

Culturally Affirmative and Linguistically Accessible Mental Health Services

Position Statement Supplement

National Association of the Deaf

In its 2003 position statement on Mental Health Services for People who are Deaf or Hard of Hearing, the National Association of the Deaf (NAD) recognized that mental health services needed to be available to deaf and hard of hearing individuals. Today, the NAD remains committed to the delivery of mental health services that are culturally affirmative and linguistically accessible. While many of the recommendations in the 2003 position statement remain applicable, the NAD addresses additional trends emerging in the field in this position statement supplement.

Access to Mental Health Services

The NAD reasserts that individuals who are deaf¹ are entitled to accessible mental health services in their language, pursuant to the Americans with Disabilities Act of 1990 (ADA) and the Rehabilitation Act of 1973, both of which require equal access to services for people with disabilities. The President's New Freedom Commission on Mental Health published their review of the status of mental health care in America in 2003, calling for equal access to mental health care for all Americans. Specifically, the Commission established the goal of eliminating disparities in mental health services and improving access to quality, culturally competent care, with a workforce of trained providers who include members of ethnic, cultural, and linguistic minorities (p. 10). Adding to the mandates of this report, the ADA, and the Rehabilitation Act, Executive Order 13166 (Improving Access to Services for Persons with Limited English Proficiency) and Title VI of the Civil Rights Act of 1964 also require language accessibility. With this in mind, the NAD continues to advocate for culturally affirmative and linguistically accessible mental health services for deaf people, particularly to those whose primary language is American Sign Language (ASL).

The NAD and mental health advocates remain very concerned that only a few states provide a continuum of mental health services for deaf people. In most states, deaf people lack meaningful access to the public mental health system. The NAD reiterates its recommendation for state governments to implement true statewide coordination of mental health services, and recognizes that non-profit and for-profit mental health providers are performing admirable work in this field. Such work efforts should be in addition to – not in lieu of – statewide coordination of mental health services for individuals who are deaf.

Evidence-Based Practices

The NAD urges that evidence-based practices (EBPs) take into account the unique cultural and linguistic needs of deaf individuals. Across America, mental health programs are under increasing pressure to implement EBPs. The Substance Abuse and Mental Health Services Administration (SAMHSA) endorsed five EBPs: Illness Management and Recovery, Assertive Community Treatment, Family Psychoeducation, Supported Employment, and Integrated Dual Diagnosis

¹ The term “deaf” is to be interpreted to include individuals who are hard of hearing, late deafened, and deaf-blind.

Treatment for Co-occurring Disorders. However, these five EBPs have not been adequately researched for their effectiveness with deaf individuals and other linguistic minorities. The lack of focus on linguistic and cultural differences in study samples raises questions about the validity and reliability of these five EBPs with respect to deaf adults and children who use ASL.

The NAD therefore cautions against blanket implementation of these EBPs when the linguistic and cultural needs of ASL users are not considered. The NAD asserted in its 2003 position statement, and asserts here again, that mental health services in the language of the consumer, namely ASL, is an EBP (Hamerdinger & Hill, 2005; Glickman & Harvey, 1996; Willis & Vernon, 2002; Mason & Braxton, 2004). In addition, the SAMHSA outlines the System of Care (SOC) principles for child and adolescent mental health services as derived from the landmark *Olmstead* case.² The right to services provided in ASL is mentioned in the SOC principles for deaf children, but it is almost always overlooked. Too often, service providers presume linguistically accessible services are required only for people of color or immigrant families, but often fail to accord the same right to deaf children and adults.

Qualified Personnel Needs

The NAD urges action to address the nationwide acute shortage of qualified mental health clinicians who are fluent in ASL. A major barrier to producing bilingual clinicians is the lack of university training programs that specialize in working with this population. The NAD calls for state governments, federal agencies such as SAMHSA, mental health organizations and universities to develop specialized clinical training programs that will prepare masters- and doctoral-level clinicians for work with deaf individuals in mental health settings.

Videoconferencing and Mental Health Interpreting

The NAD recognizes the growing practice of providing mental health services through videoconferencing (i.e., telemedicine or telepsychiatry) due in part to the shortage of bilingual clinicians. The NAD encourages the use of videoconferencing when a bilingual clinician is not available for a face-to-face meeting. Ideally, services provided through videoconferencing allow point-to-point communication between a deaf individual and a bilingual clinician. Unfortunately, at this time, many people do not have access to telemedicine. Multiple barriers include the non-recognition of professional licenses across state lines, the refusal of insurance companies to reimburse for services outside its network, and the sheer challenge of using advanced technology in many rural areas. Because tele-mental health services are disproportionately beneficial to deaf people (many of whom rely on Medicaid), such services should be billable at the same rates, or more, as in-person direct services to ensure that deaf people receive the services they need. The NAD advocates for states to work together in making telemedicine possible and accessible for all.

While the use of sign language interpreters is not an ideal practice in mental health settings, the NAD recognizes that the use of interpreting is sometimes necessary (i.e., when a sign language

² In the landmark case of *Olmstead v. L.C. and E.W.*, 527 U.S. 581 (1999), the U.S. Supreme Court ruled that Title II of the ADA required states to place persons with mental disabilities in community settings rather than in institutions when it has been determined that integration is appropriate for those individuals. This opinion has had far-reaching effects, requiring states to develop plans (now referred to as *Olmstead* plans) to ensure that people with disabilities receive treatment of various kinds (including mental health services) in an integrated manner.

competent clinician is not available for a face-to-face meeting or through point-to-point videoconferencing). When interpreting services are needed, the NAD supports the use of qualified interpreters who have received specialized mental health training. Mental health clinicians that utilize interpreting services are urged to familiarize themselves with standard practices published by the Registry of Interpreters for the Deaf (RID), including recognizing when it is necessary and appropriate to utilize qualified Certified Deaf Interpreters (CDIs) to facilitate communication.

Licensing

The NAD supports accessible license preparation workshops for deaf test takers. Licensure workshops enhance the probability of passing state licensure exams. Further, passing licensure exams may inappropriately depend more on a person's proficiency in English than on the individual's clinical knowledge and skills in working with a specialized population. As such, the NAD urges state licensing boards to comply with federal mandates by providing examinations in alternative formats for those whose primary language is ASL, including but not limited to providing examinations in ASL or extended time protocols. Additionally, the NAD calls upon those state licensing boards to include specialized content knowledge areas on the licensure tests to ensure appropriate credentialing of clinicians suited to work with people who are deaf.

Interstate Agreements

The NAD supports the development of interstate agreements in which resources are shared among states. Deaf people represent a low incidence population and it is fiscally responsible to share mental health programming on a regional basis. This is particularly true for smaller states that may not have funding available to justify the development of residential or inpatient programming for a small number of consumers. Further, the NAD recognizes that interstate agreements may lead to individuals receiving treatment outside of their home communities, yet the psychosocial benefits of receiving services from sign language fluent staff and interaction with other consumers who are deaf may outweigh distance considerations.

Conclusion

The NAD believes that access to culturally affirmative and linguistically accessible mental health services is a fundamental right for deaf people in America. Effective service design and delivery must include input from deaf consumers at local, regional, and national levels. The NAD continues to be a tireless advocate in this area.

This position statement supplement was prepared by the Mental Health Subcommittee of the Public Policy Committee, and approved April 2008 by the NAD Board of Directors.

References

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