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Christopher L. Kramer for the Master of Science

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The present study investigated the availability and accessibility of mental health services for deaf and hard of hearing people in the state of Kansas. Historically deaf people have not received mental health services in a traditional manner due to the differences in language and culture. Because of the hearing loss, deaf people are protected under several Federal and state laws when considering mental health services. Directors of community mental health centers were asked to complete an return a survey pertaining to services offered to this population. Twenty-four of 30 directors returned the survey, two of whom declined to provide information. Nineteen centers had served deaf people in the past. Although 86% indicated that they had provided services, only 86% indicated they would be able to provide services to this population. Only half of the centers have staff who have had orientation in working with the complexities of deaf and hard of hearing clientele. More training and research needs to be conducted in order to adequately serve this population in the state of Kansas.

AVAILABILITY AND ACCESSIBILITY OF MENTAL HEALTH SERVICES TO DEAF AND HARD OF HEARING PEOPLE IN THE STATE OF KANSAS

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Christopher L. Kramer

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Ken Weaver

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Approved for the Graduate Council

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CHAPTER 1

INTRODUCTION

The study of mental health services for deaf and hard of hearing (D/HH) people began in the United States in the 1950's. When dealing with issues of mental health, D/HH initially people used their own social network for support, such as deaf clubs, residential schools, and various other community based organizations (Freeman, 1989). As part of this support, the "mental health services" D/HH individuals received consisted of informally discussing the issues they had with others who could use sign language or other familiar methods of communication. They typically did not voluntarily seek professional mental health services. Reasons for this included not only communication differences, but also that historically people were often misdiagnosed as mentally retarded or mentally ill because of their hearing loss (Myers, 1993).

As recently as 1972, deaf people who were in need of psychiatric hospitalization received no psychological treatment in 46 of the 50 states. In fact, many D/HH people who were in need of mental health services were merely institutionalized in state operated mental hospitals. Rationalization for this action included the protection of society but was more likely due to society's inability to tolerate differences (McCay, 1972). Much of the time, this institutionalization was initiated by family members who were unable to deal with the hearing loss. Even today there is evidence that deaf people who are hospitalized have longer stays yet receive less treatment (Dickert, 1988).

In some ways, mental health services to D/HH people are improving. The government of the United States has passed laws requiring services and equal treatment of

the disabled, including those who are deaf and hard of hearing. In 1994, there were no longer deaf people in any state-run mental hospital in the state of Kansas, according to Cindy Winsky, Kansas's Coordinator of Mental Health services to the Deaf and Hard of Hearing (C. Winsky, personal communication, November 15, 1995). Based on a study conducted by the Michigan Department of Mental Health, Michigan published a directory that listed the services to D/HH persons and the compliance of Michigan Community Mental Health Centers with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973. They found all centers in their state were in compliance with these acts. Although progress has been made, there is evidence to suggest D/HH people are still suffering from insufficient mental health services available to them.

Statement of Problem

With the unique communication system and differences found within the deaf culture, many of the nearly 13 million Americans with hearing impairments are unable to benefit from the mental health services offered to the public at large (Tucker, 1981). The percentage of D/HH people who need mental health and crises intervention services is comparable to the percentage of the general population that require such services (McEntee, 1993). However, the percentage of D/HH people who are able to access these services is between 2% and 15% of the total D/HH population (Heller, 1987). Even when these services are made available, they are often inadequate in meeting the needs of deaf clients. Levine (1974) found the majority of people providing mental health services had no in-depth knowledge of deafness or deaf culture and were unable to communicate effectively with them. When D/HH people are able to obtain services, they are likely to be

in the area of case management or other areas where communication is less demanding and necessary (Pollard, 1994).

Statement of Purpose

The purpose of this study is to determine the availability of and accessibility to mental health services for the D/HH in community mental health centers in the state of Kansas. Many of the questions asked in this study dealt with knowledge and awareness of deaf culture and the language needs of D/HH persons. Also of interest was the availability of typical mental health services, such as testing and psychotherapy. The legal issues that deal with accessibility were also be investigated.

This study documented how D/HH people in the state of Kansas are served by mental health facilities. With such information, the deaf population should better understand issues it faces in gaining access to quality mental health services as well as having a better knowledge about where to obtain quality services. In addition, areas where training is needed for practitioners working in Kansas's community mental health centers were evaluated.

Review of the Literature

According to the National Center for Health Statistics (1982), hearing loss is the most prevalent physical handicap in the United States (Freeman, 1989). However, not all people with a hearing loss are considered deaf. To be considered deaf, individuals must identify with the deaf community, regardless of the amount of hearing loss they may have. Generally, those individuals who are considered part of the deaf community, also known as the "deaf minority," are those born deaf or who became deaf prelingually, were

educated in residential schools for the deaf, or had parents who were deaf (Higgins, 1980). This group of individuals is primarily identified by the use of manual communication, specifically the use of American Sign Language (ASL), which has significant grammatical differences from English (Baker, & Cokley, 1980; Humphries, Padden, & O'Rourke, 1991). Their use of ASL leads to the basic problem in providing services to the D/HH population: difficulty in communication.

There are other areas that cause difficulties as well. Levine (1981) points out that "the psychological benefits bestowed by hearing are the corresponding needs imposed by deafness" (p. 16). These needs indicate the areas where professional attention and intervention compensate for the environmental deficits. She also focuses attention on the emotional, psychosocial, and cognitive meanings of nonlinguistic sounds, nuances that enhance the social comprehension of hearing people. These are lacking in a D/HH person.

In the area of psychological testing, there are several issues that face the clinician working with the D/HH person. As with any minority group, cultural bias is often present. Therapists who have knowledge, training, and experience in working with deaf people, although they have a more positive attitude towards them, may evaluate deaf clients differently than they do hearing clients (McEntee, 1993). Psychological measures are often questioned when used with minority groups such as Hispanics, African Americans, and Asian Americans. The use of psychological instruments, which were normed and validated on the hearing majority, has also been questioned when used with D/HH people (Freeman, 1989).

There are linguistic biases in many of the tests that are used in the assessment of

D/HH people (Freeman, 1989). These biases are particularly evident in the area of personality testing. Many of the problems with personality tests are due to their reliance on verbal skills, as well as the inability of psychologists, not familiar with deaf culture, to interpret test results accurately (Brauer, 1980). There has been little effort in the past to develop personality assessment devices that are suitable for use with deaf individuals (Freeman, 1989).

In therapy, many of the same issues related to assessment regarding linguistics are present. Therapists cannot be effective with deaf people unless they understand their clients' culture and the forms of communication they use (McEntee, 1993). Understanding the dynamics of deafness and the language system deaf people use helps foster trust and confidence in a therapeutic relationship (McEntee, 1993). Therapists who have training and experience working with D/HH, as with any minority group, have an advantage over those who do not (Schlesinger & Meadow, 1972). However, Wyatt and White (1993) found that relatively few graduates from training courses designed specifically for professionals working with D/HH individuals actually gain employment in mental health settings.

Because many therapists lack the necessary communication skills and attitudes, many deaf people are unable to participate in therapy (McEntee, 1993). Vernon (1983) estimates that only 2% of the deaf people who need therapeutic services are actually able to receive such services. Too often, those who are able to receive services are placed in programs where ability to communicate is less demanding, such as case management (Pollard, 1994).

One solution to this problem has been the use of interpreters as a way for a non-signing, hearing therapist to be able to provide services for D/HH people. An interpreter is defined as a person who is deemed competent to provide translations between spoken English and sign language. Currently there are two national certification systems: The Registry of Interpreters for the Deaf, Inc. (RID) and National Association of the Deaf (NAD). RID currently has two levels of certification: Certificate of Interpretation (CI) and Certificate of Transliteration (CT) (The Registry of Interpreters for the Deaf, personal communication, September 12, 1996). NAD emulates RID. However, NAD uses a five level system instead of having just two levels (B. Kessler, personal communication, July 12, 1996). There is also a system used within the state of Kansas to qualify different interpreting capabilities, Kansas Quality Assurance Screening for Interpreters (KQAS). It has five levels of competency, of which only levels IV and V should be used in a mental health setting (Kansas Quality Assurance Screening for Interpreters, Summary of Components, 1986). In a therapeutic setting, any interpreter should be competent to KQAS levels IV or V whether the certification is on a national or state system, if possible. Beyond the specific skill level, the reputation the interpreter has in the deaf community is a very important consideration. That reputation may affect the therapeutic relationship in ways that the therapist may not be aware of or understand (McEntee, 1993).

The expressive and receptive skills of different signers often vary depending on the language system that is used. Deaf signers often adapt their signing to fit the situation, especially when interacting with hearing people (Hoffmeister & Moores , 1987). Therapists must recognize that these adaptations may change spontaneity and may result

in tension, stress, frustration, and misunderstanding on the part of the deaf client. An added consideration for the therapist is the importance of understanding basic aspects of sign language, personal space, eye gaze, and other linguistic and paralinguistic indicators that are important to sign language (McEntee, 1993).

When bringing in a third-party interpreter, ethical and legal issues must be addressed (McEntee, 1993). According to the KQAS Code of Ethics, an interpreter cannot become personally involved in the therapeutic process. However, in the area of mental health, the interpreter will become involved in the process by default (McEntee, 1993). Most ethical codes, however, do provide a solution for this problem with therapeutic confidentiality by requiring that a release be signed by the client before the introduction of an interpreter into the therapeutic setting. Interpreters are bound by the same ethical and confidentiality codes that bind the therapist.

Using an interpreter can cause additional problems as well. For instance, instead of communicating with the therapist, deaf people may address the interpreter directly. This could result in the interpreter assuming the role of the therapist (Maher & Waters, 1984). Introducing an interpreter into the therapeutic setting may also change the dynamics of that setting (McEntee, 1993). For these reasons, if interpreters are used in the mental health setting, they must have knowledge of the therapeutic process (Lawler, 1986; Maher & Waters, 1984). This will enable them to be aware of when they are being pulled into other roles beyond interpreter and thus be able to address this with the therapist and the client. Even if the interpreter is familiar with the therapeutic process, the communication between the therapist and client is still indirect, unlike the communication

that occurs when both the client and therapist can hear. Thus, the addition of an interpreter "does not create a situation of equal accessibility" (Harvey, 1985, p. 307).

Translation from English to sign, as with any language, is not exact. There are situations in therapy where much of the context can become distorted, regardless of the interpreter's level of competence, and it is not feasible to interpret all the nuances, facial expressions, and innuendoes. How much data the interpreter has missed in a therapeutic situation is unknown (Harvey, 1985). Introducing a third party interpreter into the therapeutic setting impacts the one-to-one relationship that is so important to the therapeutic process (Tucker, 1981).

There is even a question among therapists and interpreters whether an interpreter should be used in a therapeutic setting. Maher and Waters (1984) sent separate surveys to therapists experienced in working with D/HH people and to interpreters experienced in interpreting in therapy sessions. The results showed that 40% of the respondents were unwilling to use interpreters in therapy. The most common reason stated for this reluctance was the feeling that having a third party involved is detrimental to the therapeutic process. Thirty-six percent of these therapists believed that interpreters were not needed. Twenty-nine percent expressed a willingness to use interpreters only with certain restrictions. These restrictions included first having the opportunity to train the interpreter in specific issues of counseling, such as confidentiality and therapeutic terminology. Nineteen percent of the therapists indicated that the interpreter must be RID certified.

In the same survey (Maher & Waters, 1984) interpreters who responded appeared to agree with the therapists. Seventy-six percent of them expressed a belief that interpreters should be used in therapeutic settings with certain restrictions. Many of the concerns and restrictions they expressed were the same as those of the therapists.

Diagnosing

The exact incidence of mental illness in the deaf community is unknown (Freeman, 1989). This may be due to the lack of assessment tools and professionals with expertise in working with the deaf and hard of hearing clients. Diagnosing deaf people is often very complex. It often requires a greater sophistication of assessment than is necessary with the hearing population (Heller, 1987). The signs and symptoms of some diagnostic categories in the deaf population are very dissimilar to those of hearing people. For example, severe depression in deaf people is most likely seen as anxious agitation, with activity levels near or above normal and a somatic preoccupation with their bodies (McEntee, 1993). Although severely depressed hearing people may also have somatic illnesses, most depressed hearing people have abnormally low activity levels.

Linguistic biases may also affect diagnosis by masking a mental illness or masquerading as a mental illness (Heller, 1987). Often, deaf patients who are unable to communicate orally are perceived as being mentally ill or mentally retarded. The most common cause of misdiagnosis is experiential and linguistical differences on the part of the therapist. Rarely is lack of verbal communication seen as being caused by deafness (McEntee, 1993). In a study conducted by Rainer, Altshuler, Kallman, and Demming (1963), more than 25% of deaf patients in the New York Psychiatric Hospital were

diagnosed as mentally deficient, compared to 3.7% of the hearing patients. The most common diagnosis of deaf patients, based on the client's presentation and the therapist's ignorance of deaf and hearing impaired issues and behavior, is psychosis with mental deficiency (McEntee, 1993). "To a hearing person, the face of a deaf signer often appears much too animated to be normal and the deaf person sometimes appears excited when he or she is not, or appears negative, disapproving, or angry when this is not the case" (Stokeo & Battison, 1981, p. 190).

The Law

A study of mental health services for the deaf and hard of hearing people would not be complete without a look at the legal issues surrounding mental health and deafness. The laws restricting the discrimination against any segment of the population of the United States are plentiful, including two amendments to the Constitution. The Fifth and Fourteenth Amendments of the Constitution proclaim that states may not deny "equal protection" of the laws of our country to any segment of the population (Tucker, 1981). Section 504 of the Rehabilitation Act of 1973 (P.L. 93-112) restricts recipients of federal financial assistance from discriminating against handicapped persons (Tucker, 1981).

These laws are complex and often confusing. This confusion is often the result of differences in interpretation of these laws. What constitutes "equal protection" of the laws as stated in the Fourteenth Amendment? What constitutes discrimination under the Rehabilitation Act? Section 504 is very clear on the issue of discrimination.

The Supreme Court in its decision regarding the Regents of the University of California vs. Bakke, concluded that Title VI of the civil Rights Act of 1964 would ensure

the right to equal treatment in the enjoyment of federal funds (Tucker, 1981). Equal treatment was later defined by the Supreme Court in its decisions on Lau vs. Nichols and Trans World Airlines vs. Hardison. The court decided that accommodations must be made to ensure that the legitimate needs of a segment of the population are met. A position of neutrality will "not achieve that goal of equal treatment; unintentional discrimination may result where reasonable accommodations are not made to ensure that all persons are treated equally" (Tucker, 1981). This position of neutrality seems to be what has happened with mental health centers in regards to the D/HH population.

Seven years after the enactment of P.L. 93-112, Seliger (1980) assessed 700 of the 800 mental health centers listed in the 1979 Directory of Federally Funded Mental Health Centers on their readiness to comply with Section 504 of the 1973 Rehabilitation Act. He found that two thirds of the respondents were rated poorly in their ability to provide services for the D/HH. Seliger found that 87.2% of the respondents reported having no equipment or plans to purchase equipment that would allow deaf people to schedule appointments over the phone. This survey showed that "the majority of Community Mental Health Centers surveyed appeared to be far from compliance with 504 provisions" (Seliger, 1981 p.243).

There was a survey conducted in the state of Kansas regarding the number of deaf people receiving treatment in mental health centers and training of therapists to work with D/HH clients. There were only two agencies that requested this training (C. Winsky, personal communication, November 15, 1995).

Summary

The issues concerning mental health services for the D/HH people are very complex but clear. Differences in language, culture, and laws slated to ensure accessibility to handicapped people, make this even harder than they need be. Assuming that all people have the right to equal services and identical treatment is not equal treatment, a survey of the mental health centers may be able to determine the specific services being provided for deaf consumers, and subsequently how well mental health centers are in compliance with the American Disabilities Act and Section 504 of the Rehabilitation Act of 1973. It is expected that the results of this study can be used in assessing what training needs to be conducted for mental health providers who work with deaf and hard of hearing people. Such training would hopefully assist deaf people in finding and having confidence in quality mental health services in Kansas.

CHAPTER 2

METHOD

This study requested information from all 30 community mental health centers in the state of Kansas to determine the accessibility and availability of mental health services to D/HH people. It compared the differences between emergency and regular mental health services offered to deaf and hard of hearing individuals in the state of Kansas. These results were compared with the results of a similar survey conducted in Michigan in 1994 (Michigan Department of Mental Health, 1995), which found compliance to ADA and the Rehabilitation Act of 1973.

Participants

Population

The population for this study is composed of the directors of community mental health centers in the state of Kansas. Community mental health centers, as defined by the Kansas Statutes Annotated 19-4002 (1988), are non-profit organizations created with state and federal funding for the purpose of providing mental health counseling, evaluation, psychological testing, identification of mental retardation and/or other mental health services to the general public in the areas they serve. These facilities were targeted because they claim to serve the general public and do not specialize in services for any particular group or population. Community mental health centers are intended to be one of the most accessible sites for people to gain mental health services at an affordable price.

Sampling Procedure

All 30 community mental health centers in the state of Kansas were asked to participate in this study. Being federally and state funded and being from the state the study was being conducted in, the return rate was expected to be slightly higher than is typical for survey research. Of the 30 mental health centers surveyed, it was estimated that approximately 18, or 60% would respond. This is based on the information gained from the last survey conducted of Kansas's community mental health centers regarding deaf and hard of hearing (C. Winsky, personal communication, November 15, 1995). However, specific methods, detailed later, were used to increase response rates.

Research Method

This study used mail survey research to determine the availability of mental health services to the deaf and hard of hearing and the accessibility of the mental heath centers providing these services to this population in the state of Kansas. The survey instrument was modeled after the one used in the Michigan study (Michigan Department of Mental Health, 1995). It consisted of questions relating to the services that are provided to the general population, and if the facility has had D/HH clients, asked which services have been utilized by them. It also asked questions regarding the accessibility of all services provided to the D/HH (Appendix A).

Research Questions

The research questions this survey attempted to answer were: (1) what services are offered to D/HH people across the state of Kansas, (2) how accessible are these services, and (3) what methods are used to provide mental health services to the deaf and hard of

hearing? The first two questions were the most important to the study. The answers from these questions were used in determining the availability and accessibility of mental health services in the state and were compared to the results of the Michigan study. The third question provided information for ideas for future studies in the delivery of mental health services to D/HH people.

Procedure

Each of the 30 community mental health centers in the state were mailed a packet that included a cover letter detailing the purpose of the study, a copy of the survey instrument, and a stamped, self-addressed return envelope. Participants were informed in the cover letter that the results of the survey would be made available to them upon request, when the study was completed. Participants were also informed that the results of the survey would be shared with Cindy Winsky, Coordinator of Mental Health services for the Deaf and Hard of Hearing for the state of Kansas, for use in training and other services to the state (see Appendix B).

Two weeks after the initial packet had been sent out, a follow-up letter was sent to thank those who had already completed the survey and remind those who had not. Two weeks later, phone contact was made to those who had not yet returned the survey. This contact consisted of a request to set up a phone interview with the directors of the mental health centers. Those centers that did not comply with this request were considered non-respondents.

CHAPTER 3

RESULTS

The surveys were mailed to each of the 30 mental health centers in March, 1997. Included were instructions that the subjects were to complete the survey and return it by mail in the envelope that was provided. Two weeks later, all centers were sent a follow up letter thanking those that had already responded or reminding those that had not yet returned the survey. Those centers that had not responded by the fourth week were contacted by phone to either respond over the phone or decline participation. Those centers that did not respond after that time were considered non-respondents. Although the return rate was 24 out of 30, two centers that responded choose not to participate. After these responses were received, statistical analyses were carried out on the data from the 22 (73%) respondents.

Responses Related to Research Questions

In answering the first research question, what services are offered to D/HH people in the state of Kansas, the data from four questions (7, 20, 21 and 22) were analyzed. From the question asking if the agencies had Teletypewriters/Telecommunication devices for the deaf (TTY/TDDs), only 41% of the agencies responding to the survey had TTY/TDDs available to their staff.

Response to the question asking if the centers had specialized services for D/HH indicated only two centers (9%) did. One program is directed by the coordinator for D/HH services for the state of Kansas. The other program is directed by a social worker who is supervised by the state coordinator.

Answers to the question asking what services had been offered in the past, were all but 2 (91%) of the agencies served deaf clients in the past. Table 1 contains results of this question.

In answering whether centers would be capable of provide these services, most of the agencies that responded indicated that they would provide any services if the need arose. One center did not answer this question. Table 2 displays the responses to this question.

In answering how accessible are these services to D/HH clients, six questions were used (7, 10, 11, 14, 15, and details from 22). As previously stated, only nine centers (40%) have TTY/TDDs with only three having them available to clients 24 hours a day. Only three centers (14%) have individuals on staff who are deaf.

Eight of 22 centers (36%) reported having staff members who know sign language. One center commented that the skills of the one person who could sign were minimal. Of the eight centers that have staff who sign, four (50%) stated that their staff had ASL skills, four (50%) stated they had staff with skills in PSE/CASE, and three (37%) had staff members who could use Signed English (SEE1 and SEE2).

In answering the question, what services are provided to deaf consumers as well as what communication modes beyond spoken English are used in providing services. There were 19 centers (86%) that indicated interpreters were used in providing services. Four centers (18%) indicated that written language was used in some way. In this category there was one center (5%), that indicated written language was the sole method used in communicating with D/HH people. There were also four centers (18.18%) that indicated

Table 1

Types of Services that Have Been Offered to Deaf and Hard of Hearing in the Past (N=22)

Type of Services Offered	n	Percentage of Respondents
AA/NA	2	9.09%
Survivor Groups	2	.09%
Case Management	8	36.36%
Individual Counseling	19	86.36%
Family Counseling	11	50.00%
Marriage Counseling	7	31.81%
Psychological Evaluations	6	27.29%
Court Ordered Therapy	5	22.27%
Medication Management	5	22.27%
Emergency Contacts	5	22.27%

Table 2

Services that Agencies Would Be Capable of Providing Deaf and Hard of Hearing (N=22)

Type of Service Offered	n	Percentage of Respondents
24 hr. TTY Hotline	3	13.64%
Evaluations	14	63.63%
Referral Services	15	68.18%
Prevention Services	7	31.18%
Family Therapy	16	72.72%
Individual Therapy	21	95.45%
Case Management	14	63.63%
Substance Abuse Treatment	16	72.72%
Psychological Testing	13	59.09%

they used signing staff members for communication with deaf clients. There were three centers (14%) that indicated they used both written communication and interpreters. In three cases (14%) interpreters were also used at the centers that have signing staff.

In order to answer what methods are used to provide mental health services to D/HH people, the information from the previous paragraph was used. Also, the question asking if any member of the agency's therapeutic staff have had orientation in working with D/HH people was examined. There were 11 centers (50%) that stated at least one member of their staff had this orientation. In addition, 16 centers (73%) stated they would be interested in training about the mental health needs of D/HH people. There were three centers (14%) indicating they would possibly be interested in this training.

Additional Information Obtained by the Survey

There were several questions on the survey that were not used in answering the research questions. The information from these questions was used for general information about the centers. The question asking if an agency's TTY/TDD had an auto--on-recording function was intended to indicate the level of dedication to serving deaf people. The auto-on-recording is the same as an answering machine for a telephone. This allows deaf people to leave messages to be returned later.

The question that asked what forms of payment are accepted by the agency had little relevance to the survey. All agencies accepted all forms of payment in question.

By asking if the programs were accredited, it was hoped that there would be agencies having specialized accreditation in working with people who are handicapped. There were no responses that indicated this.

One question asked about the ages of the deaf people who have been served by the centers. This question was used to gain information about the deaf clientele agencies have served. Unfortunately, the wording of the question made the answers impossible to use.

By asking for the approximate number of deaf individuals an agency had served in 1996, it was possible to see the need for these services. It was reported 15 (68%) of the agencies had at least one deaf client in the past year.

One question asked if there were any services offered by the agency that are not identified in this survey. This question gave the centers the opportunity to state what they are doing with deaf clients. However, this question was worded in a way that the responses were not given as intended.

CHAPTER 4

DISCUSSION

This study addressed the availability and accessibility of community mental health center services to D/HH in the state of Kansas. This population is traditionally underserved in this area.

Availability

Overall results indicated that community mental health centers are willing to provide mental health service to D/HH people. Only three agencies (14%) reported that they had not provided nor did they contract for services to D/HH consumers. This study did not measure whether or not these agencies had the opportunity to serve this clientele or what resources were available to support this group of clients.

Nineteen (86%) of the community mental health centers reported individual counseling as the most frequently provided service. These same 19 centers reported family counseling as the second most frequently provided service. This makes sense because these services are traditionally used by community mental health centers. However, this does challenge previous research findings that indicate that D/HH clients are served within programs that are less demanding in regards to staff communication. Furthermore, 8 of the above mentioned 19 centers indicated that D/HH clients received case management, which is a common service for such clients to receive (Pollard, 1994).

Accessibility

When discussing accessibility, it is important to distinguish between access to services and accessible services. For purposes of this paper, the former refers to how

centers accommodate potential client's initial contact with the centers. The latter refers to what steps are taken by centers in seeing that identified services are made available to eligible clients.

Access To Services. Out of the total 22 responding agencies, 13 (59%) reported not having TTY/TDDs available. Three (14%) reported having 24 hour TTY/TDD accessibility. It is unfortunate that over half of the community mental health centers in this state fail to provide such an inexpensive, low maintenance service, especially when TTY/TDDs are now being used by both D/HH people and those with speech disorders that cannot use the telephone in a traditional manner (B. Eddy, Personal communication, June 19, 1997).

This finding is interesting because, as previously stated, centers indicate an interest in serving people who are D/HH but often do not establish a means of direct communication with these clients. However, there may be means other than TTY/TDDs that D/HH clients use when making initial contact with the centers. This study did not investigate other possible means.

Accessible Services. As discussed previously, the method by which mental health services are provided is important. This study looked at both staff training in mental health issues of D/HH people and the communication fluency of staff.

Eleven (50%) of the community mental health centers indicated that their staff had participated in orientation sessions that focused on serving D/HH clients. Interestingly, 18 centers indicated they have had D/HH clients which means seven centers provided services by staff possibly unfamiliar with the complexities of serving this population.

Eight centers (36%) reported using signing staff to provide services while 19 (86%) of the agencies stated that they used interpreter services with their clients. These findings demonstrate a willingness on the part of centers to accommodate the linguistic needs of their D/HH clients; however, this study did not ascertain the signing fluency of staff or the certification status of interpreters or if such topics are addressed by center administration.

Only one agency reported using the written word to communicate with a deaf client. It is impossible to know if this was the client's preferred mode of communication but such practice is questionable and is hopefully used only when requested by the client.

Comparison of Kansas and Michigan Services

A comparison of this study with the results from a similar study conducted in Michigan indicate several differences between the states in services provided to D/HH people. Michigan Department of Mental Health is reported to have 44 of their 59 centers with TTY/TDDs. This is 75%, whereas in Kansas this percentage was only 41%. There are 97% of centers in Michigan reporting to have staff with signing skills, while in Kansas there were only 36%. The smallest difference in the two states is that of Deaf staff. In Michigan there were 22% of the centers with Deaf staff members, compared to the 14% that are in Kansas.

Limitations

One limitation of this study is that not all of the centers responded. It is unknown what information these non-responding centers could have provided. Another problem is that no questions were asked about urban or rural settings. Had this information been

obtained we would have been able to make that comparison.

Implications

A major implication of this study is that more training needs to be done in Kansas to educate providers on the mental health needs of D/HH and how best to serve this population. Training on this topic has been offered in the past and will continue to be provided upon request of the individual centers.

Two ideas for future research emerged from this study. One is the interpreters' skill levels and their level of certification. An interpreter should be certified to at least level IV or V on a state or national level before they begin working in a mental health setting (Kansas Quality Assurance Screening for Interpreters, Summary of Components, 1986). It would also be interesting to know if the interpreters had a background in the mental health area.

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Appendix A

SURVEY OF SERVICES FOR DEAF AND HARD OF HEARING POPULATIONS

This survey is being conducted to determine what services are available to deaf and hard of hearing people in the state of Kansas. I appreciate your assistance in completing this survey.

****

1. Name of Organization:_____

2. Director's Name:_____

3. Address:_____

4. City:_____

5. Zip Code:_____

6. Telephone Number: (____)_____

7. Does your agency have a TTY/TDD? ___Yes ___No
   TTY number (if different):_____

8. Does your TTY have an "auto on" recording function? ___Yes ___No

9. Would you be interested in training about the mental health needs of deaf and hard of hearing people and how to meet those needs? ___Yes ___No

10. Does your agency provide or contract for mental health services to deaf/hard of hearing populations?
    ___Yes ___No

11. Does your organization have a contractual relationship with an agency that specializes in providing services for persons who are deaf or hard of hearing?
    ___Yes ___ No
    If yes, please list the name of agencies and city located in:
    1._____
    2._____
    3._____
    4._____

12. Does your agency accept the following types of payments?

	Yes	No
Fee for Service	___	___
Medicare	___	___
Medicaid	___	___
Third Party Payments	___	___
Other_____	___	___

13. Is your program accredited? ___ Yes ___ No

If yes, by whom?

1._____
2._____
3._____
4._____
5._____
6._____
7._____

14. Do you have individuals on staff who are deaf? ___ Yes ___ No

15. Do you have individuals on staff who know sign language?

___ Yes ___ No ___ Don't Know

If yes, which system?

___ASL
___PSE/CASE
___Signed English (SEE1, SEE2)

16. Has any member of your therapeutic staff had orientation in working with deaf or hard of hearing?

___ Yes ___ No

17. Would your therapeutic staff like to receive an orientation in working with deaf and hard of hearing?

___ Yes ___ No

18. Do you serve the following deaf populations?

	Yes	No
Mentally Ill Children (ages 0-5)	___	___
Mentally Ill Children (ages 6-10)	___	___
Mentally Ill Children (ages 10-17)	___	___
Mentally Ill Adults (ages 18-25)	___	___
Mentally Ill Adults (ages 26-35)	___	___
Mentally Ill Adults (ages 36-54)	___	___
Mentally Ill Older Adults (55 or over)	___	___
Developmentally Disabled Children	___	___
Developmentally Disabled Adults	___	___
Developmentally Disabled Older Adults	___	___
Deaf Children with Hearing Parents	___	___
Deaf Parents with Hearing Children	___	___

19. Please indicate the approximate number of individuals who are deaf that were served by your organization during the 1996 calendar year.

___ None
___ 1-9
___ 10-25
___ 25 or more

20. Do you have specialized programs for individuals who are deaf?

___ Yes ___ No

If yes,

a. What is the name of your program?_____

b. Name of coordinator of program:_____

21. If you have had deaf or hard of hearing clients, which services did they participate in? (Check all that apply.)

___ No Deaf Clients
___ AA/NA (any 12-step program)
___ Survivor Groups
___ Case Management
___ Individual Counseling
___ Family Counseling
___ Marriage Counseling
___ Psychological Evaluation
___ Court Ordered Therapy
___ Other_____

22. Please indicate which services your agency provides to deaf or hard of hearing consumers and indicate the mode of communication beyond spoken language (e.g., interpreters, written language, signing staff, etc.)

Service	**Yes**	**No**	**Mode of Communication**
24 Hour TTY Hotline			
Evaluation			
Referral			
Prevention Services			
Family Therapy			
Individual Therapy			
Case Management			
Substance Abuse Treatment			
Psychological Testing			
If testing is provided, please list tests used:			

23. Are there any services offered by your agency that are not identified in this survey?

___ Yes ___ No

If yes, please list:

_____

_____

_____

24. Are there any unique characteristics about your agency that are not indicated in this survey?

___ Yes ___ No

If yes, please describe:

_____

_____

_____

****

Name of person completing survey (if other than director):_____

Position:_____

Date survey completed (mm/dd/yy):_____/_____/_____

Would you like a copy of the results of this study. ___ Yes ___ No

Thank you for your assistance

Appendix B

March 21, 1997

Dear CMHC Director:

Enclosed is a survey of mental health services available to people who are deaf and hard of hearing. This survey is being conducted as part of a masters thesis. Upon the completion of this study the results will be made available to you upon request. It is anticipated that the results of this study will provide valuable information as to the availability of mental health services to the deaf and hard of hearing population in the state of Kansas.

If you do not wish to participate in this survey you do have the option to withdraw, to do so please fill out the name of the organization and return the blank survey so no further communication will be sent to you. By filling out the survey you do give consent to participate in the survey.

Also, upon the completion of the thesis, the results of the study, in aggregate form, will be made available to Cindy Winsky, Coordinator Mental Health Services for the Deaf and Hard of Hearing.

If you have any questions, please feel free to call me at (913) 782-7971. Thank you for your assistance on the completion of my thesis.

Respectfully,

Chris Kramer

Appendix C

April 7, 1997

Dear Community Mental Health Center Director:

Approximately two weeks ago you received a copy of a survey of mental health services that are available to deaf and hard of hearing in the state of Kansas. If you have already completed the survey, I thank you for your assistance in the completion of my thesis, for which the survey is a part..

If you have not yet completed or returned the survey, I am again requesting that you do so. If you have misplaced the survey, I would be happy to mail or fax you another copy.

If you have any questions, please feel free to contact me at (913) 782-7971, or you may contact my faculty advisor, Dr. Kurt D. Baker at Emporia State University at (316) 341-5811. Thank you again for your assistance on the completion of my thesis.

Respectfully,

Chris Kramer

I, Christopher L. Kramer, hereby submit this thesis to Emporia State University as partial fulfillment of the requirements for an advanced degree. I agree that the Library of the University may make it available to use in accordance with its regulations governing materials of this type. I further agree that quoting, photocopying, or other reproduction of this document is allowed for private study, scholarship (including teaching) and research purposes of a nonprofit nature. No copying which involves potential financial gain will be allowed without permission of the author.

Christopher L. Kramer

Signature of Author

6 Aug 97

Date

Availability and Accessibility of Mental Health Services to Deaf and Hard of Hearing People in the State of Kansas

Title of Thesis

Mary Cooper

Signature of Graduate Office Staff

August 11, 1997

Date Received