaf individuals and insurance case

managers are not likely to be aware about the availability of culturally and linguistically affirmative mental health services in their regions (Mathos, et al., 2009). Critchfield (2002) also shared that insurance provider networks often do not include clinicians who are fluent in ASL even when they live in the same geographic area.

Current population estimates indicate that there are approximately 28 million deaf and hard of hearing Americans (National Association of the Deaf, 2003), and Dew (1999) concluded that this group represents the largest "physical disability group" in America. Estimates of the number of people who are deaf (not including hard of hearing) vary widely but a conservative estimate would be five million individuals (Steinmetz, 2006). Estimates of how many Deaf people use sign language exclusively are even murkier, but 500,000 may be the best estimate possible at this time, given the lack of an accurate count (Mitchell, Young, Bachleda, & Karchmer, 2006). If we accept estimates of the prevalence of mental illness published by National Institute of Mental Health (Kessler, Chiu, Demler, & Walters, 2005), 6% of the general population have a severe and persistent mental illness, the admission criterion for most state public mental health services, there are 30,000 people who are Deaf with a severe mental illness needing services in ASL. As noted by Kessler et al. (2006), the prevalence of any mental health disorder is 26.2% in the general population. With this figure, it is estimated that approximately 130,000 people who are Deaf living in the United States will require mental health services in ASL.

The preceding assumes, as numerous studies on the prevalence of mental illness in the deaf community have shown, that the rate for psychosis is as least as high as in the hearing community (Altshuler, 1978; Carvill, 2001; Rainer, Altshuler, Kallmann, & Deming, 1963; Vernon, 1980). Other studies have shown that the rate of diagnosed personality, mood and adjustment disorders is higher (Gentile & McCarthy, 1973; Graham & Rutter, 1968; Meadow, 1981) than for the general population. The number of consumers who are Deaf served by specially trained clinicians is only a small fraction of those who receive mental health services and an even smaller fraction of those need such services, but do not receive any mental health services (Pollard, 1999; Vernon & Andrews, 1990) .

Although it may be possible to find an ASL interpreter to facilitate communication, having an interpreter involved in very personal and sensitive sessions can seriously inhibit the counseling process. For consumers who

are Deaf with mental health issues, as well as for their families, language and culture differences continue to pose enormous barriers to mental health services that could improve their well being.

For half a century, professional organizations, providers in various fields, and the Deaf community have addressed and advocated for specialized mental health services with trained personnel (National Association of the Deaf, 2003). NAD (2003) concluded that as a result of their hard-working efforts, extensive theoretical, policy, and general literature have been developed, distributed, or published on behalf of consumers who are Deaf with mental health needs. In addition, the Americans with Disabilities Act of 1990 and several landmark court cases related to mental health and deafness have led to the establishment of direct services in certain city limits or regions, but only a few states provide a true continuum of mental health services for this population. Many consumers who are Deaf continue to have limited access to the larger public mental health system. It is imperative for state governments to fund a true statewide coordination of mental health services serving this population and actively recruit existing culturally affirmative mental health providers, from the non-profit and for-profit sectors, to join in a single service continuum ensuring the highest quality of standard care. Often funding appropriate services can result in cost savings, as appropriate services can be provided in a setting that is less restrictive and expensive.

The primary objectives of this literature review are to (a) review the history of three specific statewide models currently in operation and how they were implemented, (b) discuss the successes and systemic barriers of each model and to gain greater understanding of the similarities and differences of each model, and (c) identify steps needed to establish and advocate for your model in your home state.

Statewide Mental Health Models

Throughout the United States, there are excellent local mental health programs and solo practitioners providing directly access to services. Usually located in large urban areas with high concentrations of people who are Deaf, such programs are often restricted by funding or host agencies to serving a strictly defined service area. This may be a city, a county or even a region of several counties. A hearing person living outside the service area of a particular provider would likely easily find a provider in the area he or she lives. A person who is Deaf and in need of services living outside the service

area will be greatly disadvantaged as they will not have a directly accessible resource serving their area. A statewide mental health program may be the answer to this dilemma.

Three different statewide mental health models, in Minnesota, South Carolina, and Alabama, will be discussed here. These three states do not make any claims that their programs are superior to any other program. Indeed, each program was developed in response to the unique demands and limitations of their respective states and thus looks different from the others. But all three have some important similarities and those offer ideas for promising practices, perspectives, or concepts that many other states could borrow from to develop a statewide mental health delivery system to best serve their Deaf residents.

Minnesota

History

A Deaf services inpatient unit was created at the St. Peter Regional Treatment Center in St. Peter, Minnesota, when four plaintiffs filed a lawsuit in 1984 (*Handel et al v. Levine et al*, 1984) for failure to provide adequate inpatient services. The Deaf unit was in operation from 1985 to 2006. The restructuring of Minnesota's statewide mental health services and the closing of the Deaf unit resulted in the transition of state-operated services resources to the Deaf and Hard of Hearing Services Division (DHHSD). In response to this, DHHSD appointed Dr. John Gournaris (first author) in April 2007 as director of the Mental Health Program ensuring that consumers who are Deaf are able to acquire accessible mental health services within their home areas. This was also to eliminate the need for an expensive, stand-alone Deaf inpatient unit.

DHHSD, which falls under the Continuing Care Administration, is one of 44 divisions within the Minnesota Department of Human Services. DHHSD provides information, resources, grants, and empowerment opportunities to assist Deaf, Deaf-Blind, and hard of hearing Minnesotans and their families to effectively access services in their communities. DHHSD also provides direct services including advocacy, case management, telephone equipment, and mental health services.

Model

The DHHSD Mental Health Program is composed of mental health professionals fluent in ASL and experienced in providing direct mental health services to consumers who are Deaf. The program's scope of services include:

- Crisis Intervention
- Assessment and Stabilization
- Outpatient Therapy
- Psychological Evaluation
- Telemental Health
- Consultation
- Case Coordination
- Aftercare Planning
- Community Placement Assistance

Locations

To provide culturally affirmative mental health services to the Deaf and hard of hearing population in Minnesota, DHHSD regional offices are utilized. The Mental Health Program is integrated within the human services already provided by these regional offices. These sites are also considered culturally-appropriate for Deaf individuals, ensuring easy communication access when receiving mental health services. Since November 2007, the DHHSD Mental Health Program has expanded its community-based mental health service delivery to multiple cities across Minnesota, including Minneapolis/St. Paul, Rochester, Mankato, Faribault, St. Cloud, Brainerd, Moorhead, Virginia, and Duluth, where large numbers of Deaf Minnesotans reside. Although DHHSD has eight physical offices throughout the state, not all offices have a mental health professional onsite. The Mental Health Program has four full-time mental health specialists working out of regional offices in larger cities across the state. If services are required in rural Minnesota and face-to-face sessions are not possible, they are provided via videoconferencing using secure lines.

Training

DHHSD has provided training to individuals, agencies, and professionals statewide, including topics such as how to work with Deaf and hard of

hearing people with mental health needs, how to make programs accessible, and enhancing mental health interpreting skills.

DHHSD also sponsors the Mental Health Spring conference every year for professionals throughout the state, including mental health professionals, teachers, probation officers, mental health workers and the like.

Deaf Psychiatric Unit

With the closure of the St. Peter Regional Treatment Center's Deaf Services Unit in 2006, there is no stand-alone psychiatric unit designed specifically for Deaf Minnesotans. Currently, the Anoka Metro Regional Treatment Center (AMRTC) serves consumers who are Deaf needing psychiatric interventions with the use of ASL interpreters from an interpreting agency. The DHHSD Mental Health Program officially opened its doors in November 2007, and has since helped AMRTC with aftercare planning and community placement assistance, successfully integrating those Deaf individuals within their home communities. Since July 2008 (over one year later at the time of this writing), there have been no admissions of Deaf persons at AMRTC, likely due to the direct mental health services made available throughout Minnesota.

Group Homes

Minnesota has several group homes serving adults who are Deaf and mentally ill throughout the state. Very few group homes are deaf-run, but many are part of hearing residential programs with signing staff available. Extensive collaboration and partnership efforts with other group homes in various cities in Minnesota have been implemented, ensuring that consumers who are Deaf will receive appropriate residential home placements.

Intensive Treatment Program for Deaf Children and Adolescents

Over the past seven years, DHHSD, the Minnesota State Academy for the Deaf (MSAD), and Volunteers of America-Minnesota (VOA) have combined efforts to establish a treatment program that serves the needs of Deaf children and adolescents in Minnesota. The mission is to: (1) maintain close family involvement by having a resource in Minnesota, (2) provide more efficient and effective follow-up services for the family, (3) provide for transition services with family and community supports in place, and

(4) build on existing resources. The proposed plan is for VOA to lease a building on campus and be responsible for the clinical component, with MSAD providing the education component.

This new program, Deaf/Hard of Hearing Intensive Mental Health Program for Adolescent and Child Treatment, or DHH IMPACT, opened in January 2010. The intensive treatment will provide three hours of therapy per day, five days a week, for each child or adolescent. Therapy services include individual, family, and group therapy. MSAD hosted the Midwest Superintendents' Conference in Fall 2009, and at this conference recommended that DHH IMPACT becomes a regional resource, although referrals from other states will be accepted. The intensive treatment program can serve up to 16 children or adolescents.

Grants

Although the DHHSD Mental Health Program provides direct mental health services to Deaf Minnesotans, several DHHSD mental health grants are available to agencies in the private sector. The grants include:

Grants for Adults

Regions Hospital – Health and Wellness Program (St. Paul): Providing outpatient individual & family counseling, consultation and community education services.

People Incorporated – Deaf Mental Health Services (Minneapolis): Providing community-based support services for people who are Deaf, Deaf-Blind, or hard of hearing and have a mental illness. The Deaf Mental Health Services program includes a drop-in center and the community living housing outreach program.

Grants for children and adolescents

Volunteers of America – Minnesota (Golden Valley): Providing specialized mental health services to youth with hearing loss, ages 0-21, and their families: Services can be provided in the school, home, clinic, or via telehealth.

Lifetrack Resources, Inc. – Greater Minnesota Assessment Service (St. Paul): Providing specialized, communication accessible, statewide psychological and psychosocial assessments, family assessments, follow-up

school and family consultation and training to benefit children who are Deaf, Deaf-Blind or hard of hearing, ages 0 –21, residing in greater Minnesota.

Future Goals

It is DHHSD's goal to establish statewide direct psychiatry and telepsychiatry services offered by an ASL-fluent, licensed/board-certified, psychiatrist skilled in working directly with both children and adults. This concept is modeled after the South Carolina Department of Mental Health, Services for the Deaf and Hard of Hearing. In addition, DHHSD will continue to explore strategies to launch statewide mental health services for Deaf children and adolescents. The biggest barrier to these important initiatives is obtaining additional funding from the state legislature.

South Carolina

History

In 1988, in response to a task force led by representatives from the South Carolina Association of the Deaf and staff from the South Carolina School for the Deaf and the Blind (SCSDB), the South Carolina Department of Mental Health (SCDMH) hired a director for services to the Deaf and Hard of Hearing. In 1989, the South Carolina Protection and Advocacy (SCP&A) prepared to file a complaint against the SCDMH for failure to serve consumers who were Deaf. Because the SCDMH director was on the board of SCP&A, he became aware of the proposed complaint and negotiated with SCP&A and the Department of Justice to develop appropriate services without a formal complaint being filed.

Under the leadership of Dr. Barry Critchfield, then SCDMN's Director of Services for the Deaf and Hard of Hearing, services were established. Initially, the services were at a single 11-bed inpatient unit at Patrick B. Harris Hospital, and then an ASL-fluent counselor was hired at each of four mental health centers across the state. In 1994, the McKinney House, a 10-bed community residential care facility (CRCF) was opened. The census at the inpatient unit steadily increased, from an initial nine inpatients in 1990 to a high of 22 in 1994. With the opening of appropriate community resources, the inpatient census rapidly declined until now, where the average census is less than 0.5 (meaning that most days there is no Deaf individual on an inpatient basis in the psychiatric facilities).

The length of stay has also decreased from an average 15-plus years to an average of 14 days.

The outpatient services were consolidated in 2000 and are now being administered and supervised through a single mental health center, even though staff are still outstationed in four regional teams throughout the state. This consolidation has allowed for the provision of qualified supervision, and for the supervisors to have middle management support which understands the unique programmatic considerations needed by counselors working with this population. In 2000, federal block grant funds were identified which enabled the expansion of services to include providing services to children and adolescents with a severe emotional disorder.

Model

At the SCDMH state office, Roger Williams (third author), SCDMH's Director of Services for the Deaf and Hard of Hearing, is responsible for overall program direction. He also ensures that the needs of consumers who are Deaf or hard of hearing are addressed in all department programs and initiatives, including the identification of funding resources, and that SCDMH policies and procedures reflect the needs of consumers. This position reports to the deputy director for community mental health services, who then reports to the SCDMH director.

Direct services are provided by mental health professionals, fluent in ASL and experienced in providing direct mental health services to consumers who are Deaf, administratively based out of a single mental health center. A part-time psychiatrist provides services to consumers across the state, both in person and via telepsychiatry. A full-time Deaf peer support position provides support to Deaf consumers across the state. Two full-time interpreters, both having completed the mental health interpreter training program offered by Alabama's Office of Deaf Services, provide interpreting services for staff and consumers, supplemented by contractual interpreting services as needed. The program's scope of services includes:

- Crisis Intervention
- Assessment and Stabilization
- Outpatient Therapy
- Telepsychiatry
- Consultation

- Case Management
- Inpatient Services
- Residential Services (both CRCF and supported apartments)
- Aftercare Planning
- Community Placement Assistance

Locations

In order to enhance direct accessibility to mental health services for the Deaf and hard of hearing population in South Carolina, three SCDMH mental health centers in Simpsonville, Columbia and Charleston are used as host sites for the regional teams. With these teams of two to four persons, services are available at any of the 17 mental health centers that reach Deaf adults, children, adolescents and their families through a series of satellite offices in all 46 counties. This ensures consumers have direct access to services at the SCDMH office closest to them. In addition, outpatient services are available at SCSDB for students.

Deaf Psychiatric Unit

As the experience in Minnesota showed, as the community services expanded and residential services were developed, the need for a fully-staffed inpatient unit decreased. In 1998, the clinical staff assigned to the inpatient unit at Harris Psychiatric Hospital in Anderson were transferred to the regional outpatient team, which serves the upstate area. At present, there are no identified beds for persons who are Deaf within inpatient psychiatric facilities. As Deaf adults or children are admitted to an SCDMH facility, staff from the community outpatient team provide consultation, direct services and interpreting services. For the last five years, SCDMH has not had more than one Deaf consumer in the facility at any one time, and in a typical year; there are Deaf consumers in the facility for only a third of the year.

A new challenge facing South Carolina is meeting the needs of individuals who are Deaf admitted to the sexually violent predator program, also administered by the SCDMH. As is true for hearing residents of this program, admissions are for extended periods and the number of Deaf residents is too small to justify a comprehensive and specialized program.

Residential Programming

South Carolina has one 10-bed residential program that serves exclusively Deaf adults who are mentally ill. Residential services are centered at the McKinney House (named for Charlie McKinney, a lifelong advocate for the Deaf community) in Mauldin, which provides a structured living environment for 10 individuals, most commonly as a step-down from the hospital before moving to a more independent setting. In the same county, 12 rent-supported apartment units are available that provide an alternative for individuals who do not need a congregate residential program.

Future Goals

An ongoing and unmet need is the lack of intensive services for children and adolescents, including residential programming and family support services. South Carolina is a small state and the numbers of children/adolescents who are Deaf and needing this level of programming are small and inconsistent, making it difficult to identify a stable population to develop appropriate resources. This is an area SCDMH hopes to develop collaborative programming with SCSDB as well as existing providers of intensive services to hearing children and adolescents.

As broadband and video technology become increasingly available at all of the satellite offices, SCDMH aims to continue to explore ways to make the most effective use of limited staff. This may include routine appointments being provided by use of teleconferencing and video access for crisis line calls.

SCDMH also anticipates seeing an increase in the number and comprehensiveness of peer support services. As a pioneer in the provision of Deaf peer support, SCDMH will continue to explore ways to use this resource that are both beneficial to consumers and financially feasible.

Alabama

History

Alabama's Office of Deaf Services (ODS) is also the result of litigation. Frustrated by more than 15 years of meetings with the Alabama Department of Mental Health (ADMH) without any real change, the Alabama Association of the Deaf decided that action had to be taken. The *Bailey*

v. Sawyer lawsuit was filed in 1999 and settled in 2001 (*Bailey v. Sawyer*, 1999). Steve Hamerdinger (second author) was hired as director in January 2003 and the first regional office in Birmingham was opened in August of that year. Other regional offices were opened over the next 12 months in Huntsville, Montgomery and Mobile.

As originally conceived, despite pleas from the Deaf community to make the system entirely state-operated, community-based services were entirely contracted to local mental health centers. Within 12 months, it became obvious that this approach would not work due to low population density. Centers were simply not able to work with Deaf therapists and bill enough to cover the costs. There was tremendous pressure to increase revenue and some centers experimented with assigning hearing consumers to the Deaf therapists. Not only did this result in increased interpreter costs and active resistance by the hearing consumers, but it also led to staff dissatisfaction and resignation of several therapists. By 2005, all regional staff had become state employees.

ODS works with people who have severe and persistent mental illness. At this time, there are no specialized services for people who are Deaf and have substance abuse problems; they are served by another division in ADMH. Recently, the Division of Intellectual Disabilities opened a four-bed group home for consumers who are Deaf and collaborates with ODS on meeting the residents' clinical needs.

Model

The regional staff are all ODS employees and the group homes are privately operated. In addition, the inpatient unit is state-operated and all staff are state employees. The program's scope of services includes:

- Crisis Intervention
- Assessment and Stabilization
- Inpatient treatment
- Outpatient Therapy
- Communication assessments
- Psychological Evaluation
- Telemental Health
- Technical Assistance and Consultation
- Assistance with case management

- Substance abuse referral and assistance, and co-occurring disorders therapy
- Community Placement Assistance

Regionally-Based Therapists

The heart of ADMH's Deaf Services is a network of regionally-based therapists who specialize in working with people who are Deaf. Based at community mental health centers, but employed by ODS, these therapists provide linguistically and culturally appropriate services. They are also sources of technical assistance and consultation for community mental health centers.

The Bailey Deaf In-Patient Unit

The Bailey Deaf Unit (BDU) is located within Greil Memorial Psychiatric Hospital in Montgomery. It has 10 beds, with two beds designated as statewide crisis beds. BDU is designed as a culturally affirmative program with signing staff trained to work with people who are mentally ill and Deaf.

All consumers who are Deaf in state-operated facilities have been transferred to BDU as of Spring 2009. For a variety of reasons, this transition was challenging. Greil is considered an acute psychiatric facility and since BDU is embedded there, it was assumed that BDU would also be acute care only. This created a barrier to moving consumers who were considered "long-term" care. It also was a barrier to moving forensic consumers to the program. These barriers were slowly overcome and at the time of this writing, there are no consumers who are Deaf in any state-operated facility other than BDU.

Small Group Homes

Located in Birmingham and Mobile, Alabama's residential services are made up of a series of three-person group homes and independent supported living slots. The group homes will serve as "intermediate care" options, helping people who are ready to leave BDU but not ready to live independently in the community. Admission to these homes is at the operator's discretion.

A new home for consumers who are Deaf with intellectual disabilities opened in Fall 2009. This home is privately operated under contract with ADMH's Division of Intellectual Disabilities. ODS was heavily involved in the planning of the home.

Mental Health Interpreter Training

Alabama has a definition of "qualified mental health interpreter" in the Code of Alabama (§580-3-24) in an attempt to set a floor on what it means to be a "qualified interpreter" in the context of mental health. This, in turn, has led to recognizing the need for specialized training for interpreters to help them become qualified. The annual 40-hour Interpreter Institute is internationally recognized as the best training of its kind and has been attended by participants from 35 states and the United Kingdom. ODS is also heavily involved in the interpreter training program at Troy University. In addition to funding several stipends for students, ODS is an internship and externship site.

Clinical Training

ADMH believes that training interpreters without concurrently training consumers and clinicians is not effective. A clinical/community education component was set up as a companion piece to the mental health training piece. Noteworthy activities include:

- Educational programs for Deaf and hard of hearing people about mental illness and substance abuse, emphasizing the potential for recovery.
- Training for facilities and providers to help them understand the importance of culturally and linguistically appropriate services.
- Intense and focused training for clinicians who work with consumers who are Deaf.
- A training program to teach Deaf and hard of hearing people to work as clinical professionals.

Future Goals

ODS hopes to expand the number of community residential options, including number of beds and types of beds, increase the use of telemental health services, and improve options for people with substance abuse issues who do not have co-occurring mental illnesses. As with other states, the

biggest barrier to expanding services is funding. Alabama also has the goal of overcoming the severe shortage of ASL-fluent professionals and para-professionals to fill positions if they were created.

State Model Comparisons

In the three statewide mental health models, there are important similarities and differences. All state funding mechanisms are different and no state system is exactly the same. The models described in this article are examples intended to offer ideas that can be adapted or modified to best fit the funding and governance systems in other states.

Similarities

There are several important similarities between the models presented that are considered successful and that other states should not ignore and could possibly replicate. One striking similarity is that all three state models were launched by litigation. Another important similarity between the three states is that the mental health services are regionally-based with staff located in areas with the largest concentrations of people who are Deaf. In addition, core ASL-fluent clinical staff are state employees in all three states.

Another significant similarity is that direct mental health services are provided to consumers who are Deaf and all professionals are under the direction of a state coordinator. The job specifications of the state coordinators in all three states require that they be clinically trained.

Finally, all three state models have a similar service continuum that benefits consumers who are Deaf in the state. Closer examination reveals that Alabama is a hybrid model that, structurally, is like South Carolina but shares important similarities with Minnesota. In particular, Alabama and Minnesota have similar funding streams, i.e. direct appropriation of state dollars rather than Medicaid/Medicare. Table 1 offers a summary of state model similarities.

Differences

The differences between the state models begin with which department each program operates within. Minnesota's program is housed within the Department of Human Services, Deaf and Hard of Hearing Services

Division, which is not the state mental health authority (SMHA). South Carolina's program is housed within the Department of Mental Health, Services for the Deaf and Hard of Hearing, and services are provided by the Piedmont Center for Mental Health Services. Alabama's program is under the Department of Mental Health, Mental Illness Division, in the Office of Deaf Services. Thus both South Carolina and Alabama's services are operated out of the SMHA.

There are pros and cons to operating services out of a SMHA. One is clearly that the program can operate (up to a point) at a loss. This allows attention to be given to small, isolated areas that could not be otherwise served if there was pressure to cover expenses. This flexibility comes at a price, however. In most states, the SMHA cannot bill Medicaid/Medicare directly for outpatient services, contracting instead with public or private agencies to provide billable services. For example, neither Alabama nor Minnesota has a psychiatrist on staff. South Carolina, which can bill Medicare, does.

Secondly, state governments are typically not nimble at adapting to a changing marketplace. In economic downturns, as the United States experienced in 2008-2010, states react by instituting broad-based hiring freezes that disproportionately impact small programs. Alabama, for example, has clinical positions it cannot fill due to budget restrictions, negatively impacting the ability to deliver services to persons who are Deaf.

On the other hand, while private providers can maintain flexibility to expand and contract their programs to fit economic realities, they nevertheless are faced with incredible pressure to "bill or die." They may also have to limit their service area, a problem faced in many states. In Alabama, this was solved by declaring (in administrative regulations) that the entire state was the catchment area for people who are Deaf. In South Carolina, since each mental health center is a state-operated program, services to Deaf people are provided at every location.

In the authors' experience, there are more pros than cons to operating a mental health program serving consumers who are Deaf within the SMHA. However, this is not an absolute necessity. For example, the mental health program in Nebraska is housed within the Nebraska Commission for the Deaf and Hard of Hearing (www.ncdhh.ne.gov/mh_services.html) and Kansas' statewide services are provided through the Johnson County Mental Health Center (mentalhealth.jocogov.org/special.htm) (S. Dennis,

personal communication, April 16, 2009) in Olathe, Kansas. Although Minnesota's program is not housed within the Mental Health Division, both divisions are under the state's Department of Human Services and they work jointly as needed. Where a statewide mental health program serving consumers who are Deaf is operated depends largely on where it would fit best, both financially and politically within a state system.

There are noted differences in eligibility and standards of care across the state models. Minnesota has a stand-alone program with no client criteria for outpatient services (the consumers in prisons and sex offender programs receive treatment separately), and consumers with minimal mental health problems will qualify for services, whereas South Carolina and Alabama follows the department's statutory limitations on who, among those with mental illness, can be served. Alabama has specific standards of care for consumers who are Deaf in the state code as part of community program standards. The code determines who qualifies for mental health services and sets a "floor" for the quality of the services. Most importantly, it defines "ASL-fluent" in terms of a specific score on a nationally recognized assessment of ASL (Sign Language Proficiency Interview.)

In Minnesota, culturally affirmative providers in the private sector (DHHSD grantees and those in private practice) work together well with both each other and with the Mental Health Program, often referring consumers to each other whenever necessary. South Carolina and Alabama have different challenges; they have virtually no culturally affirmative mental health providers to the Deaf community in the private sector. In South Carolina, the entire public mental health system is state-operated so there are no contractual arrangements. In Alabama, there is cooperation driven by the standards of care that have the usual hallmarks of contractual relationships between a regulatory authority and those it oversees.

In terms of clinical supervision, the three states also operate differently. In Minnesota, the state coordinator has the sole responsibility of providing clinical supervision to the mental health professionals employed within the program; therefore DHHSD owns all client charts. In South Carolina, clinical supervision is provided by the regional supervisors and then the program manager with the Director of Services for the Deaf and Hard of Hearing and the local mental health center staff being available to provide additional support. In Alabama, shared supervision is provided by both clinical directors within the local mental health centers and the state coordinator.

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Secondly, state governments are typically not nimble at adapting to a changing marketplace. In economic downturns, as the United States experienced in 2008-2010, states react by instituting broad-based hiring freezes that disproportionately impact small programs. Alabama, for example, has clinical positions it cannot fill due to budget restrictions, negatively impacting the ability to deliver services to persons who are Deaf.

On the other hand, while private providers can maintain flexibility to expand and contract their programs to fit economic realities, they nevertheless are faced with incredible pressure to "bill or die." They may also have to limit their service area, a problem faced in many states. In Alabama, this was solved by declaring (in administrative regulations) that the entire state was the catchment area for people who are Deaf. In South Carolina, since each mental health center is a state-operated program, services to Deaf people are provided at every location.

In the authors' experience, there are more pros than cons to operating a mental health program serving consumers who are Deaf within the SMHA. However, this is not an absolute necessity. For example, the mental health program in Nebraska is housed within the Nebraska Commission for the Deaf and Hard of Hearing (www.ncdhh.ne.gov/mh_services.html) and Kansas' statewide services are provided through the Johnson County Mental Health Center (mentalhealth.jocogov.org/special.htm) (S. Dennis,

personal communication, April 16, 2009) in Olathe, Kansas. Although Minnesota's program is not housed within the Mental Health Division, both divisions are under the state's Department of Human Services and they work jointly as needed. Where a statewide mental health program serving consumers who are Deaf is operated depends largely on where it would fit best, both financially and politically within a state system.

There are noted differences in eligibility and standards of care across the state models. Minnesota has a stand-alone program with no client criteria for outpatient services (the consumers in prisons and sex offender programs receive treatment separately), and consumers with minimal mental health problems will qualify for services, whereas South Carolina and Alabama follows the department's statutory limitations on who, among those with mental illness, can be served. Alabama has specific standards of care for consumers who are Deaf in the state code as part of community program standards. The code determines who qualifies for mental health services and sets a "floor" for the quality of the services. Most importantly, it defines "ASL-fluent" in terms of a specific score on a nationally recognized assessment of ASL (Sign Language Proficiency Interview.)

In Minnesota, culturally affirmative providers in the private sector (DHHSD grantees and those in private practice) work together well with both each other and with the Mental Health Program, often referring consumers to each other whenever necessary. South Carolina and Alabama have different challenges; they have virtually no culturally affirmative mental health providers to the Deaf community in the private sector. In South Carolina, the entire public mental health system is state-operated so there are no contractual arrangements. In Alabama, there is cooperation driven by the standards of care that have the usual hallmarks of contractual relationships between a regulatory authority and those it oversees.

In terms of clinical supervision, the three states also operate differently. In Minnesota, the state coordinator has the sole responsibility of providing clinical supervision to the mental health professionals employed within the program; therefore DHHSD owns all client charts. In South Carolina, clinical supervision is provided by the regional supervisors and then the program manager with the Director of Services for the Deaf and Hard of Hearing and the local mental health center staff being available to provide additional support. In Alabama, shared supervision is provided by both clinical directors within the local mental health centers and the state coordinator.

The client charts belong to the local mental health centers, not the Deaf services programs, in Alabama and South Carolina. This means, generally speaking, that the state coordinators are responsible for the general level of care given to consumers who are Deaf and the local clinical directors are responsible for specific issues related to the cases and day-to-day operations within the mental health centers. The three states also vary in terms of who actually employs the staff. It is interesting to note that all public mental health providers in South Carolina are employed by SCDMH. Alabama is slightly different, as most of the clinical staff is employed by the ADMH, but the community residential staff in group homes serving Deaf consumers are employed by the local community mental health centers. Minnesota employs its own clinical staff, and the grant-based programs separately employ their mental health staff. In addition, Minnesota has a large number of mental health professionals available in private practice, but most are located in Minneapolis and St. Paul.

Billing Medicaid/Medicare for services is a standard practice in mental health for hearing consumers. It is not necessarily so for programs serving Deaf consumers. South Carolina bills for services because all of the public mental health providers in the state are state employees, and the Medicaid/Medicare reimbursement system and state mental health agencies are intertwined by default. However, neither the programs in Minnesota nor Alabama bill for services, because most consumers who are Deaf are on Medicare (not Medicaid), and billing for services would require hiring physicians, Ph.D.-level psychologists or licensed clinical social workers to provide services. This reduces the applicant pool for positions and historically has had a disparate impact on the ability of the system to hire clinicians who are themselves Deaf. Alabama and Minnesota fund clinical services with state dollars, although Alabama does bill for residential services when possible.

Mental health services for children and adolescents who are Deaf are available in Minnesota through grants and private practice. Virtually all of the providers for this population are located in the Twin Cities, but some provide services via videoconferencing. Some providers travel to various sites outside the Twin Cities, but the frequency of services provided are often limited due to travel time. In addition, due to a shortage of culturally and linguistically affirmative school psychologists in rural areas outside of the Twin Cities, psychological assessment services are made available by contracting with licensed psychologists from other states who are fluent in

ASL. Minnesota established a children's mental health task force in 2009 to enhance the existing resources to best serve children and adolescents who are Deaf living in the state. Moreover, a day intensive treatment program (DHH-IMPACT) recently opened its doors at the Minnesota State Academy for the Deaf in Faribault.

South Carolina has direct outpatient services for children and adolescents who are Deaf throughout the state, as well as inpatient services in a program for hearing children using interpreters and Deaf Services staff for consultation. Services are also available at the South Carolina School for the Deaf and Blind. Referrals for children and family services often come from local school districts.

Alabama does not generally have direct services for children and adolescents at this time. However, regional therapists working within ODS can work with that population if they are consumers of local mental health centers in collaboration with the Department of Mental Health's Office of Children's Services.

Mental health interpreters are important components to any behavioral health system. Alabama is the only state in the country where the state code defines qualified mental health interpreters, including restrictions on some certification levels. It is also the only state that has a specialized certification for interpreters working in mental health settings. To help interpreters earn this certification, Alabama established the Mental Health Interpreter Training project (MHIT), a 40-hour intensive training solely on mental health interpreting. The training is open to interpreters from any state who are interested in obtaining a formal certification in mental health interpreting. For more information, consult www.mhit.org.

Interpreter services in all three states are provided by a mix of staff and contract interpreters. In Alabama and South Carolina, contractual interpreters supplement the staff interpreters and the cost of interpreting services is borne by the state office. RID certification is a requirement to be a qualified provider of interpreting services in both. Alabama also has a licensure law and interpreters in mental health settings are required to be licensed. Neither Minnesota nor South Carolina has a specific state code defining qualified mental health interpreters. In Minnesota, Registry of Interpreters for the Deaf (RID) certification is strongly encouraged but not required. Table 2 provides a summary of state model differences.

Establishing and Advocating Mental Health Services in Your State

The development of a statewide mental health delivery system serving consumers who are Deaf requires public and private providers, stakeholders, and the Deaf community in the respective states to work together cohesively to obtain the funding needed to establish an array of services, based on the identified needs of this population, to ensure the provision of culturally and linguistically affirmative mental health services. The National Association of the Deaf created a position paper in 2003 (National Association of the Deaf, 2003) and a supplemental paper in 2008 (National Association of the Deaf, 2008) that offer excellent recommendations for states to adopt, included in many of the below steps.

The following steps are necessary to establish mental health services in your home state and will require the coordination of key stakeholders. The first step is to create a task force that can function as an advisory council to the state mental health authority, the state department of Deaf services, or to a similar state department that shares common goals. It can also be an advocacy force if the state system is not responsive. The advisory council must consist of primary consumers who are Deaf and their family members. Additionally, active involvement of the state commission of Deaf and Hard of Hearing or association of the Deaf, or both, has been demonstrated to be effective, even necessary. Enlistment of the public and private offices of consumer affairs and community-based organizations within the state will likely result in a broad selection of members for the task force and support from more sectors of the community.

The next step is to thoroughly review the Americans with Disabilities Act (ADA) laws and landmark court cases that have led to the creation of culturally affirmative mental health care for people who are Deaf (e.g. *Handel et al v. Levine et al*, 1984; *DeViney v. Maine Medical Center*, 1998; *Tugg v. Towey*, 1994; *Bailey v. Sawyer*, 1999). Reviewing these cases will help states understand that specialized mental health services can be formed without requiring legal action. In addition, evaluating other states' recent action plans for direct mental health services can offer additional ideas for a multitude of services. Two recent plans that have been described in a very detailed manner are the plans for Missouri (Critchfield, 2006) and Colorado (Center for Systems Integration, 2008), although these states' action plans have not been fully achieved at the time of this writing.

The third step is to create a state coordinator position within the appropriate state department to supervise, coordinate, and provide technical assistance about service delivery for this population. The state coordinator must be clinically trained and this person can either create programs or integrate within the existing service delivery system in the state, thus creating a service continuum. The continuum should include separate and specialized services or programs based on the needs of each region, including identifying the "Deaf-friendly" or "Deaf-run" wraparound providers, group homes, and residential treatment facilities. The availability of video technology should not be ignored or taken lightly. It is important to create or utilize existing telemental health network resources to improve statewide access to services and provide needed technical assistance and consultation. This type of arrangement may help with the shortage of mental health professionals in the state.

A statewide directory with public and private mental health providers, who are experts in working with people who are Deaf or hard of hearing, should be made available for referral upon consumer or provider request. Such a list will allow both non-signing and ASL-fluent providers and consumers to make referrals. Reporting the efforts and results of creating this continuum of culturally and linguistically affirmative services should be made available in the state's annual plan of care. In addition, block grants and legislative mandates should be included that direct attention to the service delivery for consumers who are Deaf.

Finally, when the statewide mental health service delivery system is in place, it is also important to develop and provide professional training resources, such as seminars, workshops, conferences, and community events to build the skills and knowledge for both culturally and linguistically affirmative providers and any other non-signing providers about serving this population. Extensive training in mental health interpreting should also be part of the training continuum as well. The professional training resources can occur through coordination with academic or public institutions that educate and train human service workers throughout the state.

Conclusion

It is axiomatic that consumers who are Deaf *should* be able to access a wide range of appropriate mental health services in their preferred language, from mental health professionals or providers who are culturally and linguistically

competent. However, for most people who are Deaf, this is but a dream. The authors' ongoing professional networking on the national level indicates that there are few statewide mental health programs, an impression reinforced by the mental health directory maintained by Gallaudet University (research.gallaudet.edu/Publications/Mental.Health/listings.php) In order to create an effective statewide mental health delivery system, each state should look at their structure and identify which state department or agency the mental health services for consumers who are Deaf should fall under and where funding for such services should be coming from.

The states also must understand that the "one size fits all" concept will not work, since consumers who are Deaf vastly differ in communication preferences, cultural backgrounds, and cognitive skills. It is essential to recognize that services are already provided to adults and children who are Deaf with a mental illness or an emotional disorder. However, all too often, such services are delivered in the most expensive and restrictive manner possible, whether it be in inappropriate inpatient admissions, unnecessary criminal justice system involvement or overly long residential stays. Nor will program designs that are successful in one state necessarily translate to success in another. The authors' experiences indicate that a set of common characteristics does seem present in successful state systems and those are the characteristics that should be emulated.

Creative approaches are absolutely necessary to ensure consumer choices such as expanding services in state regions and offering an array of providers and service types (e.g., specialized services and telehealth) that consumers who are Deaf and their family members can choose from, just as a hearing consumer is able to do. In addition, the authors believe that statewide coordination helps reduce the number of people who "fall through the cracks" by creating, what is in effect, a statewide catchment area that allows limited resources to be used on a broader scale and by more people ensuring more effective statewide mental health delivery system to best serve individuals who are Deaf.

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Table 1
State Model Comparison: Similarities

	Minnesota	South Carolina	Alabama
Reason for Establishment	Initially established by lawsuit to create an inpatient unit for the Deaf; evolved to a statewide outpatient program	Established by lawsuit to create statewide outpatient and inpatient programs	Established by lawsuit to create statewide outpatient and inpatient programs
Service Locations	Services regionally based in 8 locations	Services regionally based in 4 locations	Services regionally based in 4 locations
Type of Services	Direct mental health services	Direct mental health services	Direct mental health services
Employing Agency of staff	ASL-fluent MH professionals employed by the state	ASL-fluent MH professionals employed by the state	ASL-fluent MH professionals employed by the state
Qualifications of State Coordinator	State Coordinator is clinically trained (as required by job specifications)	State Coordinator is clinically trained (as required by job specifications)	State Coordinator is clinically trained (as required by job specifications)

Table 2
State Model Comparisons: Differences

	Minnesota	South Carolina	Alabama
Location	Department of Human Services-Deaf & Hard of Hearing Services Division (DHHSD)	Department of Mental Health (DMH)-Office of Services for the Deaf and Hard of Hearing	Department of Mental Health-Mental Illness Division (DMH)-Office of Deaf Services
Standards of Care	<ul style="list-style-type: none"> a) Stand alone, no client criteria for outpatient services b) Well-coordinated with other culturally and affirmative providers (grantees and private practice) c) Has ASL fluency requirements. Use SLPI for fluency measure 	<ul style="list-style-type: none"> a) Follow South Carolina DMH's existing standards of care for all DMH consumers b) Has ASL fluency requirements. Previously used SLPI for fluency measure 	<ul style="list-style-type: none"> a) Alabama DMH has specific standards of care for D/HH people in state code as part of community program standards. Sets a "floor" b) Code specifies ASL fluency requirements for staff providing direct services using SLPI
Supervision	State Coordinator	<ul style="list-style-type: none"> a) Shared: Supervision provided by local authorities b) Access to Deafness-specific supervision from Program Manager and DMH Deaf Services Director c) Services of an ASL-fluent psychiatrist 	Shared: State Coordinator for practice and overall theory, clinical directors of MH Centers for individual cases.

	Minnesota	South Carolina	Alabama
Employment	<p>a) MH Specialists are employed by DHHSD</p> <p>b) Grant-based programs employ their own MH staff</p> <p>c) Some are in private practice</p>	All staff are employed by DMH	<p>a) Most clinical staff are employed by DMH-Office of Deaf Services</p> <p>b) Community residential staff are employed by CMHCs</p>
Client chart ownership	DHHSD	Local MH centers	Local MH centers
Insurance Reimbursement	The program is funded by the state and does not bill for services	South Carolina bills for services because all of the MH providers in the state are state employees; therefore, Medicaid/Medicare reimbursement and state MH agencies are intertwined by default	The program no longer bills for services because most of its Deaf consumers are on Medicare and would only allow payment for services provided by physicians or Ph.D.-level psychologists. The program is entirely funded by state dollars
Funding	Any funding left will be swept to the State's General Fund at end of fiscal year	No appropriated funds may be carried over to the next fiscal year. Medicaid revenue is ongoing as services are provided	Funding can carry over to the next fiscal year at the discretion of the Governor

	Minnesota	South Carolina	Alabama
Children MH services	<ul style="list-style-type: none"> a) Has direct services for children through grants b) General MH services are mostly located in the Twin Cities; some receive services via telehealth in Greater MN c) Assessment services are for Greater MN only d) Children's MH Task Force established e) Intensive treatment program recently established at MN State Academy for the Deaf 	<ul style="list-style-type: none"> a) Has direct services for children b) Services at SC School for the Deaf and Blind c) Local school-based services in districts d) Child and family services as referred from local schools 	<ul style="list-style-type: none"> a) No direct services for children at this time b) Regional therapists can work with children who are consumers of MH Centers in collaboration with DMH Office of Children's Services
Interpreters	<ul style="list-style-type: none"> a) No specific state code defining qualified MH interpreters, but RID certification is encouraged b) Training in MH interpreting are given often through DHHSD grants 	<ul style="list-style-type: none"> a) Interpreting contracts throughout the system as needed b) MHIT training provided by Alabama as available 	<ul style="list-style-type: none"> a) State code defines qualified MH interpreter including restrictions on some certification levels b) Has certifications for MH interpreters c) Mental Health Interpreter Training (MHIT) is internationally recognized

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What Counselors Say About Their Role with Deaf Students: A Qualitative Study

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Abstract

This article reports the qualitative findings of a larger study which examined the role of public school counselors serving deaf students. The American School Counseling Association (ASCA) has a model that prescribes a specific role for school counselors. However, the 6 participants revealed experiences that were different from the ASCA model. Five themes were identified from the interviews. Themes were experience as authority, Director of Negotiations/Collaborations, isolation, surrogate parent/social confidante, and martyr. Implications for practice and research are provided for practitioners, researchers, and counselor educators.

Keywords: deaf, school counseling, counselor role, qualitative research

Introduction

Since the passage of P.L. 94-142 in 1975, there has been a decrease in enrollment at residential schools for the deaf and an increase in enrollment of deaf students in public schools (Luckner, Muir, Howell, Sebald, & Young, 2005; Moores, 2006). Due to the migration of deaf students, teachers of the deaf are readily found in many public schools across the United States. However, related service providers such as counselors, social workers and school psychologists qualified to work with deaf students, readily available in residential schools, did not make the migration to public schools. When one examines the Annual Reference Edition of the American Annals of the Deaf (Moores, 2005), it is clear that the inclusion of related service providers, including counselors for deaf students, is inconsistent in public school programs for the deaf across the nation.

This article reports a portion of the findings of a larger study conducted by the first author who examined the role of counselors primarily serving students identified as deaf and hard of hearing in public schools. The purpose of the research was to more clearly identify the role of school counselors serving deaf students in public schools, advocate for additional personnel to serve deaf students in public schools, advocate for the needs