

Colorado's Deaf & Hard of Hearing Mental Health & Substance Abuse Action Plan

Pending endorsement from the
Colorado Commission for the
Deaf and Hard of Hearing

Prepared by the
Center for Systems Integration
on behalf of the
Colorado Commission for
the Deaf and Hard of Hearing



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Members of the Mental Health and Substance Abuse Task Force:

Co-Chair: Richard Durity, Mental Health Center of Denver
Co-Chair: Ami Garry, Dove
Facilitator: Lydia Prado, Mental Health Center of Denver
Joe Benedetto, Colorado Commission for the Deaf and Hard of Hearing
George DelGrosso, Colorado Behavioral Healthcare Council
Janet DesGeorges, Hands and Voices
Natalie DiDomenico, Jefferson Center for Mental Health Services
Tom Dillingham, Colorado Federation of Families for Children's Mental Health
Laura Douglas, Colorado School for the Deaf and Blind
Patricia Doyle, The Legal Center for People with Disabilities and Older People
Samantha Gartrell, Division of Vocational Rehabilitation
Jennie Germano, Early Education Programs/Colorado Home Intervention Program
Rebecca Herr, Boulder Chapter, Colorado Hearing Loss Association of America
Craig Iverson, Mental Health Center of Denver
Teresa Knaack, Health Care Policy and Financing
Jeremy Martinez, Colorado Department of Public Health and Environment
Cliff Moers, Colorado Commission for the Deaf and Hard of Hearing
Carmelita Muniz, Colorado Association of Alcohol and Drug Services Providers
Jennifer Peterson, Mental Health Center of Denver
Stacy Stratman, Colorado Mental Health Institute at Pueblo
Candice Tate, Purple Monarch

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Authors of the report:

Jewlya Lynn & Denise McHugh, Center for Systems Integration (CSI). CSI is dedicated to actively developing and promoting policy solutions to complex policy problems. For more information about CSI, please visit <http://www.csi-policy.org>.



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Executive Summary

<p>Goal #1: Governance Structure: Colorado has a governance structure to implement, support, oversee, evaluate, and sustain systemic reform in the mental health and substance abuse systems to meet the needs of deaf and hard of hearing individuals.</p>	
Strategies	Outcomes
<p>Strategy 1.1: Develop sustainable capacity within the Colorado Commission for the Deaf and Hard of Hearing to implement and evaluate systemic reform to the mental health and substance abuse systems to meet the needs of deaf and hard of hearing individuals.</p>	<p>Oversight and accountability to the implementation of the Action Plan.</p> <p>Ongoing expertise on mental health and substance abuse on the Commission.</p> <p>Ongoing monitoring and evaluation of the success of the mental health and substance abuse system at meeting the needs of deaf and hard of hearing individuals and their families.</p>
<p>Strategy 1.2: Expand participation of deaf and hard of hearing individuals within the mental health and substance abuse policymaking bodies to address the needs of deaf and hard of hearing individuals.</p>	<p>Ongoing communication and collaboration between deaf and hard of hearing communities and decision-making entities in the mental health and substance abuse systems.</p> <p>Decisions made by the mental health and substance abuse system respect the unique needs of deaf and hard of hearing individuals and their families.</p>
<p>Goal #2: Statewide Capacity: Colorado provides a statewide continuum of high quality mental health and substance abuse services to deaf and hard of hearing individuals and their families, coordinated through A Technical Assistance and Education Center and a Statewide Service Delivery Network, with capacity to support consumers, their families, and providers throughout the state.</p>	
Strategies	Outcomes
<p>Strategy 2.1: Establish <i>A Technical Assistance and Education Center</i> that provides technical assistance, training, workforce development, and leadership to mental health centers, substance abuse providers, child welfare, juvenile justice, criminal justice, aging services and senior centers, federally qualified health centers and other healthcare providers, vocational rehabilitation, workforce centers, education, private providers, and other providers and systems statewide.</p>	<p>Mental health, substance abuse, and other providers and systems statewide have the assistance they need to ensure their outreach, access, and service delivery are linguistically, technologically, and culturally appropriate for deaf and hard of hearing individuals and their families.</p>

Goal #2: Statewide Capacity: Colorado provides a statewide continuum of high quality mental health and substance abuse services to deaf and hard of hearing individuals and their families, coordinated through A Technical Assistance and Education Center and a **Statewide Service Delivery Network**, with capacity to support consumers, their families, and providers throughout the state.

Strategies	Outcomes
<p>Strategy 2.2: Establish a workforce development initiative to expand access for deaf and hard of hearing individuals to mental health and substance abuse direct service providers, interpreters, CART providers, and communication technology.</p>	<p>Colorado’s mental health and substance abuse workforce has the capacity to meet the needs of deaf and hard of hearing individuals and their families within the mental health and substance abuse systems.</p> <p>Colorado’s interpreters and CART providers have the capacity to meet the needs of deaf and hard of hearing individuals and their families within the mental health and substance abuse systems.</p>
<p>Strategy 2.3: Establish a Statewide Service Delivery Network that provides direct services in mental health and substance abuse for deaf and hard of hearing consumers statewide.</p>	<p>Deaf and hard of hearing consumers and their families throughout the state can easily access a comprehensive array of high quality mental health and substance abuse services.</p> <p>Direct service providers specializing in working with deaf and hard of hearing individuals and their families work together in a supportive, technology appropriate setting allowing for high quality service provision.</p>
<p>Strategy 2.4: Expand the capacity of the Colorado School for the Deaf and the Blind (CSDB) as a statewide resource for children and youth who are deaf and hard of hearing to support early identification and intervention for mental health and substance abuse needs.</p>	<p>Deaf and hard of hearing children’s mental health needs are identified early and services are provided in treatment and education appropriate settings.</p>
<p>Strategy 2.5: Increase Colorado’s capacity to provide appropriate in-patient services to deaf and hard of hearing individuals.</p>	<p>Deaf and hard of hearing adults and children with mental health and substance abuse needs can communicate with their providers and other patients during inpatient treatment, improving treatment outcomes.</p>

Goal #3: Consistency in the Availability and Quality of Services Statewide: Colorado adopts and monitors statewide standards for mental health and substance abuse services to deaf and hard of hearing individuals and their families.	
Strategies	Outcomes
Strategy 3.1: Develop and adopt Guidelines for Care in partnership with the Colorado Department of Health Care Policy and Financing, deaf and hard of hearing leaders and consumers, the Office of Behavioral Health, and other providers and service delivery systems.	Statewide consistency in the accessibility of outreach, emergency services, inpatient and outpatient services, other program and services, consumer choice, and technology for deaf and hard of hearing consumers with mental health and substance abuse needs and their families.
Strategy 3.2: Work with child welfare, juvenile and criminal justice, education, and other systems to develop standards for services to deaf and hard of hearing individuals and their families.	Deaf and hard of hearing individuals with mental health and substance abuse needs and their families are connected to linguistically and culturally competent services.
Strategy 3.3: Expand monitoring and oversight of service delivery providers to include monitoring compliance with guidelines and standards related to service to deaf and hard of hearing individuals and their families.	Mental health and substance abuse services to deaf and hard of hearing individuals and their families are consistent, appropriate, and of high quality.

Goal #4: Consumer and Family Leadership: Colorado's deaf and hard of hearing consumer, family, and youth advocates participate in service delivery, governance, policymaking, and monitoring/evaluation of the mental health and substance abuse systems.	
Strategies	Outcomes
Strategy 4.1: Provide advocacy trainings accessible to the deaf/hard of hearing and support the advocates as they develop a network of support among each other.	A network of deaf and hard of hearing consumers and their families who are trained and prepared to participate in service delivery, governance, policymaking, and monitoring/ evaluation of the mental health and substance abuse systems.
Strategy 4.2: Engage and support deaf and hard of hearing advocates in service delivery, governance, policymaking, and monitoring/evaluation settings.	Participation of deaf and hard of hearing consumers and their families on governance and policymaking boards at the state and local levels.

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Introduction and Background

In 1990, Colorado developed a state plan for mental health services for deaf and hard of hearing individuals. The needs assessment leading to the plan highlighted the services available at the Mental Health Center of Denver and Pikes Peak Mental Health Center and the in-patient services through the Colorado Mental Health Institute at Fort Logan. It also identified areas of the state where no services were available. The plan recommended increased service access and coordination statewide, as well as state level leadership to implement the plan and build the system. A 2002 report from the State Department of Education similarly identified gaps in services to the deaf and hard of hearing children, noting a lack of trained mental health providers, resulting in a failure to address the needs of deaf and hard of hearing children and their families.

Many of the issues identified in the 1990 plan and 2002 report are still a concern today, and many of the recommendations still need to be implemented. This second round of action planning builds on the previous work in Colorado to address the needs of deaf and hard of hearing individuals. The current Task Force charged with developing the plan expanded the focus from mental health to both mental health and substance abuse, in recognition of their frequent co-occurrence. The planning process included significant effort to learn from other states and draw on their strategies to reform policies and practices (see Appendix A). A 2008 survey of Colorado consumers, providers, and administrators supports the continued need to develop a mental health and substance abuse system for deaf and hard of hearing individuals (see Appendix B), and aligns with findings from a similar Colorado Department of Education study in 2007. In particular, the survey highlights that even where services are being provided to deaf and hard of hearing individuals, they may not be provided in a manner that is appropriate, as defined by the many national organizations focused on improving mental health and substance abuse services for this population.

Deaf and Hard of Hearing Individuals

To understand how to best meet the mental health and substance abuse needs of deaf and hard of hearing individuals, it is important to recognize that they are not one homogeneous community, but rather have diversity in their communication modes, culture, and needs. For the purposes of this plan, the term *deaf and hard of hearing individuals* will include individuals who would self-identify as any combination of the following:

- Deaf (uppercase): A group of people, with varying hearing acuity, whose primary mode of communication is a signed language (predominantly American Sign Language [ASL] in the United States), use a variety of forms of assistive communication technology, and have a shared heritage and culture.
- deaf (lowercase): Individuals with hearing loss who may, or may not, use ASL and do not share a heritage and culture of those who use ASL as a primary communication mode.
- Oral deaf: Individuals who are born deaf or become deaf pre-lingually, but are taught to speak and do not typically use ASL for communication.
- Hard of Hearing: Individuals who have hearing loss from mild to profound, beginning at any point during life. Functionally, hard of hearing individuals depend primarily on speech and listening for communication, augmented with visual cues and may use assistive technology, including hearing aids, cochlear implants, and captioning provided in real-time. Some individuals in this group use ASL for communication.
- Late-deafened: Individuals whose hearing loss begins in late childhood, adolescence, or adulthood, after they have developed oral language skills. Typically, late-deafened individuals communicate using assistive technology, including hearing aids, cochlear implants, and captioning provided in real-time. Some also learn to communicate in a signed language.

- Deaf-blind and Hard-of-hearing-blind: Individuals who have varying hearing and vision acuity. Their communication modes and specific needs vary enormously according to age, onset, type of deaf-blindness or hard-of-hearing-blindness, and upbringing.

The term *hearing impaired* is not used as it is a stigmatizing term that is not well received by most deaf and hard of hearing individuals because it implies that hearing loss is pathological.

Opportunities for Improvement

Some deaf and hard of hearing children and adults have better access to services than others. Adults with mental health needs in the Denver-metro area can access the specialized services at the Mental Health Center for Denver (MHCD). At MHCD, a team of professional staff are trained in American Sign Language and Signed English and provide a full array of therapeutic services, including psychiatric crisis/urgent services, psychiatric evaluation/medication follow-up, individual, group and family therapy, case management, psycho-education and supportive groups by special arrangement, outreach, and access to residential and inpatient treatment. MHCD, through special agreements negotiated with public and private insurers, is able to bill at an enhanced rate when serving deaf and hard of hearing clients, covering the additional costs associated with providing the specialized services.

The sixteen Area Agencies on Aging in Colorado, part of the Aging and Adult Services system, provide a wide range of services to seniors in Colorado, including employment, information and referral to services, in home programs, and other community-based programs and services. Other programs throughout the state provide similar outreach, and some, like the Senior Reach model in Jefferson County, provide mental health and substance abuse services directly to seniors. As many hearing needs emerge later in life, this system is a natural access point to identify mental health and substance abuse needs among late deafened and hard of hearing individuals. Typically, late deafened and hard of hearing individuals become more isolated as their hearing loss develops, may not always accept or identify as hard of hearing, and choose to stay in their home communities rather than move to where resources are more available. For all of these reason, it is important to draw on the existing networks of senior services to increase early identification of mental health and substance abuse needs related to hearing loss.

Children throughout the state can be placed in the Colorado School for the Deaf and Blind in Colorado Springs or, if they remain in their home communities, CSDB can also provide technical assistance and resources to their local school district to meet the child's needs. Children and families in Colorado Springs benefit from the deaf and hard of hearing communities and resources connected to CSDB and Pikes Peak Mental Health Center. CSDB is charged with being "a resource to school districts, state institutions, and other approved education programs. Resource services shall include the following: assessment and identification of educational needs, special curricula, equipment and materials, supplemental related services (this would include mental health support), special short-term programs, program planning and staff development, programs for parents, families and the public, research and development to promote improved educational programs and services. CSDB may, at the discretion of the board of trustees, provide additional educational services on a local or regional basis in the state." As part of achieving this mission, CSDB has developed statewide capacity for early intervention, with an Intensive Home Intervention Program, as well as a team of consultants who work with schools throughout the state. This model, allowing a centralized location to have statewide reach, may be equally applicable to the mental health and substance abuse treatment setting.

The capacity in these existing service delivery and educational settings are opportunities for all of Colorado to draw upon. Additionally, in both the metropolitan areas and around the state, private and non-profit resources are already in place to meet a variety of educational, advocacy, and other service delivery needs for deaf and hard of hearing individuals and their families. Now is the time to design and implement a similar model in the

mental health and substance abuse service system, as Colorado is currently in the process of “lighting-up” the state with technology to enable telemedicine equipment to connect mental health centers throughout the state. Over 100 sites will soon have televideo capacity, creating an opportunity to expand the reach of linguistically and culturally competent providers of mental health and substance abuse services to deaf and hard of hearing individuals throughout the state!

Providers can be encouraged to access appropriate treatment through a telemedicine model by instituting standards and providing training, technical assistance, and technology solutions. Similar to the experiences of the developmental disability community, the deaf and hard of hearing communities have not received the mental health and substance abuse treatment that they need. To address this gap, the developmental disability community worked with mental health leaders and state government on Guidelines for Care that were adopted by the Community Mental Health Program of the Colorado Department of Healthcare Policy and Financing in 2007. The development of guidelines by the developmental disability community is an opportunity for the deaf and hard of hearing communities to replicate, following a similar path to ensure standards are in place.

Additionally, the need for technical assistance and training to help providers understand the needs of their consumers, as well as strategies to meet those needs, has been met in other Colorado systems through the use of centralized training and technical assistance hubs. The School for the Deaf and Blind already models this approach in their partnership with schools statewide. Other systems have created this type of centralized capacity as well, including in healthcare workforce recruitment (Colorado Rural Health Center), emergency management for schools (Readiness and Emergency Management for Schools Technical Assistance Center), and family-centered and responsive services (Colorado Foundation for Families and Children). A similar model specific to deaf and hard of hearing mental health and substance abuse services could address the current geographic inequity in services.

In 2000, the Colorado Legislature created the Colorado Commission for the Deaf and Hard of Hearing, housed in the Colorado Department of Human Services. The Commission is charged with serving as a liaison between the deaf and hard of hearing communities and the Legislature, Governor, and Colorado Departments by centralizing and unifying resources for interpreters, teletype machines, and other resources to enable access. Additionally, the Commission is charged with assessing the needs of the deaf and hard of hearing communities, identifying methods, programs or policies to improve communication accessibility and quality of services, and specifically identifying how the state may improve implementation of state policies and access to governmental services. Finally, the Commission is intended as an informational resource to deaf and hard of hearing individuals statewide. Within this charge exists the opportunity for leadership from the Commission for the implementation of a plan to increase access to and quality of public mental health and substance abuse services to deaf and hard of hearing individuals in Colorado.

The Action Plan

Building on these many opportunities and addressing the challenges that have been consistently identified in Colorado since the 1990 plan, the Action Plan has four goals and with eleven strategies to accomplish the goals. The goals are:

Goal #1: Governance Structure: Colorado has a governance structure to implement, support, oversee, evaluate, and sustain systemic reform in the mental health and substance abuse systems to meet the needs of deaf and hard of hearing individuals.

Goal #2: Statewide Capacity: Colorado provides a statewide continuum of high quality mental health and substance abuse services to deaf and hard of hearing individuals and their families, coordinated through a Technical Assistance and Education Center and a Statewide Service Delivery Network, with capacity to support consumers, their families, and providers throughout the state.

Goal #3: Consistency in the Availability and Quality of Services **Statewide:** Colorado adopts and monitors statewide standards for mental health and substance abuse services to deaf and hard of hearing individuals and their families.

Goal #4: Consumer and Family Leadership: Colorado's deaf and hard of hearing consumer, family, and youth advocates participate in policymaking, governance, monitoring, evaluation, and service delivery in the mental health and substance abuse systems.

The appendices to the plan also include the findings from a nationwide literature review and results of a Colorado survey of deaf and hard of hearing consumers and mental health and substance abuse providers and administrators.

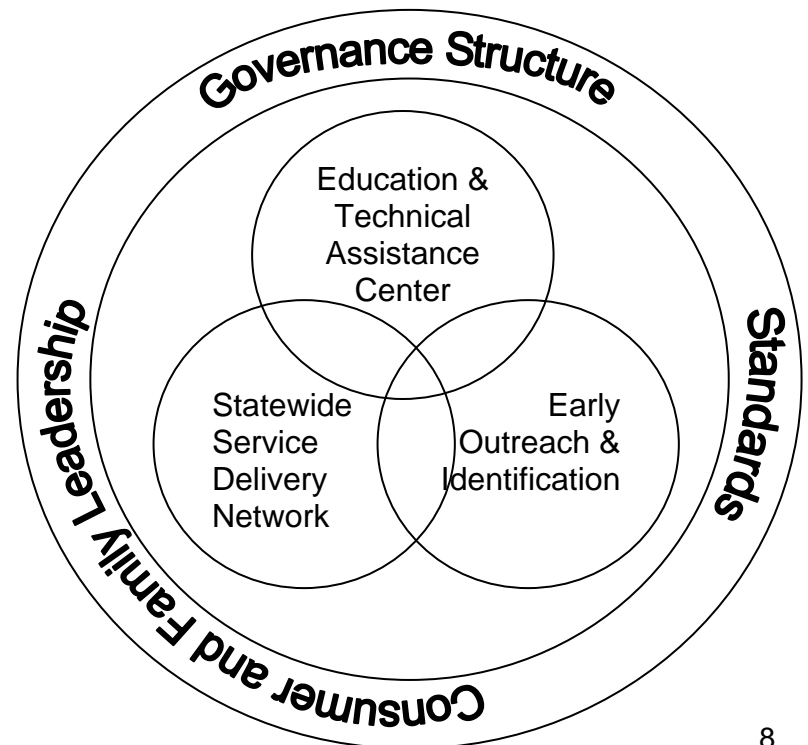
Components of the Action Plan

The Goals, Strategies, and Actions center around a statewide system built on three essential legs (Goal #2, Statewide Capacity Building):

- **A Technical Assistance and Education Center** to provide technical assistance and training, including working with providers to increase their access to and competency with technology that can assist in communicating with deaf and hard of hearing individuals.
- **A Statewide Service Delivery Network**, to provide direct mental health and substance abuse services statewide to deaf and hard of hearing consumers and their families, using telemedicine and other technology to connect providers and consumers.
- **Early Outreach and Identification**, using existing capacity in Colorado's communities to identify mental health needs among children and seniors who are deaf and hard of hearing and connect them to early intervention resources.

Supporting the three legs of the system are three essential components (Goals #1, #3, and #4):

- **A Governance Structure** to ensure the successful implementation of the plan and long-term implementation, and oversight of between systemic reform in the mental health and substance abuse systems to meet the needs of deaf and hard of hearing individuals.
- **Standards** that assist providers in understanding how to best provide services to deaf and hard of hearing consumers, as well as allow the state to monitor the success of service delivery.
- **Consumer and Family Leadership** from the deaf and hard of hearing communities, with participation from consumers and family leaders in the policymaking structures of the mental health and substance abuse systems.



Goal #1: Governance Structure

Colorado has a governance structure to implement, support, oversee, evaluate, and sustain systemic reform in the mental health and substance abuse systems to meet the needs of deaf and hard of hearing individuals.

Strategies	Actions	Outcomes
<p>Strategy 1.1: Develop sustainable capacity within the Colorado Commission for the Deaf and Hard of Hearing to implement and evaluate systemic reform of the mental health and substance abuse systems to meet the needs of deaf and hard of hearing individuals.</p>	<ul style="list-style-type: none"> • Convene an Implementation Team of key state agencies and deaf and hard of hearing leaders, charged with overseeing and supporting the implementation of this Action Plan. • Determine funding needs for the implementation of the Action Plan and secure the funding. • Secure funding for the evaluation of the Action Plan implementation, including: <ul style="list-style-type: none"> ○ Tracking strategies and activities completed and revised as well as any barriers to implementation. ○ Evaluating changes in state policy, state practice, local governance, and service delivery as well as monitoring consumer and family outcomes and satisfaction. ○ Developing and adopting a sustained evaluation strategy for tracking the changes to the system and consumer and family outcomes and satisfaction with services. • Work with the Division of Behavioral Health to identify and sustain a representative on the Commission and to the Implementation Team. 	<p>Oversight and accountability to the implementation of the Action Plan.</p> <p>Ongoing expertise on mental health and substance abuse on the Commission.</p> <p>Ongoing monitoring and evaluation of the success of the mental health and substance abuse system at meeting the needs of deaf and hard of hearing individuals and their families.</p>
<p>Strategy 1.2: Expand participation of deaf and hard of hearing individuals within the mental health and substance abuse policymaking bodies to address the needs of deaf and hard of hearing individuals.</p>	<ul style="list-style-type: none"> • Identify the priority policymaking venues for deaf and hard of hearing leaders to participate, such as the Medical Advisory Board and the Mental Health Planning and Advisory Council. If appropriate, secure formal appointments to such boards and ensure compensation for their participation (e.g. stipends, consultation fees, mileage reimbursement, child care, etc.). • Work with the identified policymaking bodies to secure long-term communication access for deaf and hard of hearing participants. 	<p>Ongoing communication and collaboration between deaf and hard of hearing communities and decision-making entities in the mental health and substance abuse systems.</p> <p>Decisions made by the mental health and substance abuse system respect the unique needs of deaf and hard of hearing individuals and their families.</p>

Goal #2: Statewide Capacity

Colorado provides a statewide continuum of high quality mental health and substance abuse services to deaf and hard of hearing individuals and their families, coordinated through a **Technical Assistance and Education Center** and a **Statewide Service Delivery Network**, with capacity to support consumers, their families, and providers throughout the state.

Strategies	Actions	Outcomes
<p>Strategy 2.1: Establish a Technical Assistance and Education Center that provides technical assistance, training, workforce development, and leadership to mental health centers, substance abuse providers, child welfare, juvenile justice, criminal justice, aging services and senior centers, federally qualified health centers and other healthcare providers, vocational rehabilitation, workforce centers, education, private providers, and other providers and systems statewide.</p>	<ul style="list-style-type: none"> • Identify the organizational home for the Technical Assistance and Education Center and define its staffing, technology, and budget needs. • Secure start-up and sustainable funding for the Technical Assistance and Education Center, including identifying training and technology funding streams from other service delivery systems that will benefit from the work of the Center. Develop strategies for funding technical assistance, training, and technology, including fee-for-service strategies. • Develop technical assistance, trainings, and strategies for engaging providers of mental health and substance abuse services to increase their capacity to appropriately identify, assess, and serve deaf and hard of hearing consumers. • Develop technical assistance, trainings, and strategies for engaging providers of all types of services to increase their capacity to accurately identify and refer deaf and hard of hearing individuals to mental health and substance abuse services. • Develop technical assistance, training, and other strategies for aiding providers in the purchase, use, and maintenance of technology to enable better service delivery to deaf and hard of hearing individuals. Include technology strategies such as hearing aid-compatible telephones, closed-captioned televisions, open-captioned video materials, video phones, amplified and captioned telephones, telecommunication devices for the deaf (TDD, TTY), and computer-based communication (e.g. email and instant messaging). • Partner with the Colorado Behavioral Healthcare Council and other leaders in telemedicine statewide to ensure the application of the technology supports efforts to connect deaf and hard of hearing consumers to culturally and linguistically competent mental health and substance abuse providers. Ensure the needs of deaf and hard of hearing individuals and their families are addressed in telemedicine standards as they are developed. Particularly explore how telemedicine equipment can be adapted to work successfully with hard of hearing individuals who do not use ASL. • Develop and disseminate technical assistance materials specifically on strategies for 	<p>Mental health, substance abuse, and other providers and systems statewide have the assistance they need to ensure their outreach, access, and service delivery are linguistically, technologically, and culturally appropriate for deaf and hard of hearing individuals and their families.</p>

Goal #2: Statewide Capacity

Colorado provides a statewide continuum of high quality mental health and substance abuse services to deaf and hard of hearing individuals and their families, coordinated through a **Technical Assistance and Education Center** and a **Statewide Service Delivery Network**, with capacity to support consumers, their families, and providers throughout the state.

Strategies	Actions	Outcomes
	<p>covering costs of interpreters and communication technology, including billing codes for communication services and strategies for negotiating with public and private insurers to cover the additional costs associated with serving deaf and hard of hearing individuals.</p> <ul style="list-style-type: none">• Develop and disseminate videos, brochures, manuals, and website resources to provide guidance to community providers seeking to make their policies and service systems more appropriate and accessible to deaf and hard of hearing consumers.• Compile and update yearly a database of providers who have successfully met or exceeded best practice standards for service deaf and hard of hearing individuals. Use currently existing systems for evaluation and monitoring of providers to gather the information (see Strategy 3.3).• Develop and disseminate materials specifically for deaf and hard of hearing consumers in accessible formats such as ASL and closed captioned videos, addressing consumer rights, diagnoses, treatment options, and types of services.• Connect Technical Assistance and Education Center resources to state agency and provider websites and clearinghouses to increase their visibility and accessibility.	

Goal #2: Statewide Capacity

Colorado provides a statewide continuum of high quality mental health and substance abuse services to deaf and hard of hearing individuals and their families, coordinated through a **Technical Assistance and Education Center** and a **Statewide Service Delivery Network**, with capacity to support consumers, their families, and providers throughout the state.

Strategies	Actions	Outcomes
<p>Strategy 2.2: Establish a workforce development initiative to expand access for deaf and hard of hearing individuals to mental health and substance abuse direct service providers, interpreters, CART providers, and communication technology.</p>	<ul style="list-style-type: none"> • Create an ongoing workforce development initiative within the Technical Assistance and Education Center that partners with Universities, providers, deaf and hard of hearing organizations, the Colorado Rural Health Center, the Area Health Education Centers, and local communities to: <ul style="list-style-type: none"> ○ Incorporate deaf and hard of hearing issues into existing trainings already underway throughout the state for mental health, substance abuse, child welfare, juvenile justice, criminal justice, and other providers statewide. ○ Recruit deaf and hard of hearing individuals into training and education programs for a wide range of mental health and substance abuse specialties. ○ Create and sustain internship opportunities in a wide variety of service delivery systems for deaf and hard of hearing individuals trained in mental health and substance abuse specialties. ○ Train and support deaf and hard of hearing individuals to provide peer services in their local communities, including facilitating support groups and serving as <i>cultural brokers</i> who can help their deaf and hard of hearing peers access services through a wide range of providers. ○ Create placement opportunities for deaf and hard of hearing peer service providers within local mental health centers and substance abuse provider organizations. ○ Review licensure requirements for mental health and substance abuse providers at all levels to identify barriers for deaf and hard of hearing individuals to become licensed. ○ Recruit new interpreters and CART (Computer Aided Real-Time) providers throughout Colorado. ○ Ensure training and licensing of interpreters and CART providers addresses the need for providers who are competent in mental health and substance abuse settings. ○ Provide ongoing training to technology staff throughout the state to maintain and operate assistive communication technology, particularly in rural communities. 	<p>Colorado's mental health and substance abuse workforce has the capacity to meet the needs of deaf and hard of hearing individuals and their families within the mental health and substance abuse systems.</p> <p>Colorado's interpreters and CART providers have the capacity to meet the needs of deaf and hard of hearing individuals and their families within the mental health and substance abuse systems.</p>

Goal #2: Statewide Capacity

Colorado provides a statewide continuum of high quality mental health and substance abuse services to deaf and hard of hearing individuals and their families, coordinated through a **Technical Assistance and Education Center** and a **Statewide Service Delivery Network**, with capacity to support consumers, their families, and providers throughout the state.

Strategies	Actions	Outcomes
<p>Strategy 2.3: Establish a Statewide Service Delivery Network that provides direct services in mental health and substance abuse for deaf and hard of hearing consumers statewide.</p>	<ul style="list-style-type: none"> • Identify a leadership, fiscal, and administrative structure for the Statewide Service Delivery Network (the Network) to coordinate providers statewide and facilitate providing contract services statewide through a telemedicine system. • Identify culturally and linguistically competent providers and providers with experience working with deaf and hard of hearing individuals statewide to include in the Network. • Identify additional specialized providers inside and outside the state who can be connected into the Network to expand capacity to serve populations with complex needs and from diverse backgrounds. • Develop a plan for increasing regional level capacity over time as workforce development initiatives expand the availability of providers throughout the state. • Connect the Network to other providers and service delivery systems through contracts, technology, and billing agreements with public and private insurers. • Connect or co-locate the Network and Technical Assistance and Education Center to ensure providers statewide are trained in appropriate identification, assessment, and referral of deaf and hard of hearing consumers. • Connect the Network to existing deaf and hard of hearing organizations to develop trusted relationships and referral opportunities within the deaf and hard of hearing communities. 	<p>Deaf and hard of hearing consumers and their families throughout the state can easily access a comprehensive array of high quality mental health and substance abuse services.</p> <p>Direct service providers specializing in working with deaf and hard of hearing individuals and their families work together in a supportive, technology appropriate setting allowing for high quality service provision.</p>

Goal #2: Statewide Capacity

Colorado provides a statewide continuum of high quality mental health and substance abuse services to deaf and hard of hearing individuals and their families, coordinated through a **Technical Assistance and Education Center** and a **Statewide Service Delivery Network**, with capacity to support consumers, their families, and providers throughout the state.

Strategies	Actions	Outcomes
<p>Strategy 2.4: Establish Early Identification and Intervention capacity by building on the Colorado School for the Deaf and the Blind (CSDB) existing role as a statewide resource for children and youth who are deaf and hard of hearing.</p>	<ul style="list-style-type: none"> • Expand training for providers in the Colorado Home Intervention Program (CHIP) to include identification of possible mental health needs of young children who are deaf and hard of hearing and support for their families • Support efforts to increase the CSDB’s capacity to meet the needs of children and youth who are deaf and hard of hearing that may also have substance abuse and mental health needs. • Through the use of technology, connect schools throughout the state with the Statewide Service Delivery Network to ensure appropriate interagency collaboration in addressing the mental health needs of children who are deaf and hard of hearing. 	<p>Deaf and hard of hearing children’s mental health needs are identified early and services are provided in treatment and education appropriate settings.</p>
<p>Strategy 2.5: Increase Colorado’s capacity to provide appropriate residential and in-patient services to deaf and hard of hearing individuals.</p>	<ul style="list-style-type: none"> • Identify existing adult and child residential and in-patient programs in Colorado to participate in a demonstration program specific to deaf and hard of hearing individuals. Ensure demonstration sites: <ul style="list-style-type: none"> ○ Renovate the physical environment to be deaf and hard of hearing accessible, including visual alarms and signals instead of auditory and communication technology access. ○ Include deaf and hard of hearing staff members and sign-fluent nursing, patient care staff, and treatment professionals. • Work with residential and in-patient programs in Colorado receiving public funds including the demonstration sites, to connect them with the Technical Assistance and Education Center and the Statewide Service Delivery Network: <ul style="list-style-type: none"> ○ To ensure appropriate providers are available to deaf and hard of hearing individuals whose needs vary in type and severity. ○ Establish plans for transition services and supports as deaf and hard of hearing consumers transition back to their communities. ○ Adapt physical environments to meet the needs of deaf and hard of hearing individuals. 	<p>Deaf and hard of hearing adults and children with mental health and substance abuse needs can communicate with their providers and other patients during residential and in-patient treatment, improving treatment outcomes.</p>

Goal #3: Consistency in the Availability and Quality of Services Statewide

Colorado adopts and monitors statewide standards for mental health and substance abuse services to deaf and hard of hearing individuals and their families.

Strategies	Actions	Outcomes
<p>Strategy 3.1: Develop and adopt Guidelines for Care in partnership with the Colorado Department of Health Care Policy and Financing, deaf and hard of hearing leaders and consumers, the Office of Behavioral Health, and other providers and service delivery systems.</p>	<ul style="list-style-type: none"> • Convene a committee of State Department representatives, deaf and hard of hearing leaders and consumers, local providers and administrators of services, and other interested parties to develop <i>Guidelines for Care for Mental Health and Substance Abuse Services to Deaf and Hard of Hearing Individuals and Their Families</i> addressing: <ul style="list-style-type: none"> ○ Appropriate and best practice service delivery models for deaf and hard of hearing individuals and their families; ○ Consumer choice in communication strategies, services, and providers; ○ Accessibility of outreach programs, front door/gatekeeper staff, emergency services, out-patient, and in-patient services; ○ Accessibility of telemedicine technology to connect with the Statewide Service Delivery Network; ○ Continuum of services available; ○ Qualifications of communications providers including interpreters and CART providers. • Work with the Department of Health Care Policy and Financing to ensure the guidelines are adopted as part of the Community Mental Health Services Program, CHP+, and other appropriate programs. • Develop a consumer grievance process that is visible and easily accessible to deaf and hard of hearing individuals and their families to identify problems with the implementation of the Guidelines. • Identify the technical assistance, training, and technology needed by mental health and substance abuse providers to meet the standards. Ensure the priorities of the Technical Assistance and Education Center align with the needs of the providers. • Identify the service array and capacity needed for providers to meet the standards. Ensure the priorities of the Statewide Service Delivery Network align with these needs of the providers. 	<p>Statewide consistency in the accessibility of outreach, emergency services, inpatient and outpatient services, other program and services, consumer choice, and technology for deaf and hard of hearing consumers and their families with mental health and substance abuse needs.</p>

Goal #3: Consistency in the Availability and Quality of Services Statewide

Colorado adopts and monitors statewide standards for mental health and substance abuse services to deaf and hard of hearing individuals and their families.

Strategies	Actions	Outcomes
<p>Strategy 3.2: Work with child welfare, juvenile and criminal justice, education, and other systems to develop standards for services to deaf and hard of hearing individuals and their families.</p>	<ul style="list-style-type: none"> • Convene a committee of representatives from the deaf and hard of hearing communities and state child welfare, juvenile and criminal justice, education, and other systems to create and adopt best practice standards to ensure deaf and hard of hearing individuals and their families are appropriately assessed for mental health and substance abuse needs and, if needed, connected to culturally and linguistically competent services. • Work with the Division of Behavioral Health, Colorado Department of Regulatory Affairs, and other state agencies to develop specialization standards for therapists working with deaf and hard of hearing individuals and their families. • Work with the Division of Behavioral Health, Colorado Department of Regulatory Affairs, and other state agencies to develop licensing or other standards for interpreters and CART providers. • Work with the Division of Behavioral Health to develop specialization standards for substance abuse providers working with deaf and hard of hearing individuals and their families. 	<p>Deaf and hard of hearing individuals with mental health and substance abuse needs and their families are connected to linguistically and culturally competent services.</p>
<p>Strategy 3.3: Expand monitoring and oversight of service delivery providers to include monitoring compliance with guidelines and standards related to service to deaf and hard of hearing individuals and their families.</p>	<ul style="list-style-type: none"> • As guidelines and standards are adopted in mental health, substance abuse and other service delivery systems, identify and implement monitoring mechanisms to incorporate into current monitoring and evaluation activities. • At least yearly, assess compliance with guidelines and standards using data from the monitoring mechanisms. • At least yearly, revisit the success of the guidelines in partnership with the oversight agencies for each service delivery system. 	<p>Mental health and substance abuse services to deaf and hard of hearing individuals and their families are consistent, appropriate, and of high quality.</p>

Goal #4: Consumer and Family Leadership

Colorado's deaf and hard of hearing consumer, family, and youth advocates participate in policymaking, governance, monitoring, evaluation, and service delivery in the mental health and substance abuse systems.

Strategies	Actions	Outcomes
<p>Strategy 4.1: Provide advocacy trainings accessible to the deaf and hard of hearing individuals and their families and support the advocates as they develop a network of support among each other.</p>	<ul style="list-style-type: none"> • The Technical Assistance and Education Center partners with deaf and hard of hearing advocacy organizations already trusted by the communities, as well as health and mental health consumer and family organizations, to implement advocacy trainings specifically for deaf and hard of hearing individuals and their families. • The Center partners with deaf and hard of hearing advocacy organizations as well as health and mental health consumer and family organizations, to create an ongoing support network among trained advocates, including using websites and other technology to support the network of advocates. 	<p>A network of deaf and hard of hearing consumers and their families who are trained and prepared to participate in policymaking, governance, monitoring, evaluation, and service delivery in the mental health and substance abuse systems.</p>
<p>Strategy 4.2: Engage and support deaf and hard of hearing advocates in service delivery, governance, policymaking, and monitoring/evaluation settings.</p>	<ul style="list-style-type: none"> • The Center partners with the Colorado LINKS for Mental Health subcommittees on Family and Youth Involvement in Policymaking and Budget, Funding, and Finance to ensure funding strategies for family, youth, and consumer involvement include funding accommodations for deaf and hard of hearing individuals. • The Center partners with the Colorado Commission for the Deaf and Hard of Hearing to place trained advocates on appropriate policymaking boards in the mental health and substance abuse systems. 	<p>Participation of deaf and hard of hearing consumers and their families on governance and policymaking boards at the state and local levels.</p>

Appendix A: Literature Review

State Policy Options for Meeting the Mental Health and Substance Abuse Needs of Deaf and Hard of Hearing Individuals and Their Families

Prepared in July 2008 by Jewlya Lynn, Denise McHugh, & Pa'Ticia Moion,
Center for Systems Integration

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Executive Summary and Matrix of Policy Options

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

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

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

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

Mental Health and Substance Abuse Services:	Fiscal Policy Change	Other State Policy or Practice Change
Increase deaf/hard of hearing awareness of services	Develop funding strategies for culturally appropriate psycho-education specific to this community.	Ensure service array includes prevention programs and activities specifically for families with deaf children (Missouri).
Increase competency to work with deaf/hard of hearing within existing workforce		Develop and implement strategies for training interpreters on cultural and linguistic needs of their consumers (Missouri).
Increase access to deaf/hard of hearing providers	Develop a financing mechanism to support regional teams of deaf/hard of hearing providers (social work, mental health, substance abuse, advocates/navigators, etc.) that work across catchment areas (Missouri). Mandate coverage by public/private insurers for additional costs associated with providing services to this population, including ensuring an enhanced billing code is available (Denver).	Develop targeted recruitment and training efforts to increase the number of deaf/hard of hearing providers (Missouri). Develop standards to ensure appropriate referrals are made so that deaf/hard of hearing consumers receive linguistically /culturally competent services.
Increase awareness of deaf/hard of hearing issues among providers		Develop and disseminate brochures and training materials to providers statewide (Missouri).
Increase access to interpreters who are trained & competent in mental health and substance abuse settings		Increase use of video relay interpreting to ensure access to competent interpreters. Create state standards defining a qualified interpreter in a mental health or substance abuse setting.
Need for telemedicine access within and between provider networks	Ensure all services appropriate for telemedicine can be billed as telemedicine services. Ensure provider networks have a mechanism in place for billing for providers outside catchment areas, accessed via telemedicine.	Work with providers to ensure that telemedicine equipment is standardized statewide. Include requirements in state contracts / standards requiring telemedicine equipment and plans for meeting deaf/hard of hearing needs, and monitor and provide technical support (Illinois).
Need for videophone access to treatment	Ensure all services appropriate for videophones can be billed.	Develop mechanisms for providers and consumers to access videophone equipment. Develop standards for ethical and confidential use of videophones for treatment.
Need for all deaf/hard of hearing consumers to have communication access	Identify funding options for providers and consumers to increase their access to assistive technology (e.g. amplification technology, CART, TTY/TDD, etc.).	Create standards in provider contracts related to the range of assistive technology that must be available, including during treatment and when a consumer is attempting to access treatment (Missouri).

Mental Health and Substance Abuse Services:	Fiscal Policy Change	Other State Policy or Practice Change
Need for deaf/hard of hearing consumers to be aware of their rights and treatment options		Develop ASL videos explaining patient rights, diagnoses, and treatment options (Missouri).
Need to ensure deaf/ hard of hearing consumers have choices in services and supports		Work with providers to engage cultural brokers or technology as a means for ensuring consumers have a choice in providers and types of services.
Need to ensure that the full range of mental health, substance abuse, and related services are linguistically and culturally competent		Develop standards throughout the service delivery systems that focus on consumer choice in communication mechanism and providers.

Quality Monitoring and Evaluation:	Fiscal Policy Change	Other State Policy or Practice Change
Need to understand if changes to the system are resulting in increased access and satisfaction with services.		Develop program evaluation activities in partnership with the deaf/hard of hearing communities to ensure they overcome linguistic and cultural barriers. Recognize limitation of written consumer satisfaction surveys (Missouri).

Introduction and Overall Themes

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

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

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

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

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

State Governance and Planning

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

Deaf/Hard of Hearing Governance and Planning Structures

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

Colorado has partially met these recommendations, with the Colorado Commission for the Deaf/hard of hearing, housed in the Colorado Department of Human Services. The Commission created a temporary Task Force to study mental health and substance abuse issues. Task Force members include individuals who are deaf/hard of hearing, advocacy organizations, providers and provider associations, the state Medicaid

agency, and others. It does not, however, explicitly include any deaf or hard of hearing consumers of mental health and substance abuse services. Colorado also has a State Coordinator that is housed in the department and is a Task Force member and chair of the Commission.

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

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

Successful advisory structures like these can accomplish meaningful change. In Illinois, the Deaf Mental Health Task Force has developed service accessibility standards, a technical support and adherence monitoring system, and the beginnings of a statewide telepsychiatry service, along with establishing new treatment and independent-living programs (Mundro-Ludders, Simpatico, & Zvetina, 2004).

Integrating Governance and Planning Structures

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

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

State Level Financing Issues

All of the components of a successful mental health and substance abuse system for deaf/hard of hearing individuals discussed in this literature review require funding. While many may be able to be funded using current funding streams, it would be a mistake not to specifically explore

funding strategies. Funding is required at multiple levels to successfully meet the mental health and substance abuse needs of deaf/hard of hearing individuals:

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

Funding Governance and Planning Structures

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

Funding Direct Service Delivery

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

Local Example, Mental Health Center of Denver: Here in Colorado, the Mental Health Center of Denver has had success in securing funding to cover the additional expenses of providing services to deaf/hard of hearing individuals. In a study prepared by the center, they found culturally appropriate services to the deaf/hard of hearing cost approximately 20% more than for other populations. Using this study, they have been able to negotiate with public and private insurers to use an enhanced billing code to cover the costs of the specialized services.

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

Funding for Workforce Development

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

State Policy to Support Consumer & Family Leadership

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

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

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

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

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

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

At the policy and governance level, barriers can include:

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

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

State Policy Related to Mental Health and Substance Abuse Services

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

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

Barriers to Seeking Services

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

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

State Policies to Address Barriers to Seeking Services

Many of the strategies to address these barriers will also be of value when addressing more general service access and utilization barriers, thus workforce development and similar strategies will be discussed later. Specific to seeking services, a couple of state policy strategies may be of use:

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

Barriers to Accessing and Utilizing Services

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

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

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

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

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

State Policies for Addressing Workforce Development

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

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

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

1. Increase capacity for existing workforce to provide services by developing and implementing mechanisms for training staff on cultural and linguistic needs of their deaf/hard of hearing consumers (Missouri's short-term strategy).
2. Increase number of competent deaf/hard of hearing providers within the workforce through targeted workforce recruitment and training efforts (Missouri's long-term strategy).
3. Develop regional teams to provide competent services to deaf/hard of hearing, with a mix of skills and specialties on each team (Missouri's strategy).

4. Development of statewide teams, particularly in the area of crisis intervention and referral, to address the urgent and immediate needs of deaf/hard of hearing individuals and ensure they are able to access appropriate longer-term services (National Association of the Deaf, 2008).
5. Mandates that ensure public and private mental health providers ensure referrals to appropriate, specialized services for the deaf/hard of hearing, including defining what “appropriate” is for this population (National Association of the Deaf, 2008).
6. Mandate coverage by public and private insurers for the additional costs associated with providing services to deaf/hard of hearing consumers (National Association of the Deaf, 2008).

Training Providers: Many of these strategies include training of non-deaf/hard of hearing providers to increase their competence in working with these consumers. Training could include information on the unique biological, developmental, social, and cultural implications of deafness (Glickman & Gulati, 2003) as well as the mental health issues arising from developing a hearing impairment later in life. Strategies for training staff could include developing classes, workshops, conferences, and community events that are specific to mental health and substance abuse staff or more broadly engage human services professionals who deliver services to this population. The training might benefit from being coordinated with academic institutions who are already engaging in training with these providers. Regardless of how it is provided, the training must address the need for clinicians and other health professionals to have knowledge and skills to increase their ability to work successfully with deaf/hard of hearing consumers (Connolly, Rose, & Austen, 2006).

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

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

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

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

Along with training programs and other workforce development strategies, Missouri has defined the state role to include developing and disseminating information materials for providers and consumers. The state has committed to disseminating a brochure on the general needs of

deaf/hard of hearing consumers in a wide variety of therapeutic settings, including both mental health and substance abuse treatment. The brochure includes suggested changes to make the settings more linguistically and culturally appropriate (Critchfield, 2006).

State Policies for Expanding Availability of Trained Interpreters

Training to increase the cultural competence of the current workforce will only benefit deaf/hard of hearing consumers who use sign language if their interpreters are also culturally competent. It is important to keep in mind that sign language interpreters are not only interpreting between two different languages, they are interpreting between two different modalities (signed and spoken), where the relationship between the source and the target can be highly complex. For this reason, a sign language interpreter, particularly in a medical setting, may face extreme linguistic and cultural difficulties interpreting the language used in these settings (Paijmans, Cromwell, & Austen, 2006). Additionally, interpreters who are not familiar with mental health and substance abuse settings may not be prepared for the traumatic content that can be revealed in such settings. It may be necessary to prepare the interpreter for the content of the session, debrief the interpreter afterwards, or otherwise accommodate the interpreter's needs in such a challenging situation (National Child Traumatic Stress Network, 2004).

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

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

State Policies on Telemedicine to Increase Access to Appropriate Providers

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

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

Videophones and telemedicine are strategies that may help in addressing the barriers to developing a competent workforce in areas where the total population of deaf/hard of hearing individuals is proportionally very small. Specific state policy actions to build telemedicine and videophone

capacity for this population include establishing service delivery standards around accessibility, providing technical support and monitoring to the telemedicine system, and beginning the development of the statewide system (Mundro-Ludders, Simpatico, & Zvetina, 2004).

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

State Policies on Other Technology to Increase Access

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

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

State Policies to Ensure Appropriate Service Array is Available

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

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

- Ensuring employment opportunities for consumers who are deaf/hard of hearing.

- Implementing assistive technology in inpatient settings, including flashing lights for emergencies and alerting people.

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

Another strategy for ensuring the full array of services is appropriate for a deaf or hard of hearing consumer is to engage a cultural broker or other consultant from the deaf/hard of hearing community (National Child Traumatic Stress Network, 2004). Although the concept of a cultural broker is relatively new, research has shown it has improved outcomes for a variety of culturally distinct populations (Amaya et al, 2004).

State Standards to Increase Access and Utilization

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

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

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

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

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

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

Quality Monitoring/Evaluation

Any changes made to state policies and practices must be evaluated to ensure successful implementation at the service delivery level. As is true with any service delivery system, regularly conducted program evaluations help to ensure goals are being met and true improvements are made in consumer outcomes. However, with the deaf/hard of hearing population, new and unique “language-free” measures may be needed to capture improved outcomes (Critchfield, 2006). For example, traditional consumer satisfaction surveys may be inaccessible to deaf/hard of hearing individuals who have limited English proficiency. If they are dependent on their provider or interpreter to understand and respond to the survey, their answers may not be as open and critical as they would otherwise.

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

Conclusion: Areas for Focus in the Planning Process

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

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

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

References

- Alvarez, J., Adebajo, A.M., Davidson, M. K., Jason, L.A., & Davis, M.I. (2006). Oxford House: Deaf-affirmative support for substance abuse recovery. *American Annals of the Deaf*, 151(4), 418-422.
- Amaya, M., Bridgewater, R., Chaviano-Moran, R., Patnosh, J., Rhee, K., Sahami, S., SenGupta, I., Surh, D., & Torres, E. (2004). *Bridging the cultural divide in health care settings: The essential role of cultural broker programs*. National Center for Cultural Competence. Washington, DC: Georgetown University Medical Center, Center for Child and Human Development.
- Austen, S. & McGrath, M. (2006). Telemental health technology in deaf and general mental-health services: Access and use. *American Annals of the Deaf*, 151(3), 311-317.
- Center for Public Representation. (2004, March). *Memorandum of understanding between the Center for Public Representation and the Department of Mental Health regarding provision of services to Department of Mental Health clients who are deaf or hard of hearing*. Massachusetts: Childs, E., Stefan, S., & Fleischner, R.
- Colorado Department of Education. (2004, August). *Colorado quality standards: Programs and services for students who are deaf/hard of hearing*. Denver, CO: Colorado Department of Education, Exceptional Student Services.
- Commonwealth of Virginia, Department of Mental Retardation and Substance Abuse Services. (2001, October). *Consumer and family involvement project for people who are deaf or hard of hearing, late deafened or deaf-blind*. Virginia: Christensen, J., Bush, M., McLaughlin, M., Jones, E., Ebeling, B., & Baker, K.
- Commonwealth of Virginia, Mental Health Planning Council. (2001). *Summary of the Mental Health Planning Council Meeting – July 18, 2001*. Richmond, Virginia: Pacer-Ramsey, C.
- Connolly, C.M, Rose, J., & Austen, S. (2006). Identifying and assessing depression in prelingually deaf people: A literature review. *American Annals of the Deaf*, 151(1), 58.
- Critchfield, B. (2006, July 13). *Mental health commission meeting services to deaf/hard of hearing people*. Slide show presented at the meeting of the Missouri Department of Mental Health, Jefferson City, MO.
- Glickman S. & Gulati S. (2003). *Mental health care of deaf people: A culturally affirmative approach*. Mahwah, New Jersey: American Psychiatric Association.
- Hogan, M.F. (2003). The President's New Freedom Commission on Mental Health. Rockville, Maryland.
- Moore, D., McSweeney, M. (2006). Demographic characteristics and rates of progress of deaf/hard of hearing persons receiving substance abuse treatment. *American Annals of the Deaf*, 151(5), 508-512.

- Mundro-Ludders, B, Simpatico, T, & Zvetina, D. (2004). Making public mental health services accessible to deaf consumers: Illinois deaf services 2000. *American Annals of the Deaf*, 148, 396-401.
- National Association of the Deaf. (2008, June). *Position statement on mental health services for people who are deaf/hard of hearing*. Silver Spring, MD: NAD Mental Health Committee, State Directors of Mental Health, and NAD staff.
- National Child Traumatic Stress Network. (2004). *Adapted trauma treatment standards work group subgroup on the deaf/hard of hearing*. Los Angeles., and Durham, NC: Durity, R., Garry, A., Mallah, K. Nicolaisen, J., Oxman, A., Sterritt, M., Stewart, A.
- Office of the Deaf/hard of hearing. (2006, July). *Washington state strategic plan for the Washington State Department of Social and Health Services (pp.7-9)*. Washington, DC: Raff, E.
- Paijmans, R., Cromwell, J., and Austen, S. (2006). Do profoundly prelingually deaf patients with psychosis really hear voices? *American Annals of the Deaf*, 151(1), 42-48.
- Plessow-Wolfson, S & Epstein, F. (2005). The experience of story reading: Deaf children and hearing mothers' interactions at story time. *American Annals of the Deaf*, 150(4), 369.
- Russell, L. (2003, March 13). *Mental health forum*. Slide show presented at the meeting of the Wisconsin Council for the Deaf/hard of hearing, Madison, WI.
- Stefanz, S. (2004). Health care providers and interpreters for person who are deaf. *Center for Public Representations*. Retrieved June, 17, 2008, from <http://www.centerforpublicrep.org/emergency-rooms/-information-about-the-rights-of-deaf-person-to-interpreters-in-hospitals>.
- Strauss, K.P. (2002). *Memorandum*. July, 7, 2008. Technology Access Program: Gallaudet University.
- Texas Deaf-Blind Project, (2006, May). *Deaf-blind multiple disabilities medicaid waiver program*. Austin, Texas: Schoen, S.
- Vernon, M. & Leigh, I. (2007). Mental health services for people who are deaf. *American Annals of the Deaf*, 152(4), 375-379.
- Western Interstate Commission for Higher Education (WICHE). (2006, May). *Information gaps on the deaf/hard of hearing population: A background paper*. Retrieved June 15, 2008, from <http://wiche.edu/MentalHealth/InformationGapsResearchPaper.pdf>

Appendix B: Survey Results

Survey of Colorado Deaf and Hard of Hearing Consumers and their Families and Providers of Services to the Deaf and Hard of Hearing

Prepared in September 2008 by Jewlya Lynn, Center for Systems Integration

To help inform the action planning process, a survey was conducted with providers and deaf and hard of hearing individuals in Colorado. The survey used convenience sampling due to the tight time frame and lack of information on the number and contact information of the two populations of interest: providers with experience serving deaf and hard of hearing individuals and deaf and hard of hearing individuals with mental health and/or substance abuse needs. The survey invitation was sent out via email through the network of contacts involved with the Deaf and Hard of Hearing Mental Health and Substance Abuse Task Force (Task Force). The invitation went to all of the publically funded mental health centers in the state, directly to the Executive Directors. It went to deaf and hard of hearing specific providers in both mental health and education. It was disseminated via list serves and newsletters that are specific to the deaf and hard of hearing community.

The survey for providers included questions designed by Candice Tate on behalf of Western Interstate Commission on Higher Education. The survey questions overall were designed to reflect the priority issues from the literature review including service accessibility and appropriateness, range of communication options, consumer choice, service array, and outcomes for the consumers.

The results are reported in two groups: consumers and family members; and providers and administrators of services.

Results of the Consumer Survey

Among 36 consumers and family members who answered the survey, 25 identified as deaf, four as late deafened, and three as both deaf and family members of deaf or hard of hearing individuals. Ten respondents identified as hard of hearing and one respondent identified as a family member of a deaf person. Most of the respondents live in urban areas and are female.

As the total number of consumers answering each question was low, few quantitative results can be reported and no statistically significant findings can be reported. Instead, the results are reported as the qualitative, or narrative, experience of the consumers answering the survey.

The respondents were asked about their experiences with mental health and substance abuse issues through a list of possible symptoms indicating a need for services. Twenty-one of the consumer respondents reported they have felt depressed, 14 reported feeling sad about their hearing loss, and 21 reported feeling alone. Other symptoms reported by ten or fewer respondents included self-harm, harm to others, hallucinations, and feeling out of control. Only four respondents reported drinking too much and three reported using drugs too much.

Felt...	Deaf	Late deafened	Hard of Hearing
Depressed	12 of 25 (48%)	0 of 4 (0%)	5 of 10 (50%)
Sad about loss	5 of 25 (20%)	2 of 4 (50%)	7 of 10 (70%)
Alone	12 of 25 (48%)	3 of 4 (75%)	6 of 10 (60%)

Consumers had the opportunity to answer a variety of questions related to the appropriateness of services and access to an array of services. Consistently, consumers reported barriers related to providers' lack of understanding of deaf and hard of hearing issues. One of the hard of hearing consumers experiencing sadness about their hearing loss reported:

"There is a serious need to include disability education in the coursework for social workers and psychologists. They either don't get "it" (the impact of the disabilities) at all or are pitying."

A deaf consumer noted that her health issues seem to take a back burner to the issue of being deaf:

"Focusing on my health is the focus....not educating staff and leaders the language; very frustrating because I believe my recovery process will recover faster if people were educated how to work with Deaf/HH."

The respondents identified a need for more providers who are themselves deaf and hard of hearing. As one deaf respondent noted:

"Deep down I truly believe that a hearing individual will never be able to grasp the real issue... it. It is almost like having the Deaf trying to understand the Hearing world."

The need for providers who are deaf is also due to the barrier presented by having an interpreter in the room during therapy sessions. One consumer explained that she is unable to access therapy services because the presence of an interpreter prevents the conversation from being sufficiently "private."

Service Availability from the Consumer Perspective

Although mental health and substance abuse services specifically for deaf and hard of hearing consumers are available in targeted areas of the state, consumers from those areas reported not knowing about any available services. This suggests that information about the array of services available is lacking. Three deaf consumers living in urban areas reported:

"I cannot say as there aren't any services accessible for deaf and hard of hearing people in Colorado."

"There are no services for substance abuse here in CO and non deaf providers do not understand our cultural differences."

"There is a huge need for both services for the Deaf community. I was appalled to discover how much Colorado really lacks the services as well as lack of resources. We need to hire more Deaf professionals to provide these services. This will ensure

security and relief for Deaf individuals to have access to receive necessary services and have access to communication without any barriers.”

“There are absolutely no services in the city of Colorado Springs for mental health with the exception of Pikes Peak Mental Health. This makes it difficult if you have insurance since PPMH will not accept all insurances. There also needs to be a counselor here in town that signs, eliminating the need for an interpreter. It's difficult especially when the courts order counseling, whether it be individual, family or child counseling, there is not a list of counselors that sign and most private insurances will not pay for an interpreter and you can definitely count on counselors refusing to pay for interpreters even though its the law.”

A consumer in a rural area agreed with the lack of available services:

“There is insufficient or lack of deaf counseling services especially for those who live far away from the Denver area, like Northern or Southern Colorado. It would be great if there would be more deaf counselors or deaf counseling available in these areas outside Denver so they don't have to drive the long distance just to make that single trip to the appointment especially during the time of crazy skyrocketing gas prices.”

Access to Assistive Technology

Each of the deaf consumers requested many different types of communication, including interpreters, ASL competent providers, closed captioning, video phones, note takers, text messaging, instant messaging, email, and captioning devices. Among the four hard of hearing consumers, all of them preferred talking to their therapists rather than using written means of communication or interpreters. However, one consumer indicated he did not know if he understood what his therapist was saying, because it was impossible to know what he was failing to hear. The one hard of hearing consumer who had access to a range of technology options indicated they were helpful. Most hard of hearing consumers did not report that their providers used assistive technology to increase their ability to access services.

Consumer, In Patient

One consumer received treatment in an in-patient setting where communication was impossible for hours until an interpreter was found. He explained that he could not join in group activities due to lack of interpreters, and did not wake in time to participate in other activities as there was no visual alarm. His story is an example of why a full range of services need to be made accessible, not just therapy.

Consumer, Choice

Consumers noted multiple issues related to the "choices" they have available. One deaf consumer pointed out the limitation of having only a couple deaf providers as an issue of confidentiality:

“Very limited, limited to one or two therapists who can sign, yet knowing them personally made it more harder for confidentiality.”

Another consumer compared her ability to access services to the experience of hearing-enabled individuals:

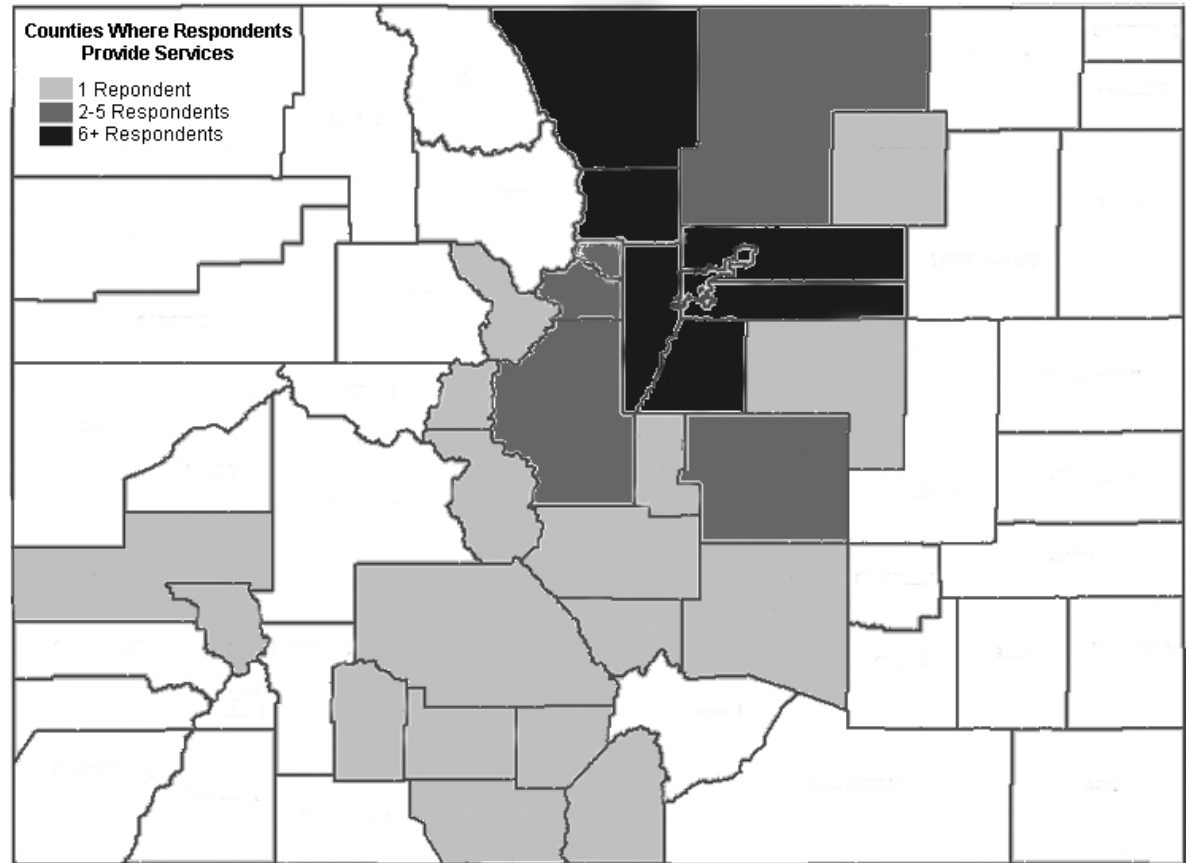
“We suffer knowing [the Mental Health Center of Denver] can't provide the basic needs for [deaf and hard of hearing] while hearing ones have choices all over the city itself.”

Figure 1.1

Results of the Provider Survey

Survey respondents included: 19 providers of services; 25 administrators of services; and one state agency. They were not geographically dispersed throughout the state. Rather, they were primarily on the I-25 corridor running north and south along the Front Range. Figure 1.1 shows the catchment areas of the providers who participated. Most providers listed multiple counties in their catchment areas. This was particularly true among the 25 providers who reported their role as the administrators of services, rather than direct service providers.

The providers represented a range of service delivery types. Most respondents reported providing mental health services, but some also provided substance abuse, vocational, and school-based services. The providers who answered the survey reported they are providing services to individuals who are deaf and hard of hearing. Of the 44 respondents, 30 reported that their organization has more than 20 providers of direct services.



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Providers, Financing

Respondents were asked how their deaf and hard of hearing clients pay for services. Among the 44, 19 reported that some of their deaf and hard of hearing consumers are self-pay, 16 reported that some have private insurance, 24 reported that some are on public insurance programs like Medicaid and CHP+, and 14 reported providing services free of charge to some or all of their deaf and hard of hearing consumers.

When respondents were asked how they paid for services and accommodations for individuals whose insurance did not cover the accommodations, survey respondents reported their agencies were largely footing the bill:

“Incorporated into our general operating expenses.”

“Have so far used volunteers or other techniques not billed for.”

“We just pay for it so the client can get the services they need.”

“Paid for from our agency.”

Some of the respondents have been able to bill for the increased costs associated with providing services to deaf and hard of hearing consumers. For example, three have agreement with private insurers and eight have agreements with Medicaid. Four respondents requested technical assistance to increase their reimbursement for service delivery expenses.

Providers, Staff Capacity

Only 9 survey respondents reported they or their staff have received training on deaf and hard of hearing issues. Of the 23 survey respondents reporting they have mental health counselors in their office, only four reported that any of the staff in their office received training on deaf and hard of hearing needs. Thirty-five respondents have no staff in their organization who have been trained and only one respondent’s organization had all staff trained. Eight respondents reported individuals who are themselves deaf or hard of hearing are providing services in their organization. Among these, at least three of the organizations are likely to be specializing in deaf and hard of hearing services, as the three organizations reported 20, eight, and five staff within each of their organizations who are deaf and hard of hearing individuals. In total, respondents identified over 40 deaf and hard of hearing staff employed among their organizations. This suggests that Colorado may have some capacity available to provide direct services by individuals who are deaf and hard of hearing, but the capacity may not be geographically distributed.

Providers, Awareness

Of the 33 providers who described their outreach activities related to mental health and substance abuse services, only six reported that these outreach activities were accessible to the deaf and hard of hearing communities. 15 reported they can make them accessible if requested.

One of the providers demonstrated a commitment to serving deaf and hard of hearing consumers, but a lack of knowledge on appropriate ways of serving the consumer. This large mental health organization has no deaf and hard of hearing providers or providers trained on these issues. Due to a lack of funds, they have used volunteer interpreters, including family members, to provide services to their deaf and hard of hearing consumers. They have not assessed the qualifications of these interpreters. The only technology they are using is TTY/TTD accessibility. They report very few barriers to serving this population, despite the lack of communication mechanisms that the best practice literature would support as appropriate.

Access to Interpreters

Providers are mixed in their approach to ensuring interpreters are competent in a mental health or substance abuse setting. Eight of the respondents will ask the consumer if they feel the interpreter is competent. Others will assess the qualifications internally or with an external assessor. Most, however, do not assess the qualifications of the interpreters to provide interpretation services in a service delivery setting. The

lack of consistency suggests clear definitions of "qualified" may be needed, or if they already exist, may need to be disseminated to provider organizations.

Over 60% of providers felt that a significant barrier was the lack of access to interpreters who are qualified to work in a mental health or substance abuse setting. For some providers, this was also a financial barrier. Perhaps due to the financial barrier, 16 reported that they have used family members as interpreters in service delivery settings.

Access to Communication Technology

Interpreters are the primary method that survey respondents reported using to increase communication between service delivery providers and deaf and hard of hearing consumers. Interpreters may not be an appropriate mechanism for all populations. For deaf individuals, services in sign language, rather than through an interpreter, may be more comfortable. For hard of hearing or late deafened individuals, interpreting may be of little to no help. While 29 respondents reported access to contracted interpreters, and 16 reported TTY/TTD telephones, only between 4 and 10 providers reported access to other types of communication technology appropriate for hard of hearing and late deafened populations (e.g. amplification technology, CART, note taking, closed captioned televisions, and assistive listening devices).

Conclusion

Survey results suggest that many of the issues facing other states, and highlighted in the literature review, are also present in Colorado. Consumers reported barriers to access, lack of awareness about services available, desire for other types of communication access, and a lack of consumer choice due to limited service availability. Provider responses suggest they may not be aware of the best means for providing services, billing for services, and training their staff. The combination of consumer and provider responses suggests that deaf and hard of hearing individuals in Colorado may not be able to access high quality, appropriate mental health and substance abuse services throughout the state. Additionally, the geographically narrow distribution of providers responding to the survey makes it impossible to know if more rural areas of the state have equal or less availability of services.

Appendix C: Reviewer Comments

Detailed Comments from Stakeholders Who Reviewed the Draft Action Plan

**Prepared in October 2008 by Jewlya Lynn & Pa'Ticia Moion,
Center for Systems Integration**

The draft Deaf and Hard of Hearing Mental Health and Substance Abuse Action Plan was disseminated online to stakeholders throughout the state for review. Stakeholders were asked about the appropriateness of the overall design, the definitions, and specific strategies. They were also asked to prioritize the strategies within the plan. Below are all of the comments received from the stakeholders.

Definitions

Does anything need to be added, changed, modified, or removed from the definitions listed above?

- No: 19
- Great definitions, Looks good.
- Deaf (uppercase) primary mode of communication is Sign Language (predominantly American Sign Language [ASL] in the United States) and who share a common heritage and culture.
- Deaf: uses visual cues, speech-reading, captioning, assistive devices to the degree they can be used. Hard of Hearing: also uses assistive technology, including hearing aids, and captioning.
- Late-deafened: The d in deafened should not be capitalized to be consistent with the previous definition. Most late-deafened do not use ASL as their common language. The same for Oral-deaf.
- Remove degrees from the definitions. Varying hearing acuity is clear enough and should be sufficient. You may want to note that some late-deafened individuals learn to sign too. Add Hard of Hearing-Blind as there are hard of hearing people who are blind and they have different needs than those who are deaf.
- Your explanation about the term hearing impaired is placed under Deaf Blind when it actually is a definition in itself. It shouldn't be placed under Deaf Blind. People may overlook this part.

Do you have any other comments on this section?

- No: 10
- I think you have done a great job of making this succinct and clear, Looks great
- Can you simplify the language for the lay person?
- The reason for the suggested language change is that many members who identify as Deaf use other modes of signed language such as PSE, SEE, cued speech, etc. While ASL is the predominant signed language, over the course of the last 10-12 years, with the advent of

more college educated Deaf, there has been a marked increase in the use of ASL with English word order (PSE). To only say ASL is limiting and not truly representative of the Deaf culture as a whole.

- Probably need to point out that these are *general* descriptions, and that people who self-identify may actually fit into multiple definitions.
- The definitions stands correct however the newer group are the Cochlear Implants now that are creating a new sub-culture.

Opportunities to Build Upon

Does anything need to be added, changed, modified, or removed from the list of opportunities included in this section?

- No: 9
- I would like to see bullet 3 indicate home intervention and outreach services. This limits what we do to the birth to 3 groups.
- Work with medical facilities. Kaiser Permanente is a good example of a medical facility that can reach the community.
- Include the HLAA - Colorado as a resource for disseminating information and garnering information.
- Hearing Loss Association of America in Colorado: To help disseminate pertinent information and collect critical information from the target population.

Do you have any other comments?

- No: 11
- Looks fine to me.
- Should have opportunity to help the developing guideline care of finance by taxes like 5 to 10 cents to collect to build upon.
- Developmental Disabilities: I strongly recommend that the CDF helps financing the appropriate placement for DEAF Dev. Disabled: they need their own place (group homes) for the sake of their Deaf DD culture and 100% effective communication with their own peers. The DDD can NOT be integrated will in a Hearing world, period! Thanks for your attention.
- There is a high need to have role models in the area and apparently there are not enough of those who do have the qualifications to work in these are. If they do have the qualifications then they do not get hired in spite of their MA degree because they are not given the chance to work in that field. It is not always having the technology but the REAL role models within the Deaf Culture but there is too much oppression to even allow that avenue to open.
- It makes sense to work through existing networks
- I never know you have other options like this. How will this be funded?
- Not an addition to the list, but more linkage & marketing of services available to draw on in providing services
- 1) With the location of CSDB in Colorado Springs there is a large population of Deaf who remain in Colorado Springs after graduation. There also is a large adult Deaf community. Therefore only focusing on providing competent MH services through MHC of Denver is inappropriate. There is a great need for competent and direct services at the MH center in Co Springs. Traveling to Denver for services is often cost prohibitive for many people who are in need. In addition many people with mental health issues are not psychologically organized enough to make arrangements for out of town transportation, etc. 2) CHIP the Home Intervention Program at this time does not hire Mental Health professionals and restricts their staff to Audiologists and Early childhood specialists only. This is a major limitation of the program as it prohibits early screenings as well as early intervention and services on the family systems level. They have also have a reputation for putting greater emphasis on deafness as a disability and this has caused many families in the Deaf community to feel as if CHIP is lacking in the promotion and support of cultural relativity. While CHIP does an excellent job from an Educational standpoint, from a mental health

standpoint they are not even in the ballgame. This is an area that needs immediate correction. 3) CSDB as a whole does an excellent job of supporting mental health services for its students on campus. They also give a valiant effort to with regard to outreach services throughout the state. However, CSDB is not a residential treatment facility, and often by the time some of the older students fail out of their home school districts due to issues too numerous to list here (although I would be happy to meet with the commission to discuss the types of psychosocial and behavioral issues that contribute to Deaf students being more at risk for failing out of predominantly hearing schools), they are in need of intense mental health intervention before being placed at CSDB. For some students, placement in a Deaf friendly environment where they can participate directly in sports, drama, social activities, above and beyond classroom instruction, is enough to allow them to flourish. Others, as mentioned have much deeper seated issues that need a more residential treatment approach that allows for direct services in their native language, as well as assessments done by MH professionals who are skilled in diagnostics and are familiar with what the statistical norms are for deaf/Deaf individuals on the various assessment instruments. Options for treatment are nearly non-existent in CO with the exception now of Denver. There are highly qualified treatment centers outside of CO, and these must be included as options for services when in-state placement is not available or not up to the best standards of care. 4) The NAD has standards of care and best practices as well as a means of evaluating facilities. It is suggested that CO partner with the NAD to ensure that its policies and standards meet or exceed those outlined by the NAD. 5) A demographic analysis needs to be conducted in order to identify the area of greatest concentration of Deaf/deaf individuals, and the Center of Excellence placed in that local. It is natural to think of Denver as the hub for any major program, but if the majority of those in need of services do not reside in the Denver area, then the Center would not be reaching most of the population for which it is intended. 6) As you are already aware, having the best facilities and programs is not going to be enough if there are not culturally competent professionals to provide the services. It is a major challenge to recruit professionals as the number of MH professionals who are culturally and linguistically competent is very small within the entire United States, and it is difficult to recruit the existing professionals away from the more populated hubs of Deaf culture like the East and West coasts. More competitive pay and benefits packages must be considered due the highly specialized nature of the practitioners. 7) Given the length and complexity of the survey as well as what would be the length and complexity of my answers, it would be better if we could have a dialogue via telephone or in person. It is wonderful to see the State take such a focused interest in this specialized topic, and I'm happy to lend any assistance I can to help ensure its success.

- Not completely sure exactly what is being asked for here, if this is for publicity, development, working with existing agencies, etc.
- It is not so much the needs of the Deaf and the counterpart Sub-cultures rather it is the need to train the Able bodied in the educational area on how to get it.

Overall Components of the Plan

Does the structure of the plan emphasize the appropriate priorities to improve access and quality of mental health and substance abuse services for deaf and hard of hearing individuals?

- Yes: 9
- It is a good start, Looks good!, The graphic is helpful, It seems like these will work
- Was hoping to see a plan to implement services specifically for Deaf and Hard of Hearing rather than to set up a clearinghouse (CCDHH is Clearinghouse).
- Charts look good, and goals seem good, but until we see something in action, how do we know it's inclusive of everything that is needed? We're embarking on new territory here.

- Make sure to describe who makes up each of the supporting groups. The Governance Structure definition should include: To ensure the successful development, implementation and oversight of. For the Service Deliver Network definition, add education. ie: To provide direct mental health and substance abuse services and education...
- Is the Center of Excellence and actual place or a team? Consider re-naming to something like Educational and Technical Assistance Center which is more descriptive of what it is (I think). Center of Excellence doesn't really tell me anything.

Do you have any other comments on this section?

- No: 5
- Its fine, not sure how clear it is though. I know it needs to be kept simplistic at this level, but it becomes vague to a certain extent, even with the definitions above--then again, I haven't thought this through fully or analyzed it thoroughly.
- Not really, I am still a firm believer that a lot of this information needs to be dispersed among more than just these groups. Still feel there is a high need to have in incorporated in the college level education as they produce these grads before they enter the working field
- Change the name of the Center of Excellence to actually describe what the center does, ie: Educational and Technical training Center. Only use the term Center if it's an actual place, otherwise department would be a more appropriate term. Likewise, Service Delivery Network is less wordy.
- Too vague right now. Where would the mental health specialists and providers be? In which circle? Please delineate who is each circle, ie, the center of excellence is run by what type of people. Early outreach and identification is run by whom? What job descriptions overlap? Maybe change the name from Network of Service delivery to simply Statewide Service Delivery Network.
- I do find it odd that there's no mention of some type of program or training or encouragement to develop and retain D/deaf, hard of hearing, deaf blind and late deafened mental health workers (counselors, social workers or psychologists).
- I am concerned that the standards are not so rigid as to make it impossible to implement in our rural and frontier areas. I wonder if center of excellence is too challenging, and how do we know when we meet this goal. I think Technical assistance center is a better description of what can be built.

<p>Goal 1. Governance Structure:</p>

Does anything need to be added, changed, modified, or removed from the GOAL above?

- No: 9
- This is CCDHH's Position.
- Just make it an educational requirement for all counselors and teachers. The need to have those like myself to teach the hearing, by letting individuals like myself as a role model example. I have a Master's Degree in Deaf Leadership which is way ahead of my times but our society is not ready for people like me to teach the hard facts. Currently I am unemployed seeking to 'fit' into the educational field. The Hearing community still seems to reject the qualified highly educated Deaf. My skills go from the legal area all the way to the educational area. They only want my volunteer services but not paid services. My research has validated that plus including there is a need to empower the Deaf and their subculture needs.
- If it's truly a goal it has not yet been done, so the text should read Colorado will have.... Should also add develop if that's appropriate.

Strategy 1.1. Develop sustainable capacity within the Colorado Commission for the Deaf and Hard of Hearing to implement and evaluate systemic reform of the mental health and substance abuse systems to meet the needs of deaf and hard of hearing individuals:

Does anything need to be added, changed, modified, or removed from the strategy above?

- No: 9
- It looks good,
- I think the commission in coordination with existing state agencies. The current evaluation/monitoring agencies need to be part of this, not just the commission.
- And evaluate systemic reform of the mental ...How about funding for accountability? Where does it come from?

Does anything need to be added, changed, modified, or removed from the outcomes for strategy 1.1?

- No: 8
- There should be a provision about evaluating specific staff member's qualifications.
- Add: ongoing collaboration and communication with state agencies that have a monitoring role.
- Through education by the role models which there is not enough of us out in the visible community and substance abuse available to the Commission, unless there will be a member of those specialties on the commission.

Strategy 1.2. Expand participation of deaf and hard of hearing individuals within the mental health and substance abuse policymaking bodies to address the needs of deaf and hard of hearing individuals:

Does anything need to be added, changed, modified, or removed from the strategy above?

- No: 8
- Should be developing services within rather than capacity.
- We should emphasize that we have the right people in place to make those decisions.
- Add: and their families (*this comment was repeated for most strategies*).
- Identity of councils is needed if we want to ensure representation of deaf and hard of hearing people on those councils.

Does anything need to be added, changed, modified, or removed from the outcomes for strategy 1.2?

- No: 8
- respect and address the unique...

Do you have any other comments on this goal and the strategies within it?

- No: 8
- Looks great, Doing good so far
- I don't really have any comments, because these seem like good goals, strategies, and desired outcomes. They may be a little too general, but time will tell.
- High need of action and less talk

Goal #2: Statewide Capacity

Does anything need to be added, changed, modified, or removed from the goal above?

- No: 7
- Service Delivery or Referral/Clearinghouse.
- I know we discussed the name change for the hub but this new name is longer and perhaps a bit confusing? Center of Excellence and Network of Service Delivery Excellence maybe just drop Excellence from the Network of Service Delivery. I would imagine that these two would become into one eventually, as I can't see these two being separate entities. As who would be better qualified to provide technical assistance/training than the experts who would already be at the center of excellence? But then again, I am speaking from personal experience knowing that there are not that many qualified professionals that work w/ the deaf/hoh in the state. It would be nice to have a center of excellence separate from the network of service delivery that way the center of excellence can have oversight over ALL programs in the state, including the network. And leave the experts to doing direct work instead of travelling the state etc.
- There are other states that provide the higher level of services-Colorado is very mediocre in its attitude and its funding. It is a shame to say that but it is the truth to this fact Colorado will provide a statewide continuum of high quality mental health and substance abuse services for the deaf and hard of hearing. These services will be provided by the Educational and Training Center and disseminated via the Service Delivery Network. (Easier to read and understand, in my opinion).

Strategy 2.1. Establish a ***Technical Assistance and Education Center*** that provides technical assistance, training, workforce development, and leadership to mental health centers, substance abuse providers, child welfare, juvenile justice, criminal justice, aging services and senior centers, federally qualified health centers and other healthcare providers, vocational rehabilitation, workforce centers, education, private providers, and other providers and systems statewide:

Does anything need to be added, changed, modified, or removed from the strategy above?

- No: 8
- The name change to actually describe the center. Other than that it looks complete.

Does anything need to be added, changed, modified, or removed from the outcomes for strategy 2.1?

- No: 6
- Beautiful
- There is still a discriminatory attitude in the Hearing field of their professions
- No, however my hunch is this Center of Excellence will be in Denver where they already have the most resources. I think there needs to be more than one center.

Strategy 2.2. Establish a workforce development initiative to expand access for deaf and hard of hearing individuals to mental health and substance abuse direct service providers, interpreters, CART providers, and communication technology:

Does anything need to be added, changed, modified, or removed from the strategy above?

- No: 5

- Access or service provision?
- This is unclear to me in what this would entail and how would this work? Even a few words added would be helpful about how the workforce would be engaged
- Service Provider Development?
- I don't know what workforce development initiative means I am confused by this language.

Does anything need to be added, changed, modified, or removed from the outcomes for strategy 2.2?

- No: 5
- There is not enough to set examples; Need to use more Deaf role models --I will keep saying that till there is a viable exposure and awareness in these areas. (*this comment was repeated for most strategies*)
- There is not enough to set examples
- I'm confused as to the definition of workforce; do you mean employers, service providers, workers or what?

Strategy 2.3. Establish a ***Statewide Service Delivery Network*** that provides direct services in mental health and substance abuse for deaf and hard of hearing consumers statewide:

Does anything need to be added, changed, modified, or removed from the strategy above?

- No: 6
- Yes, services needed more than anything else as we have nothing in Colorado.
- Good one

Does anything need to be added, changed, modified, or removed from the outcomes for strategy 2.3?

- No: 5
- Change wording: Direct service providers specializing in working with persons who are deaf or hard of hearing and their families work together.
- Yes--can easily access or can reasonably access--can access makes it sound like a possibility if someone drives 150 miles--we want to make it relatively convenient.
- Good idea

Strategy 2.4. Establish ***Early Identification and Intervention*** capacity by building on the Colorado School for the Deaf and the Blind (CSDB) existing role as a statewide resource for children and youth who are deaf and hard of hearing:

Does anything need to be added, changed, modified, or removed from the strategy above?

- No: 6
- Early Identification and intervention is already in place through CSDB. Add training for EI and I providers ideal.
- Need to add additional sources to address the needs of those children who do not utilize the CSDB. School audiologists throughout the state can help identify some of the children that may be missed if you only use the CSDB for the intervention. You may reach most of the deaf children but will miss the HOH children.

Does anything need to be added, changed, modified, or removed from the outcomes for strategy 2.4?

- No: 6
- Change education to in educationally.
- a....settings--plural confusion. And also, this says that treatment needs are being met; what about early identification? This outcome doesn't mention identification, and yet that's part of the strategy

Strategy 2.5. Increase Colorado's capacity to provide appropriate in-patient services to deaf and hard of hearing individuals:

Does anything need to be added, changed, modified, or removed from the strategy above?

- No: 8
- Yes: 1
- We should add to the outcomes that there should be an established place for this to happen.
- Clean and descriptive.

Does anything need to be added, changed, modified, or removed from the outcomes for strategy 2.5?

- No: 8
- Very good

Do you have any other comments on this goal and the strategies within it?

- No: 7
- Looks great.
- Again, this goal and strategies are admirable, in that they aspire to the ideal. The concern that I would have is will these goals lead service providers to over-evaluate the mental health needs of all deaf and hard of hearing adults and children, providing services where people should remain independent? In other words, would this lead to too much involvement with too many individuals instead of just those who truly need the services.
- I am curious as to what the need is for these services? How often are individuals hospitalized?
- How does the task force define high quality? The task force will need to develop standards if they want to be able to measure statewide capacity.

Goal #3. Consistency in the Availability and Quality of Services Statewide:

Does anything need to be added, changed, modified, or removed from the goal above?

- No: 6
- I like it.
- I thought the state already has this sin protocol we used to have statewide program for alcohol/substance abuse services for D/HH and it was killed due to no money.
- This sounds like an adult focused goal. If you change to deaf or hard of hearing individuals and their families, you include children and youth.

- This state really does not give enough compare to the other states I have visited/lived in--very sad view of what is really needed to empower the Deaf community.
- Colorado will adopt statewide guidelines of care for Mental Health and Substance abuse services for the deaf and HOH.
- Just make sure they aren't so rigid that we will be unable to provide the services.
- Is this a lower priority than Goal #2?

Strategy 3.1. Develop and adopt Guidelines for Care in partnership with the Colorado Department of Health Care Policy and Financing, deaf and hard of hearing leaders and consumers, the Office of Behavioral Health, and other providers and service delivery systems:

Does anything need to be added, changed, modified, or removed from the strategy above?

- No: 7
- Yes: 1

Does anything need to be added, changed, modified, or removed from the outcomes for strategy 3.1?

- No: 6
- Modify: deaf or hard of hearing This also needs to be checked throughout the document. It should reflect a person being either deaf or hard of hearing, not both.
- Delete consumer choice, because it doesn't describe anything clearly.

Strategy 3.2. Work with child welfare, juvenile and criminal justice, education, and other systems to develop standards for services to deaf and hard of hearing individuals and their families:

Does anything need to be added, changed, modified, or removed from the strategy above?

- No: 6
- Yes: 1
- There really are lots of mental health needs within the families as well, such as grief, responsibility issues, isolation, sibling issues. Add family.

Does anything need to be added, changed, modified, or removed from the outcomes for strategy 3.2?

- No: 6
- Good one

Strategy 3.3. Expand monitoring and oversight of service delivery providers to include monitoring compliance with guidelines and standards related to service to deaf and hard of hearing individuals and their families:

Does anything need to be added, changed, modified, or removed from the strategy above?

- No: 6

- CCDHH Position
- Work?
- Develop monitoring and oversight of service delivery providers to assure compliance with the standards, and knowledge of the guidelines, related to service of the deaf and HOH.

Does anything need to be added, changed, modified, or removed from the outcomes for strategy 3.3 above?

- No: 6
- Deaf or?
- Are consistent, appropriate and of high quality.

Do you have any other comments on this goal and the strategies within it?

- No: 7
- This looks great
- I think absolutely, these standards are needed. Can they be monitored effectively?

Goal #4: Consumer and Family Leadership:

Does anything need to be added, changed, modified, or removed from the GOAL above?

- No: 6
- Develop new advisory board for this aspect.
- Policymaking should come first in the statement.
- You might say instead, family members and advocates are invited to participate.

Strategy 4.1. Provide advocacy trainings accessible to the deaf and hard of hearing individuals and support the advocates as they develop a network of support among each other:

Does anything need to be added, changed, modified, or removed from the strategy above?

- No: 6
- Trained professionals like CAC 2 or LCSW.
- Deaf/hh individuals?

Does anything need to be added, changed, modified, or removed from the outcomes for strategy 4.1?

- No: 7
- Too wordy, consider ...and their families who are trained in policymaking, delivery, governance and monitoring/evaluation...

Strategy 4.2. Engage and support deaf and hard of hearing advocates in service delivery, governance, policymaking, and monitoring/evaluation settings:

Does anything need to be added, changed, modified, or removed from the strategy above?

- No: 7
- CCDHH'S POSITION

Does anything need to be added, changed, modified, or removed from the outcomes for strategy 4.2?

- No: 7

Do you have any other comments on this goal and the strategies within it?

- No: 6
- With any oversight, I think it's good to involve the community, but I also think we need to recognize that not every individual is a good choice to have on an oversight committee. There are very real limits and constraints to what can be accomplished, and individuals who participate need to be committed to making it work, not unduly burden the system. Not sure how you address this.
- Would leadership for this Goal come from the Center of Excellence.

Questions on the Plan as a Whole

Does the plan resonate or conflict with what you know?

- No: 3
- Yes: 1
- Seems okay, Sounds hopeful and optimistic
- It looks good. I just hope it does get things into action!
- Resonates.....lots of ongoing gaps and needs for services
- Resonates very much. I agree with the three essential components as the basic support for the system. Goals areas 2-4 also address needs, etc that I agree with
- It sounds good on the surface, and the goals are on the high side of the ideals.

From your perspective, is the overall approach to meeting the mental health and substance abuse needs of deaf and hard of hearing individuals appropriate for Colorado?

- Yes: 5
- Yes, we surely miss the old statewide program that was in place for the years and hope it will come back to stay!
- I believe that the state of Colorado is lacking in this area, but this is a good start to get it going.
- Yes, I think so. We need to start with leadership somewhere!
- Yes, I think it does address the need for accessibility along a continuum of MH/SA services that are currently available to the general, hearing population.
- Yes, as long as it doesn't become cumbersome.

- I think it is a well thought out set of goals and strategies. I think we also have to recognize that mental health and substance abuse needs are not necessarily all due to a person having hearing loss, but rather that the person happens to have hearing loss in addition to the other needs. It might be as simple as coming up with an appropriate communication plan, or it may be more involved.

What is missing from the plan?

- I feel that figuring out the structure of running this whole thing is missing. How do we determine who is qualified for this and where we should recruit staff for this?
- I think this plan is very ambitious.
- Implementation and other components do not have an end date or completion, i.e. no later than. I think things move when there is a deadline.
- Timeframe and measurement parameters.
- How it will be sustained.

How can the plan be improved?

- I like it
- The state of Colorado needs to recognize the issue before anything can happen. I realize that Deaf population is a low incidence group but here we don't have communication access equally to any other disability groups.
- I think, we should gather resources from highly recommended mental health services for the Deaf from places such as Washington, D.C. and the New York state.
- Could add housing or residential opportunities

Reviewers' Votes for Their Top Five Priority Strategies

Strategies	1	2	3	4	5
Strategy 1.1: Develop sustainable capacity within the Colorado Commission for the Deaf and Hard of Hearing to implement and evaluate systemic reform to the mental health and substance abuse systems to meet the needs of deaf and hard of hearing individuals.	3	2	2	3	2
Strategy 1.2: Develop capacity within the mental health and substance abuse policymaking bodies to address the needs of deaf and hard of hearing individuals.	1	3		1	1
Strategy 2.1: Establish an Education and Technical Assistance Center that provides technical assistance, training, workforce development, and leadership to mental health centers, substance abuse providers, child welfare, juvenile justice, criminal justice, senior aging services, federally qualified health centers, other healthcare providers, senior centers, vocational rehabilitation, workforce centers, education, and other providers and systems statewide.	4	2	4	2	
Strategy 2.2: Establish a workforce development initiative to expand access for deaf and hard of hearing individuals to mental health and substance abuse direct service providers, communication providers, and communication technology.	2	1		3	1
Strategy 2.3: Establish a Statewide Service Delivery Network that provides direct services in mental health and substance abuse for deaf and hard of hearing consumers statewide.	3	4	4	1	2
Strategy 2.4: Expand the capacity of the Colorado School for the Deaf and the Blind (CSDB) as a statewide resource for children and youth who are deaf and hard of hearing to support early identification and intervention for mental health and substance abuse needs.			2	1	1
Strategy 2.5: Increase Colorado's capacity to provide appropriate in-patient services to deaf and hard of hearing individuals.	1	2	1	1	4
Strategy 3.1: Develop and adopt Guidelines for Care in partnership with the Colorado Department of Health Care Policy and Financing, deaf and hard of hearing leaders and consumers, the Office of Behavioral Health, and other providers and service delivery systems.	1		1	5	5
Strategy 3.2: Work with child welfare, juvenile and criminal justice, education, and other systems to develop standards for services to deaf and hard of hearing individuals.		1	2		
Strategy 3.3: Expand monitoring and oversight of service delivery providers to include monitoring compliance with guidelines and standards related to service to deaf and hard of hearing individuals.		1			1
Strategy 4.1: Provide advocacy trainings accessible to the deaf/hard of hearing and support the advocates as they develop a network of support among each other.		2	4	3	
Strategy 4.2: Secure funding to support ongoing deaf and hard of hearing consumer involvement in service delivery, governance, policymaking, and monitoring/evaluation settings.	6	4	1		2

