Developing Mental Health Services for Deaf Persons in Rural Areas

When deaf persons seek mental health services, they are often confronted by a system that is completely inaccessible. Language and communication barriers, as well as cultural issues, often prevent the provision of even the most basic services. In some highly populated urban areas such as Washington D.C. there are specialized organizations that address the mental health needs of the deaf. In rural areas, however, services for this population are largely non-existent. Based on the experiences of a mental health program for the deaf in the Appalachian region of Southwest Virginia, this article proposes five recommendations for developing specialized services for the deaf in rural areas.

With the national prevalence of hearing loss at 8.6% (NCHS, 1994), there is no mental health system, rural or urban, that is immune from serving the deaf and hard of hearing population. The low numbers of deaf clients actually seeking services, however, may lead administrators to believe that the needs of this population are being met, or that there is not a major problem to address. Although the mental health needs of deaf persons are similar to the general population (Gore & Critchfield, 1992), it is estimated that only between two percent (Vernon, 1983) and ten percent (Steinberg, 1991) of deaf persons who have mental health needs actually receive services. When Steinberg, Sullivan, and Loew (1998) investigated the knowledge, attitudes, and beliefs of deaf adults towards the mental health system they found a, "mistrust of providers," "profound concerns with communication issues in therapy," and a, "widespread ignorance about how to obtain services." With deaf persons often reporting that the mental health system is inaccessible to them (Pollard, 1994), the normal meeting ground for this population and the mental health system seems to be situations of crisis.

Many excellent mental health programs for the deaf have grown out of litigation that is the result of inadequate services rendered in crisis situations or the following care received in an inpatient setting. A consumer complaint assisted in establishing the Regional Deaf Services Program (RDSP) in Southwest, Virginia. A deaf man who was fluent in sign language was screened for psychiatric hospitalization by a community mental health agency who used the consumer's mother as an interpreter. The information that was obtained from the client was therefore filtered through an individual who had personal involvement in the situation, questionable sign language skills, and the belief that the client needed hospitalization. As a result of the crisis service, the consumer was hospitalized against his will. A complaint was filed and the issue gained recognition at the state level.

The State of Virginia, who already funded four regionally based mental health professionals for the deaf and hard of hearing, provided additional funding for a position in Southwest Virginia. This region takes approximately 4 hours to drive from east to west and is comprised of 12 counties with a total estimated population of 381,109 people (Census Bureau, 2000). When

Cumberland Mountain Community Services (CMCS) established the Regional Deaf Services Program in the Fall of 1999 there were six deaf clients being served by the five community mental health agencies who cover the region. RDSP has provided mental health services to over 60 persons since program inception, currently maintains an active case-load of more than 35 persons, and averages one new referral per month. It is now estimated that 30% of deaf persons who have mental health concerns in this region are receiving services. Although the professional literature reflects the growing interest in developing specialized and culturally sensitive mental health services for the deaf, there is little information specific to developing programs in rural areas. This article provides five recommendations for agencies in rural areas who wish to reach out to this vastly underserved population.

1) Focus on Providing Services in Sign Language

With the low number of deaf persons seeking services, it may be tempting for a rural mental health agency to address this population by simply getting a list of sign language interpreters in the area who can assist already existing clinicians in providing services. Although this is a necessary step in the right direction, especially with the provision of crisis services in mind, the use of interpreters as an end-solution brings several problems. The first is the fact that deaf persons will not walk in the door because a list of interpreters is in place. Second, there is an extreme shortage of qualified sign language interpreters in most rural areas. Third, there are many complicating factors and complex dynamics which accompany bringing a third party into therapy as the median between two persons who have a different language and a different culture. The alternative to using interpreters is to provide services to deaf consumers directly in their preferred communication mode, which is often sign language. RDSP hired a sign language fluent clinician, called the Regional Coordinator, who was trained and experienced in working with deaf and hard of hearing persons. As a long term approach, the benefits of providing mental health services in sign language cannot be overemphasized. In light of the fact that deaf consumers view communication issues as a major contributor to their mental health concerns, it is not surprising that they also view sign language fluency as an essential quality of mental health professionals (Steinberg et. al., 1998). At the time of program inception, CMCS was fortunate to already employ a psychiatrist on a contractual basis who was fluent in sign language. With a team of specialized "direct service" professionals in place, the newly formed RDSP provided outreach to the deaf community.

2) Establish an Aggressive Outreach Program

In addition to providing mental health services in sign language, it is also possible for a sign fluent professional to build relationships with the leaders of the local deaf communities. With the assistance of deaf leaders, RDSP hosted "community dinners" around the region where the Regional Coordinator and the psychiatrist introduced themselves and discussed the mental health services now available in sign language. Community members performed skits to provide education on situations where a person might benefit from mental health services. This outreach went a long way to de-stigmatize mental health services and to reduce the widely held belief that seeking help inevitably leads to an involuntary hospitalization. Many deaf persons sought

out services after attending an outreach activity. Referrals also came from other state and community agencies that serve the deaf community. Most notably, the Virginia Department of Rehabilitative Services and the local Centers for Independent Living employed deaf professionals who knew of individuals in need of services. By establishing and maintaining an aggressive outreach program, RDSP has also located many deaf and hard of hearing persons with mental health concerns who are not connected with the deaf community. Unlike many urban areas with vibrant and self-supporting deaf networks, many persons who are deaf in rural areas are largely isolated from other people who use sign language. In many current cases, the signing mental health provider is the only sign fluent individual in the consumer's life. Expanding a person's social network is a common treatment goal.

3) Begin with Community Based Services and Centralized Psychiatric Services

RDSP initiated services with a focus on providing clinic based psychotherapy services at different locations throughout the region. This model was selected based on the successful experiences of the other regional programs in the State of Virginia that are located in more populated areas. As program referrals increased, however, it became apparent that a community based model of case management services was better suited to actual consumer needs. The Regional Coordinator now spends a majority of his time in the community engaged in case management activities such as monitoring mental health symptoms, coordinating medical care, linking consumers to assistive technology equipment, advocating to make other community services accessible, providing supportive counseling, and monitoring medications. What has been successful through the program's history is the centralized provision of psychiatric services. The sign language fluent psychiatrist conducts psychiatric evaluations and medication clinic two days a week in an office which is central to the region and shared by other RDSP staff. RDSP has reduced the impact of staff travel time by piggybacking on the region's already established teleconferencing network. The Appal-Link Network of Virginia provides 10 sites within the region that are equipped with state of the art teleconferencing equipment. Deaf consumers typically see the psychiatrist in person for their initial psychiatric evaluation and then attend follow-up medication clinics through their local Appal-Link site. Three years of experience has shown teleconferencing to be an effective and promising tool in providing mental health services to persons who use sign language. If a signing psychiatrist was not available, RDSP would still desire to centralize psychiatric services by pairing a nationally certified interpreter with one psychiatrist who is interested in learning about deaf culture and the unique diagnostic and communication issues related to this population.

4) Establish a Unique Deaf Services Program Identity

In fiscally austere times, a rural mental health agency may not have the financial resources or the necessary number of existing deaf clients to stand-up a specialized program on their own. CMCS partnered with four other community mental health agencies to establish RDSP. In this sense, RDSP is similar to other initiatives within the Appalachian region to build agency coalitions in order to provide a specialized health service. Although administered by CMCS and supported by partner mental health agencies, RDSP has established a unique deaf services program identity.

This identity has been reinforced by the centralized psychiatric services as well as the fact that RDSP "owns the cases" of the consumers being served. RDSP maintains consumer charts in accordance with the policies of its parent agency and bills third party payers for the services it provides to deaf consumers across the region. The revenue generated by RDSP from billing for services has further enabled the program to hire a full time Case Manager for the Deaf. Establishing a unique program identity has proven beneficial in two key ways. First, the deaf community has the opportunity to see RDSP as a new entity which assists in breaking the old stereotypes and myths that are associated with the various mental health agencies in region. Second, a unique program identity has assisted in attracting a team of specialized mental health providers. The Regional Coordinator was attracted to this position largely for the opportunity to coordinate a "program" and also to work with a sign language fluent psychiatrist. The Case Manager for the Deaf, who is hard of hearing herself, was attracted by the opportunity to work with deaf and hard of hearing clients, as well as the opportunity to work with a team of sign language fluent professionals.

5) Coordinate Accessibility Across the Continuum of Care

Providing direct services in sign language across the entire continuum of care may never be possible in a rural area. Having a signing provider in one key area, however, such as case management, greatly assists deaf consumers in maintaining a connection with the mental health system. In areas in which RDSP does not yet provide direct services, such as intensive mental health supports and residential services, the Regional Coordinator works closely with partner mental health agencies to coordinate accessibility with existing services. This is accomplished by providing education on the Americans with Disabilities Act, consulting on the use of technology to provide communication access, providing training on deaf cultural issues, and assisting in locating and working with qualified sign language interpreters. In the important area of inpatient treatment, RDSP benefits from a close relationship with the Mental Health Center for the Deaf, a culturally sensitive inpatient facility at Western State Hospital in Staunton, Virginia. The Mental Health Center for the Deaf employs a sign language fluent psychiatrist, psychologist, counselor, and social worker and provides patients the incredible benefit of receiving treatment with deaf and hard of hearing peers. The use of teleconferencing equipment to connect patients at the hospital with family members and treatment staff in the community lessens the impact of the 250 mile distance between this facility and Southwest, Virginia. Although making a local inpatient facility communication accessible is always a placement consideration, most deaf persons prefer to travel to a facility that provides communication freedom and a treatment environment where deaf culture is understood.

Summary

Establishing a specialized mental health program for the deaf in a rural area has been a successful and rewarding venture for both consumers and professionals. Every rural region will have unique challenges and unique assets in their ability to make the entire continuum of care accessible to this population. The first step is gaining an awareness of the large unmet mental health needs of deaf and hard of hearing persons that exist in almost every community. The next

step is making a commitment to serve this population without waiting for a crisis experience to force the issue. Our experience in Southwest, Virginia has shown that signing professionals who are sensitive to deaf culture can bridge the gap between the hearing world and the deaf world and effectively locate and serve 'hidden' consumers before they show up in crisis situations. Future projects for RDSP include establishing residential services for the deaf, providing intensive mental health support services in sign language, and making psychiatric day programs more accessible by hiring sign fluent staff or training current employees. Rural agencies who are interested in establishing specialized services for this population are welcome to contact RDSP for feedback, ideas, or assistance. Please contact Michael Bush by email at: mbush@cmcsb.com, by telephone at (276) 889-3785, or by TDD/TTY at (800) 347-4939.

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