



# COLORADO DAYLIGHT PARTNERSHIP

Advancing Access to Mental Health and Substance Abuse  
Services for Deaf and Hard of Hearing Coloradans

## **Guidance Document to Accompany Standards of Care for Serving Deaf and Hard of Hearing Clients**

**Prepared by Spark Policy Institute  
with the Standards Work Group on behalf of the**

### **Colorado Daylight Partnership**

**A partnership of the Mental Health Center of Denver and the  
Colorado Commission for the Deaf and Hard of Hearing**

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## Standards of Care for Serving Deaf and Hard of Hearing Clients

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## Standards of Care for Serving Deaf and Hard of Hearing Clients

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# Standards of Care for Serving Deaf and Hard of Hearing Clients

## Introduction and Purpose

This guide provides information on how to implement the Daylight Standards of Care to improve the delivery of mental health and substance abuse services to deaf and hard of hearing individuals. The Standards of Care address a wide range of issues, including administrative procedures, record keeping, communication access, and clinical practices. The guidance document is intended to make the standards more accessible for organizations seeking to implement them.

**Origin of the Standards:** In 2008, the Colorado Commission for the Deaf and Hard of Hearing's Mental Health and Substance Abuse Task Force identified several problems with state public mental health and substance abuse services (Spark Policy Institute, 2008). In particular, services to deaf and hard of hearing clients were not provided in accordance to the recommendations of national organizations focused on addressing the mental health and substance abuse needs of this population. The standards in this document were created to address these shortcomings.

The development of these standards was a multi-faceted process. An initial set of standards were drafted based on recommendations from academic journals, national organizations, government agencies at the state and federal levels, and publications from specialized providers with experience working with deaf and hard of hearing clients. Extensive reviews of the standards were conducted by the Colorado Daylight Partnership's Standards Work Group, composed of members of the deaf and hard of hearing communities, representatives of advocacy organizations, mental health and substance abuse clinicians, and administrators of mental health and substance abuse programs. The Standards Work Group provided insight on existing Colorado standards, practices, and needs, and additional information was provided through consultation with experts outside of Colorado.

The result of this development process is a set of standards rooted in both research and practice. The document includes detailed information about the origin of each standard. Though most standards were developed using best practices, guidance from national organizations, and policies from other states, some standards were developed entirely through the participatory process.

**Origin of the Guide:** Adopting these standards is critical to successful mental health and substance abuse service delivery to deaf and hard of hearing Coloradans. The Standards of Care were designed to provide general standards that can be incorporated into an organization's existing policy and practices. However, the Colorado Daylight Partnership recognized that organizational changes need more support than a set of standards – technical assistance, training, and more can assist in the implementation of the standards. This guide is intended to provide such tools. They were developed after consultation with seven organizations in Colorado currently implementing one or more standards. The tips and tools reflect the practices of these organizations and address the barriers they experienced.

**Structure of the Guide:** Each Standard of Care is included in this guide, with accompanying information on the reason the standard is important, strategies for implementing it, questions to ask your organization as you seek to implement it, and resources that are available to assist you. The questions are designed to give concrete ways to explore current policies and needed changes. Feedback on the guide is welcomed and encouraged. If you have questions, have examples of how you implemented a standard, or want additional information, please contact the Colorado Daylight Partnership.

# OVERALL GUIDANCE TO IMPLEMENTING THE STANDARDS OF CARE

The Standards of Care reflect the best practices of providing services to deaf and hard of hearing clients. Nearly all of the standards are based on research that has found improved outcomes or client satisfaction due to these practices.

When implementing the standards of care, it is not realistic to expect any organization to make all of these changes at once, or even to fully implement one of the standards at any time. That ideal situation is dependent on resources, expertise, staff capacity, and many other factors. Rather than guiding organizations to tackle all standards, we strongly recommend each organization review the standards of care and identify those where you can make the quickest wins - find the small things your organization can do. Tackle small, easier steps first to build momentum. Some organizations who have implemented the standards have begun with an agency-wide focus, but others have tackled the standards within a single program and expanded to others later. For example, you may wish to begin with your older adult program, where hearing loss is most likely to be present. Building from the success in one part of your organization, you may be able to expand to others. It is also critical to understand and embrace the motivation of your organization. Is it to improve outcomes? To decrease costs associated with using interpreters? To create new populations that can be served and generate revenue? Or maybe the motivation is it due to a social justice mission or the passion of one or two staff with personal experience in the Deaf community? Whatever the motivation, craft your implementation strategy for the standards around that motivation, while also seeking to sustain the implementation even as staff turnover and motivations changes.

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# IMPLEMENTING THE GENERAL STANDARDS

### GUIDANCE TO IMPLEMENT STANDARD 1

*Standard 1: Organizations shall integrate the deaf and hard of hearing standards in this document into existing policies, operational plans, management, and monitoring activities. Organizations shall cover these standards in staff orientation and training.<sup>1</sup>*

#### Why is Standard 1 Important?

Modifying existing policies to also address the needs of deaf and hard of hearing clients helps build visibility and awareness of the modifications. While policy changes do not ensure practice changes, without policy changes, practice changes may not be sustained as staff and leadership change. Additionally, changes to policies and procedures provide concrete guidance to staff at all levels, allowing for full implementation. For example, it may be important to change the intake policies to reflect the importance of identifying whether a new client needs communication services or technology to access services. Additionally, procedures will be needed to outline the specific questions to ask, along with procedures for arranging for the services or technology. Intake staff will need training to be prepared to implement the revised policies and procedures. Finally, any peer review, case file review, or other quality assurance process should be updated to reflect specific questions to assess if the client's accommodation needs were clearly identified and addressed up front in alignment with policies and procedures.

#### Questions to Ask

1. Which current policies and procedures relate to the standards, and where can the standards be applied?
2. Are deaf and hard of hearing cultural issues included in cultural responsiveness trainings?
3. Are the standards covered during new employee orientation?
4. Are the standards integrated into organizational plans?

#### Example Strategies for Implementing

As portions of the policies are reviewed and updated, your agency could include updates specific to deaf and hard of hearing populations. Alternatively, a policy and standards committee could consider policies specifically to update for deaf and hard of hearing clients.

### GUIDANCE TO IMPLEMENT STANDARD 2

*Standard 2: Organizations shall ensure timely and effective communication access of the client's choice at no cost to deaf and hard of hearing clients during normal operating hours and all points of contact, including, but not limited to: consent; identifying communication preferences; assessment; evaluation and testing; medication check and adjustment; treatment' case management; recreational, physical, or occupational therapy, psycho-educational classes or groups; support groups; and continuing services. Communication access shall include.<sup>2</sup>*

- a. Certified sign language interpreters or sign-fluent providers.



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- b. Hearing assistive technology that is encrypted.*
- c. Captioned video materials.*
- d. Other communication services such as Computer Assisted Real-time Transcription (CART) as appropriate.*

### Why is Standard 2 Important?

Timely and effective communication access helps reduce frustrations and misunderstandings that lead to ineffective treatment. This is particularly evident in emergency situations, where timing is critical and poor communication can exacerbate problems. The need also exists in non-emergency situations because clients who face long wait times may choose not to seek services at all.

Deaf and hard of hearing clients are not one population with one type of communication need. One of the most important first steps an agency can take to increase access is to understand and prepare for a range of communication needs. Some clients will have the greatest communication access through interpreters, but many other clients will not use sign language and may instead need assistive hearing technology to increase their ability to access services. Understanding the range of needs and designing agency procedures to ask about communication needs, rather than self-identification as deaf or hard of hearing, will facilitate your clients having access to the communication services that will best enable them to participate in treatment.

### Questions to Ask

1. Does the agency provide certified sign language interpreters when necessary to provide communication to those who request these services?
2. Does the agency provide computer assisted real-time transcription (CART), captioned video materials, and hearing assistive technology?
3. Does the agency employ staff who would be able to successfully communicate to deaf clients or those with profound hearing loss through ASL or other devices?
4. Does the agency provide these communication accommodations for all points of contact?
5. What is the process for intake and front-desk staff to identify that a client has a communication access need? Is this process focused on the functional communication need of the client, rather than the self-identification as deaf or hard of hearing?
6. What is the process for intake and front-desk staff to arrange for the client to have full communication access at all points of contact? Does the process address interpreters and technology?
7. Does the agency have the needed technology, including hearing assistive technology, captioned video materials, and access to other technology options and services?

### Example Strategies for Implementing

For deaf clients, the preferred way to implement this strategy is to have sign-fluent staff available to deliver direct services. However, this is not always a possibility given the lack of sign-fluent behavioral health

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clinicians, and this does not address the needs of hard of hearing clients who do not use sign language for communication. Alternate strategies include:

- Existing contracts or business agreements with interpreter or other communication services agencies, including those that provide CART. See the section on Interpreters for more detail.
- Existing contracts or business agreements with other behavioral health agencies that can provide direct services. See the standard on Telebehavioral Health for more detail.

Organizations can also purchase an FM system that can be used by hard of hearing clients. The Colorado Daylight Partnership recommends the Contego FM system because of its encryption capabilities and compatibility with hearing aids that include a telecoil.

Not every accommodation is appropriate for every setting. For example, CART is typically more appropriate for group settings rather than individual sessions. However, individuals may differ in their preferences, so it is important to discuss accommodation options with clients.

### Daylight Resources

The Daylight Toolkit has several tools that may assist with identifying communication needs. The *Decision Tree for Communication Access* will guide staff to types of communication access that may be appropriate for a given situation. Clinicians can also use the *Tools for Assessment of Consumers* and the *Intake Addendum for Deaf and Hard of Hearing* to facilitate conversations about hearing loss or communication options.

## GUIDANCE TO IMPLEMENT STANDARD 3

*Standard 3: Organizations shall ensure that complaint and grievance policies address accessibility for deaf and hard of hearing clients, including cultural and linguistic accessibility and strategies for identifying, preventing, and resolving conflicts, cross-cultural issues, or complaints by clients.<sup>3</sup>*

### Why is Standard 3 Important?

Historic perceptions of deaf and hard of hearing persons have led to mistrust of the behavioral health system within the deaf and hard of hearing communities. In order to address this, organizations must make an effort to show they are serious about improving their services to deaf or hard of hearing clients. Complaints and grievances provide organizations with an opportunity to evaluate whether their services are meeting the needs of their clients, but an absence of complaints may reflect a lack of access to the complaint process rather than an absence of service problems. It is especially important to note that complaint processes that require a written statement are not accessible to individuals who do not use a written language as their primary mode of communication.

### Questions to Ask

1. Does the agency have policies that ensure communication access for deaf and hard of hearing clients during complaint and grievance processes?
2. Has the agency identified culturally or linguistically competent staff within or outside the agency to participate in a complaint or grievance process with a deaf or hard of hearing client?

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3. How does the agency inform deaf and hard of hearing clients about the complaint and grievance process and their right to communication access as part of it?

### Example Strategies for Implementing

Implementing this standard will depend on how each organization handles complaints and grievances overall. For example, if complaints regarding adult services are handled by a different person than complaints regarding child and family services, multiple staff members will need to be trained on communication rights and access. However, if all complaints for the organization are handled by a single department, training multiple staff may not be necessary. Regardless of how the complaint and grievance process is structured, staff who handle complaints from deaf or hard of hearing clients should be familiar with communication rights, types of communication access, and how to locate communication access providers. It may also be helpful for complaint and grievance staff to participate in the implementation of other standards (see Standard 11 on consent and rights).

Organizations who work with consumer advocates may need to provide these advocates with communication access equipment or services. For example, a hearing consumer advocate may need to use an interpreter to communicate with a deaf client. Inviting consumer advocates to training sessions, such as those offered to front desk staff, will help build their awareness of deaf and hard of hearing issues. In addition, organizations may wish to work with consumer advocates who themselves are deaf or hard of hearing. This may be a useful way of reaching deaf or hard of hearing consumers as well as educating staff members.

### Daylight Resources

Materials from previous in-person trainings are available on the Colorado Daylight Partnership website, and online trainings are also available. These can provide complaint and grievance staff with information on organizational responsibilities and consumer rights. For more detailed information on rights and responsibilities, contact the Colorado Commission for the Deaf and Hard of Hearing for referrals to technical assistance providers.

The Colorado Daylight Partnership has also trained deaf and hard of hearing individuals to serve as consumer advocates in the behavioral health system. Contact the Colorado Daylight Partnership to be connected with one of these advocates.

## GUIDANCE TO IMPLEMENT STANDARD 4

*Standard 4: Organizations shall ensure adequate time is available for communication with deaf and hard of hearing clients in all settings, including scheduling appointments, consenting to services, and delivery of services.<sup>4</sup>*

### Why is Standard 4 Important?

The amount of time required for an interaction often depends on the communication styles of participants and whether or not those communication styles are compatible. People tend to estimate their time with the assumption that interactions will take place with others who share the same communication style, but this is often not the case even when both parties are hearing. For example, a person who is introverted and

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plans for quick interactions may find that meetings take more time than expected because others are more verbally expressive. Clinicians and staff members must consider differences in communication styles when interacting with deaf or hard of hearing consumers, especially when communication is achieved through a third party, such as an interpreter or CART provider.

### Questions to Ask

1. Does the agency allow and instruct staff to adjust appointment times for delivery of services to deaf, hard of hearing, or other clients who do not use spoken English as their primary mode of communication?
2. Does the agency allow and instruct staff to schedule longer times for communication access providers to be present when securing consent from deaf and hard of hearing clients?
3. Is there a place in the client record, accessible to the staff person responsible for scheduling, to indicate if a longer appointment is needed?

### Example Strategies for Implementing

To implement this standard, it is necessary to consider the front-end (scheduling), the session itself (expectations of concurrent documentation), and the review or management process (case file review, employee productivity reviews). At each step, it is important to ensure that staff training, technology or paperwork used, and policies or procedures that are relevant are all updated to reflect the permissibility of longer sessions and flexibility in documentation processes.

Concurrent documentation is an important issue to address in setting expectations for clinicians who are providing direct services to someone who uses sign language or lip-reading for communication access, including hard of hearing individuals who utilize lip-reading as one component of communication access. Concurrent documentation can result in the provider's face being at an angle to the consumer, making lip-reading difficult if not impossible. Additionally, providers who are communicating through sign language cannot enter information into a computer while their client is signing or while they are signing themselves. For all of these reasons, clinicians who are providing services to deaf and hard of hearing clients may not only need a longer session to deliver the services, as described in the standard, but may also need additional time afterward to complete the documentation.

## GUIDANCE TO IMPLEMENT STANDARD 5

*Standard 5: Organizations shall utilize telebehavioral health when additional expertise from providers who specialize in services to deaf and hard of hearing clients is needed to ensure linguistic and culturally competent services, including for consultation and/or direct service delivery.<sup>5</sup>*

### Why is Standard 5 Important?

Researchers have suggested that only 2% of deaf and hard of hearing individuals receive the appropriate behavioral health care. Barriers to appropriate treatment are often due to a lack of knowledge about a specific population. People who are unfamiliar with deafness and hearing loss lack the skills and

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knowledge to respond appropriately to situations where hearing is not present. By using telebehavioral health, organizations have access to more professionals with specialized experience.

### Questions to Ask

1. Does the agency have telebehavioral health available, or has it explored possible telebehavioral health options?
2. Has the agency established business agreements for specialized providers who work through telebehavioral health?
3. Does the agency have a process for identifying clients appropriate for specialized services through telebehavioral health, introducing clients to the option, and securing their consent prior to beginning treatment?
4. Does the agency have its own telebehavioral health protocols to guide service delivery, including the capacity needed onsite while the client is receiving services from the far-site? If not, has the agency utilized the Daylight Telebehavioral Health Protocols?

### Example Strategies for Implementing

The Colorado Daylight Partnership has developed a set of telebehavioral health protocols designed to be relevant for all populations, with additional protocols specific to services to deaf and hard of hearing clients. These protocols provide detailed information from scheduling processes to staff training to technology needs.

In addition to building your agency's capacity to access telebehavioral health services, it is critical to identify qualified specialists to provide the services. A specialized provider should be someone with both clinical training in working with deaf and hard of hearing clients and cultural background, either through training or personal experience. If the clinician will be providing services to deaf individuals who sign, the clinician should also be sign-fluent to allow for direct services. Finally, the clinician must have the clinical skills for the population you are referring. For example, if a clinician is available by telebehavioral health that specializes in serving culturally Deaf clients, and primarily serves older adults, you should not utilize this clinician to provide child and family services on behalf of a Deaf child.

### Daylight Resources

The Colorado Daylight Partnership's telebehavioral health protocols are available as part of the Colorado Daylight Partnership Toolkit.

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### GUIDANCE TO IMPLEMENT STANDARD 6

*Standard 6: Organizations shall inform clients through prominently displayed visual and written information of their right to communication access through hearing assistive technology and interpreters/communication services, as well as sign language fluent providers when available. Organizations shall also include such information in promotional materials.<sup>6</sup>*

#### Why is Standard 6 Important?

Barriers to fully accessible communication are unfortunately common in many provider organizations. Clients will not know that your organization has taken steps to address these barriers unless you share this information with them. By having prominently displayed visual and written information, your clients will know to ask for the support they need, which will improve the outcomes of the services they receive. Including this information in promotional materials will assist clients in being proactive in helping your staff respond to their needs.

#### Questions to Ask

1. Where does the agency have visual and written information displayed to inform clients of their communication rights?
2. Is information on communication access included on the website and in other promotional materials?

#### Example Strategies for Implementing

Signage at the front desks of all of your clinical offices, brochures, and front page of websites will help inform clients that your organization is prepared to meet their needs. Short statements, for example, "Please let us know what communication services you need! We can provide interpreters and assistive technology to improve your access to care," can also convey this message. Take care to draft the language in a way that empowers clients to want to ask for help, and do not imply this will be a problem or additional burden to your organization.

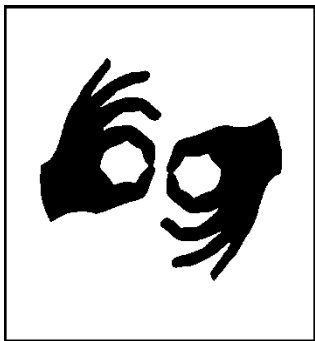


Figure 1. Example signage  
Interpreter available upon request

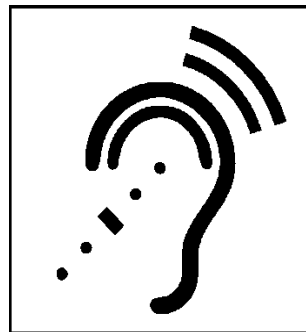


Figure 2. Example signage  
Hearing assistive technology available upon request

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### Daylight Resources

The Colorado Daylight Partnership technical assistance staff can review the language on websites or signage. Examples of signage are available from the Colorado Daylight Partnership website. Signage may also be available from vendors that sell assistive equipment, such as Harris Communications ([www.harriscomm.com](http://www.harriscomm.com)).

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# PHYSICAL ENVIRONMENT STANDARDS

### GUIDANCE TO IMPLEMENT STANDARD 7

*Standard 7: Organizations shall ensure the physical environment at facilities where services are provided to deaf and hard of hearing clients includes:<sup>7</sup>*

- a. Signaling systems that have visual notification related to both safety (e.g. fire alarms with flashing lights) and privacy (e.g. visual door-knockers in consultation rooms).*
- b. Captioning on televisions, including information on how to turn it on.*
- c. Telecommunication access equipment for clients to call for an appointment, call hotline services in case of emergency, or for enabling clients to make calls from the organization's offices (e.g., calling a taxi, family member).*
- d. Visual information to help clients to find their way around the building without having to ask for directions.*
- e. Adequate lighting for visual communication.*
- f. Consultation and psychiatric assessment rooms that ensure confidentiality; are appropriately sized for the number of participants (including the communication providers); have appropriate seating arrangements; and improve speech comprehension through have adequate acoustics and minimized visual and other sensory distractions.*

### Why is Standard 7 Important?

The physical environment affects many aspects of visual communication and should be adapted for the safety, comfort, and confidentiality of those who do not use verbal or auditory communication. Additionally, having accessible safety and communication equipment will create more inclusive environments and help you meet the requirements of many public funders

Visual notification and signaling systems can alert clients of emergency situations or notify them that someone is about to enter a room. Television captioning may also alert clients about emergency situations as well as provide access to entertainment and educational materials. Signs that convey directions and locations are helpful for all consumers, especially in large buildings such as hospitals or multi-floor office buildings. Asking for directions may be particularly difficult for deaf or hard of hearing consumers if they are unable to find someone familiar with their communication mode.

Lighting and room considerations must be addressed when using visual communication. Insufficient light, a light source from the wrong angle, or objects such as columns can obstruct vision and make communication inefficient. Windows facing a busy hallway or street can be distracting and may not provide confidentiality if others can see into the room and see the conversation (e.g. observe someone communicating in sign language or read CART transcripts).



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### Questions to Ask

1. Does the agency have fire alarms with visual signaling?
2. Does the agency have door knockers with visual signaling for consultation, residential, or other rooms used by deaf or hard of hearing clients?
3. Does the agency have at least one television with closed caption technology available for clients?
4. Does the agency have telecommunication access equipment that deaf or hard of hearing clients can use to make calls from the agency's office?
5. Can agency staff give directions by pointing to signs and without the use of verbal instructions?
6. How does the agency ensure deaf and hard of hearing clients are referred for treatment in rooms with appropriate door knockers and other physical features?

### Example Strategies for Implementing

Some aspects of this standard may be easier to implement while others may require more time and other resources. For example, most televisions are already equipped with closed captioning, so implementing this standard is a matter of using already existing capabilities, including training staff or providing easily accessible instructions on how to turn on the captioning. On the other hand, the agency may need to purchase new equipment to implement other aspects of this standard, such as visual messaging boards; visual notification and signaling devices; telecommunication access equipment such as amplified handsets; videophones; web conferencing software; and TTY (teletype device). Thus, full implementation of this standard may require a slow rollout.

Organizations should determine what devices or building modifications are needed, and include these needs in organizational plans. Construction or modification of consultation or assessment rooms could be included in this; however, many agencies likely already have appropriate rooms, so implementing this aspect of the standard can be addressed by training scheduling staff to reserve the appropriate space.

### Daylight Resources

The Colorado Daylight Partnership can provide information on types of devices that can be used to implement this standard, and referrals can be made to organizations that loan or sell devices and signs. In addition, the telebehavioral health protocols include a list of physical environment considerations for organizations who are undertaking construction or renovation projects. These protocols can be incorporated into planning documents. The Colorado Commission for the Deaf and Hard of Hearing's Education and Training Program can also provide technical assistance and consulting services that will aid in implementing this standard.

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### GUIDANCE TO IMPLEMENT STANDARD 8

*Standard 8: Organizations shall ensure the physical environment of in-patient and residential settings where services are provided to deaf and hard of hearing clients includes:<sup>8</sup>*

- a. Wakeup alarms (e.g., vibrators, amplified, flashing lights) available for client rooms.*
- b. Secure storage for clients' hearing assistive technology.*
- c. Adequate room for private visits with relatives and friends, small group activities, social events, and recreational activities.*
- d. Adequate time and space for private phone calls and access to videophones, amplified telephones and/or other telecommunication equipment for deaf and hard of hearing clients.*

### Why is Standard 8 Important?

Residential facilities present unique situations not found in outpatient settings. In addition to safety concerns, the physical environment of residential facilities must allow access to additional activities of daily living. Wakeup alarms are important for the daily routine of all consumers, and deaf or hard of hearing consumers will need appropriate alarms. Secure storage is important because stolen devices are costly to replace and cannot be replaced quickly. Space and time considerations must be taken because sign language and amplified sounds can be overseen or overheard, thus precluding confidential conversations. Excessive background noise or distracting movements may also impede communication.

### Questions to Ask

1. Is lighting at an appropriate direction and level of brightness for visual communication?
2. Does the agency have consultation and psychiatric assessment rooms that meet all of the following criteria: ensure confidentiality; are appropriately sized for the number of participants (including the communication providers); have appropriate seating arrangements; and improve speech comprehension through have adequate acoustics and minimized visual and other sensory distractions?
3. Does the agency train staff to schedule all deaf and hard of hearing clients in consultation and psychiatric assessment rooms meeting the above requirements?

### Example Strategies for Implementing

As with Standard 7, this standard may require implementation in stages. An organization may need to undergo a fundraising or grant writing process in order to support the purchase of equipment such as wake-up alarms and lock boxes or other secure storage devices or to modify existing rooms as needed. ADA kits are available from various sources (such as [www.assistech.com/ada-compliance-kits.htm](http://www.assistech.com/ada-compliance-kits.htm)) and include technology to address many, though not all, components of this standard.

### Daylight Resources

The Colorado Daylight Partnership can provide information on types of devices that can be used to implement this standard, and referrals can be made to organizations that loan or sell devices and signs. In addition, the telebehavioral health protocols include a list of physical environment considerations for

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organizations who are undertaking construction or renovation projects. These protocols can be incorporated into planning documents.

## PROVIDER QUALIFICATIONS & TRAINING STANDARDS

### GUIDANCE TO IMPLEMENT STANDARD 9

*Standard 9: Organizations shall ensure staff members who provide services to deaf and hard of hearing clients have specialized training/experience commensurate to their staff position to work with such clients or shall receive supervision by a staff member with specialized training/experience. At minimum, staff shall receive training in:<sup>9</sup>*

- a. Culturally and linguistically appropriate service delivery.*
- b. Implementation of the Intake Addendum for Deaf and Hard of Hearing.*
- c. Adaptation of psychiatric or other assessments and factors that can influence the results.*
- d. Adaptation and explanation of terminology.*
- e. Scheduling adequate time for sessions.*
- f. Working knowledge of relay services and other telecommunication alternatives.*
- g. How to use and troubleshoot hearing assistive equipment.*
- h. Working with interpreters, including the role of interpreters and the parameters within which interpreters work.*

### Why is Standard 9 Important?

Specialized training will help providers feel confident that services are within their scope of practice. Even when interpreters or assistive technologies are present, unique cultural needs or difficulties interpreting behavioral health jargon can lead to misdiagnosis and ineffective treatment. For example, the term *DUI* may not be easily understood by a deaf person due to language and cultural differences. Working with an interpreter also requires additional skills and knowledge, including the reality that interpreters can make mistakes. For example, *JW* can be misinterpreted as Jewish instead of as Jehovah's Witness. Both of these examples result in ineffective treatment, with disconnects between the provider and client.

Alabama's standards for the delivery of services to deaf and hard of hearing clients requires that, "Staff who provide services primarily to specific subgroups (such as people who are elderly or deaf/hard of hearing) shall have either 2 years supervised experience with the specific subgroup or 2 specialized graduate courses related specifically to the subgroup or 12 continuing education credits of training in the specialty area to work with such subgroups or shall receive supervision by a staff member with the required training/experience."<sup>10</sup>

If your organization makes the decision to dedicate a staff member to primarily providing services to deaf and hard of hearing individuals, the Colorado Daylight Partnership recommends you hire specialized staff with background in deaf and hard of hearing clinical treatment, rather than train existing staff who lack this specialized experience.

### Questions to Ask

1. Have agency staff who work with deaf or hard of hearing clients received training on:

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- a. Culturally and linguistically responsive service delivery?
  - b. Implementing the *Intake Addendum for Deaf and Hard of Hearing*?
  - c. Adapting psychiatric, psychological, or other assessments and factors?
  - d. Adapting mental health/substance abuse terminology?
2. Have staff, including front desk and scheduling staff, received training on:
- a. Scheduling adequate time for sessions, including how to make time accommodations for various communication styles?
  - b. Using relay services and other telecommunication alternatives?
  - c. Using and troubleshooting hearing assistive equipment offered by the agency?
  - d. Working with interpreters, including the role of interpreters and the parameters within with interpreters work?

### Example Strategies for Implementing

In addition to sending clinicians to the available Daylight trainings, organizations will need a process for referring a deaf or hard of hearing client to the clinician with the necessary training. A roster of trained clinicians may be helpful for support staff to identify which clinicians can best serve a specific consumer. If no clinician is available, the organization will need a process for accessing shared services from a provider with qualified clinicians (e.g., through telebehavioral health).

### Daylight Resources

The Colorado Daylight Partnership periodically provides training for clinical providers, including 101 and 201 level classes that cover culture, identity, needs, working with interpreters, using assistive technologies, and adapting screening, assessment, and treatment. You can also request training specifically for your agency.

## GUIDANCE TO IMPLEMENT STANDARD 10

*Standard 10: Organizations shall ensure staff members who provide services in sign language are measured as proficient in sign language. A recognized instrument, such as the ASL Proficiency Interview, should be used to measure a clinician's competency in sign language.<sup>11</sup>*

### Why is Standard 10 Important?

Direct services by a sign language fluent clinician are generally the preferred way to deliver services to deaf consumers. However, a clinician must have a high degree of fluency in order to provide effective services. The language skills needed to converse in social situations are different than the language skills needed in professional or clinical settings. Ratings from a recognized instrument will help gauge whether a clinician has the language skills to converse on the wide variety of topics that may arise during a clinical session.

Alabama's standard for delivery of services to deaf and hard of hearing clients includes a specific definition of fluent, using the Sign Language Proficiency Test. Clinicians delivering direct services are required to

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have advanced proficiency, while non-clinical staff that come into contact with sign-fluent clients are encouraged to have on the job training to learn sign language.<sup>12</sup>

### Questions to Ask

1. Does the organization have a process for measuring fluency of staff that provide services in a language other than English?
2. Has a proficiency exam measured the sign language fluency of staff that provide direct services to deaf clients?

### Example Strategies for Implementing

The Colorado School for the Deaf and the Blind, located in Colorado Springs, conducts the Sign Language Proficiency Interview (SLPI) in American Sign Language. The interview is videotaped and then reviewed by a team of three evaluators who assess areas such as vocabulary, grammar, and facial and body language. As of July 2011, the cost of is \$150 per assessment, which includes a fluency rating level and a list of areas for improvement. The interview can be scheduled by calling the school's outreach office at 719-578-2100. Colorado does not currently have standards regarding the specific rating that must be achieved in order to work in a behavioral health setting, but Alabama laws require residential staff to have a minimum rating of Intermediate Plus and clinical providers to have a minimum rating of Advanced.

## CONSENT AND RIGHTS STANDARDS

### GUIDANCE TO IMPLEMENT STANDARD 11

*Standard 11: Organizations shall ensure that informed consent is achieved and that any paperwork, including forms, policies, and procedures are provided in a manner that the client can understand, including in language and communication modes appropriate for the client, as appropriate to the client's mental status.<sup>13</sup>*

#### Why is Standard 11 Important?

Many deaf consumers use English as a second language; for these consumers, written materials may not be easily understood. As with any consumer who is not a native user of English, written materials must be adapted for deaf consumers so that information can be understood.

#### Questions to Ask

1. Are organizational documents provided to deaf and hard of hearing clients in the clients' primary language?
2. Is admission paperwork completed in a manner that ensures informed consent is achieved with deaf and hard of hearing clients, including using communication providers or technology to facilitate communication access?
3. Are rules and regulations provided in a language and communication mode appropriate for the client?

#### Example Strategies for Implementing

Ideally, consent forms and other admissions or intake paperwork would be completed by clients with the assistance of a sign-fluent clinician or a hearing clinician and an interpreter. If a clinician is not available to assist with paperwork, interpreters can review forms with consumers.

## COMMUNICATION ACCESS THROUGH INTERPRETERS

### GUIDANCE TO IMPLEMENT STANDARD 12

*Standard 12: Organizations shall perform due diligence when selecting interpreters, including confirming interpreters.<sup>14</sup>*

- a. Are certified according to Colorado Revised Statutes 6-1-707.*
- b. Demonstrate professional boundaries and judgment.*
- c. Demonstrate adherence to confidentiality and code of ethics as defined by the interpreting professional, agency, state, and federal law.*
- d. Understand and are prepared to interpret in a mental health and substance abuse setting.*

### Why is Standard 12 Important?

Interpreters are part of a treatment team, and as with all other members of the treatment team, an organization should use interpreters who are competent, professional and will behave in an ethical manner. Certification by the Registry of Interpreters for the Deaf (RID) conveys that an interpreter has met a nationally recognized standard of competence and professionalism. Although clients' friends, family members, or even an organization's staff member may be fluent in sign language, fluency in a language is not the same as being skilled in interpretation of a language. Specifically, there is a distinct skill-set associated with interpretation and facilitating communication. For sign language interpreters, this skill-set is demonstrated by certification through RID.

Colorado law requires that anyone using certain terms must be registered with the Registry of Interpreters for the Deaf (RID). Such terms include:

- Sign language interpreter
- Interpreter for the deaf
- ASL-English interpreter
- American sign language (ASL) interpreter
- Certified sign language interpreter
- Certified interpreter for the deaf
- Certified deaf interpreter
- Certified ASL-English interpreter
- Certified American sign language (ASL) interpreter

In the event that an uncertified interpreter is the only available option, an organization has an additional duty to ensure that the interpreter will perform professionally, ethically, and with adherence to confidentiality laws.

All interpreters, regardless of their certification status, will need to understand the unique situations that may arise in behavioral health settings. Interpreters who are not familiar with mental health or substance



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abuse issues may not be aware of the potential for highly emotional situations, may not understand the difference between communication issues and psychosis or other behavioral health situations, and may be unprepared to translate specialized language used in a behavioral health setting

### Questions to Ask

1. Do the agency's interpreters use titles protected by Colorado statute, and if so, do they hold the corresponding RID certification?
2. Does the agency have and enforce a firm policy to not use friends and family as interpreters in any setting?
3. Do the agency's interpreters demonstrate professional boundaries and judgment, and do they adhere to confidentiality rules and code of ethics as defined by the interpreting professions, agency, state, and federal laws?
4. Do the agency's interpreters have a good understanding of mental health and substance abuse issues, including their own biases and judgments?

### Example Strategies for Implementing

In contracts with interpreters and interpreting agencies, explicitly state the requirement that the interpreters meet 6-1-707 C.R.S. requirements for certified interpreters, that they are registered with the Registry of Interpreters for the Deaf (RID). The RID website contains useful information on the process of hiring interpreters (<http://www.rid.org/interpreting/hiring/index.cfm>) as well as a directory of certified interpreters. Organizations can ask whether the interpreter has experience in settings where confidentiality is required, such as different types of healthcare, education, or legal settings.

RID has also published a Standard Practice Paper that describes issues facing interpreters in mental health settings ([http://www.rid.org/UserFiles/File/pdfs/Standard\\_Practice\\_Papers/Mental\\_Health\\_SPP.pdf](http://www.rid.org/UserFiles/File/pdfs/Standard_Practice_Papers/Mental_Health_SPP.pdf)). The handout can be used to help interpreters understand the uniqueness of working in behavioral health settings. A copy of the paper can be given to interpreters prior to being hired; this would provide the interpreter and opportunity to self-assess whether they have adequate preparation for the job. Organizations may also wish to provide general behavioral health information, such as fact sheets or brochures, to determine if the interpreter will have difficulty with behavioral health terminology or topics.

Organizations who have previously used an uncertified interpreter may wish to consider sponsoring or subsidizing certification courses or offering enhanced billing rates as an incentive to obtain certification.

Once an organization has some experience with interpreters, it may be useful to keep a list of preferred interpreters or interpreter agencies, including a ranking of interpreter choices based on their experience and skills in working in a behavioral health setting.

### Daylight Resources

The Colorado Daylight Partnership can help organizations sort through the various checklists above in order to form questions to ask when identifying an interpreter. These are useful when talking with agencies, individual interpreters, or hiring new staff interpreters. The Colorado Commission for the Deaf and Hard of Hearing can also assist with identifying interpreting agencies.

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### GUIDANCE TO IMPLEMENT STANDARD 13

*Standard 13: Organizations shall seek to utilize interpreters trained to work in mental health and/or substance abuse settings. If specialized interpreters are not available, organizations shall provide interpreters the following information available prior to interpreting in mental health and/or substance abuse settings.<sup>15</sup>*

- a. Knowledge of abnormal psychology and common diagnoses, especially specific psychological disorders that have significant implications for communication and interpreting.*
- b. Knowledge of mental health and substance abuse treatment protocols (policies, goals, dynamics, interventions, procedures) and the ability to work safely in the many settings of the modern continuum of care.*
- c. The ability to differentiate between the purposes and goals of treatment plans and diagnostic assessments.*
- d. An understanding of the roles and functions of mental healthcare and substance abuse providers.*
- e. Organizations that utilize restraint and seclusion shall ensure interpreters have knowledge of restraint and seclusion purposes and practices available prior to interpreting.*

### Why is Standard 13 Important?

Training on mental health and/or substance abuse settings provides interpreters with the specialized knowledge needed to work in behavioral health. Necessary specialized terminology includes names of medications and classifications and axes in the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DMV-IV). Other specialized knowledge includes prevalence of childhood trauma and sexual abuse in psychiatric populations, and communication impacts of medical conditions. Interpreters must also be prepared to work in highly emotional situations and the impacts on the interpreter's own personal mental well-being. More detailed information on necessary interpreter competencies is available through the National Consortium of Interpreter Education Centers (<http://healthcareinterpreting.org/new/prof-development/mental-health-resources/domains-a-competencies.html>). An example of specialized training is the Alabama Mental Health Interpreter Training ([www.mhit.org](http://www.mhit.org)). When interpreters with specialized training are not available, organizations must be sure to give basic information to the interpreters that are available.

### Questions to Ask

1. Does the organization have basic information on behavioral health available to provide to new interpreters?
2. What is the organization's process to ensure that the first interpreters selected are those with training and experience in behavioral health?
3. When specially trained interpreters are not available, does the organization ensure the untrained interpreter understands the requirement to review the materials in advance of the interpreting session?

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### Example Strategies for Implementing

Organizations are strongly encouraged to invite interpreters to internal organizational trainings. This will provide interpreters an opportunity to learn new topics and concepts that are relevant to their work as well as to become familiar with organizational staff members. Interpreters may also benefit from attending Mental Health Interpreter Training from the Alabama Department of Mental Health ([www.mhit.org](http://www.mhit.org)). Alabama is currently the only state with this type of training. Organizations should consider paying interpreters for their time at trainings or consider offering an enhanced billing rate for interpreters who successfully complete training.

### GUIDANCE TO IMPLEMENT STANDARD 14

*Standard 14: Organizations shall have Healthcare Information Portability and Accountability Business Agreements with interpreters and interpreting companies prior to their involvement in any healthcare setting.<sup>16</sup>*

### Why is Standard 14 Important?

The Healthcare Information Portability and Accountability Act (HIPAA) requires organizations to take certain precautions regarding confidential health information. Interpreters are part of the treatment team and will have access to and be exposed to confidential information covered by HIPAA. Thus, business agreements with interpreters and interpreter agencies should include language to comply with HIPAA.

### Questions to Ask

1. Does the organization have a HIPAA compliance officer who reviews agreements and contracts?
2. Has the agency established appropriate agreements, including a Healthcare Portability and Accountability Business Agreement, with interpreters or interpreting agencies prior to when an interpreter is needed?

### Example Strategies for Implementing

Each organization likely has several existing business agreements that address HIPAA. These existing agreements can serve as guides for business agreements with interpreters or interpreter agencies. Agreements with Spanish or other spoken-language interpreters may be especially helpful. Each organization's HIPAA compliance officer should be contacted to review new business agreements.

### GUIDANCE TO IMPLEMENT STANDARD 15

*Standard 15: Organizations shall develop a strategy for locating, authorizing, and paying for sign language interpreters, including strategies for accessing after-hours and short notice interpreters.<sup>17</sup>*

### Why is Standard 15 Important?

Waiting until a client requests an interpreter to identify when, how, and where to seek an interpreter increases the likelihood that your agency will not have time to ensure the interpreter is certified, has experience in behavioral health settings. Additionally, failure to have a policy for paying for interpreters may leave staff without enough information to feel confident telling a client that the agency can provide an

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interpreter. Finally, having agreements in place in advance with interpreting agencies can prevent delays in services being accessible as these arrangements are made at the last minute. Because interpreters often require advanced notice for their services, having a strategy in place for after-hours or short notice situations is an important component of effective services.

### Questions to Ask

1. Does the agency have a policy for hiring interpreters of any language, including for after-hours or emergency situations? Does this policy cover sign language interpreters?
2. Has the agency established a policy for paying for interpreters? Is this policy known by all relevant staff, including contact information for the interpreter or interpreting agency?
3. Has the agency located and established appropriate agreements, including a Healthcare Portability and Accountability Business Agreement, with one or more interpreters and interpreting agencies that can provide pre-scheduled, after hours, and short-notice interpreters?

### Example Strategies for Implementing

Local interpreters can be identified through the RID website ([www.rid.org](http://www.rid.org)). Once your organization has identified the interpreting options available locally, the next step is to perform due diligence (Standard 12) in selecting the interpreter or agency. The HIPAA agreements and training on behavioral health can also be established. Contracts with interpreters or interpreter agencies will need to address such things as fees for last-minute interpreting, fees for cancellation within 24 hours and before 24 hours, and qualifications of interpreters that can be sent to your agency to provide services in a behavioral health setting. If local interpreters are not available for some services, such as after-hours or short-notice, remote video interpreting is an option. However, remote video interpreting has several limitations, including the inability to ensure the interpreters have experience in behavioral health settings, and it is not an ideal option.

## GUIDANCE TO IMPLEMENT STANDARD 16

*Standard 16: Organizations shall ensure that clinicians are permitted to have pre- and post-session meetings with interpreters, including sharing information on communication issues specific to the deaf or hard of hearing client.<sup>18</sup>*

### Why is Standard 16 Important?

Pre- and post-session meetings will help orient both the clinician and interpreter to issues that may affect treatment. For example, a pre-session meeting can be used to review any behavioral health jargon and terms that will be used during the session while a post-session meeting could reveal concerns about a client's fluency or comprehension level.

### Questions to Ask

1. Are clinicians allowed to and aware that they may have a pre-and post-session meeting with interpreters to share information on communication issues specific to the deaf or hard of hearing client?

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2. Are scheduling staff aware of the need to schedule additional time for pre- and post-session meetings for both clinicians and the interpreter
3. Is there a mechanism for clinical staff to make scheduling staff aware of the need for a pre- or post-session with the interpreter for a particular appointment or all appointments with a specific client?

### Example Strategies for Implementing

Implementation of this standard will depend on an organization's scheduling process. For example, clinicians who schedule their own appointments may have an easier time adjusting for pre- and post-session meetings with interpreters. On the other hand, organizations with centralized scheduling will need to train scheduling staff on the need for pre- and post-session meetings as well as develop a process for clinicians to request additional time when needed. Pre- and post-session meetings do not necessarily need to be for long periods of time, especially once a clinician becomes more familiar with providing services through an interpreter; a five minute pre-session with the interpreter, 50 minute session with the client and interpreter together, and five minute post-session with the interpreter may be sufficient time in some situations.

### GUIDANCE TO IMPLEMENT STANDARD 17

*Standard 17: Organizations shall ensure an interpreter will be present when either the client or clinician requests a sign language interpreter to facilitate communication, including when the clinician is a sign language fluent provider.<sup>19</sup>*

### Why is Standard 17 Important?

Communication is a two-way process, and interpreters serve both the client and the clinician. Thus, both parties have the right to request an interpreter. This includes sign-fluent clinicians who may find that additional interpretation is needed. An interpreter may be needed if the client uses home-sign, a different sign language than the clinician, or for another reason that impedes the clinician's ability to communicate fully with the client. If the clinician feels the interpreter is necessary for communication access, an interpreter should be arranged even if a client does not want an interpreter.

### Questions to Ask

1. Does the agency require an interpreter be present whenever requested?
2. Does the agency have a policy that specifically addresses a clinician's right to request an interpreter, even if the clinician is sign-fluent?

### Example Strategies for Implementing

Training clinicians and administrators is an important part of implementing this standard. Staff and clinicians must be made aware that they have the right to request an interpreter while administrators must be aware that such requests are legitimate even when made by sign-fluent staff.

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### GUIDANCE TO IMPLEMENT STANDARD 18

*Standard 18: Organizations shall ensure an ongoing evaluation of the effectiveness and quality of language services being provided through an interpreter.<sup>20</sup>*

#### Why is Standard 18 Important?

Although an organization must perform due diligence in hiring an interpreter, the reality remains that the quality of interpretation can vary from person to person. Just as other professionals routinely receive performance reviews, so must interpreters.

#### Questions to Ask

1. Does the agency ensure ongoing evaluation of the effectiveness and quality of language services being provided through an interpreter?
2. How are interpreters for other languages, such as Spanish, evaluated for quality?
3. If interpreters are provided through an interpreting agency, what is the interpreter agency's quality assurance or client satisfaction process?

#### Example Strategies for Implementing

Sign-fluent clinicians at other organizations may be able to consult on ways to assess the quality of interpretation and provide resources on the use of interpreters. In particular, they may be able to relate some key indicators of quality that could arise in a clinical session. Organizations can also request information about the experience and background of the interpreter. Organizations that use interpreters for other languages, such as Spanish, may have existing quality assurance procedures that can be adapted to include sign language interpreters. The Robert Wood Johnson Foundation ([www.rwjf.org](http://www.rwjf.org)) has funded several projects related to the evaluation of interpreter services although these projects were not focused specifically on sign language interpreters.

One option for assessing the quality of interpreters is to collect feedback from clients. Client satisfaction information may not be able to answer all questions about an interpreter's competency, but can be an important part of a broader quality assurance effort.

### GUIDANCE TO IMPLEMENT STANDARD 19

*Standard 19: Organizations shall not use family and friends to provide interpretation services.<sup>21</sup>*

#### Why is Standard 19 Important?

Using family and friends as interpreters violates confidentiality and provides little assurance of interpretation quality. In addition, the presence of friends and family members may alter a clinical session, especially in situations where relationships are clinically significant. It is important to understand that interpreters or direct communication should be present for interactions between the client and staff at all times, not just for clinical sessions. An interpreter should be available to assist with reviewing and completing paperwork and participating in recreational or vocational activities. Using a friend or family member as an interpreter in any of these settings can result in insufficient communication access.

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When a survey of Colorado behavioral health providers was conducted, over half of the providers who responded indicated their organization uses family members and friends as interpreters in non-clinical settings and nearly one third reported their organization uses family members and friends as interpreters in clinical settings. Many of the organizations whose providers reported the use of family and friends had existing policies forbidding this practice. This highlights the need to not only have such a policy, but give easily accessible alternatives to your staff and create oversight specifically on this issue.

### Questions to Ask

1. Does the agency have and enforce a firm policy to not use friends and family as interpreters in any setting?
2. Does the agency train staff on this policy and provide resources for accessing interpreters, including in short-notice situations?

### Example Strategies for Implementing

Training staff members at all levels is an important part of implementing this standard. Staff and clinicians must be made aware that using the client's friends or family members as interpreters is never acceptable, even outside of clinical sessions.

## GUIDANCE TO IMPLEMENT STANDARD 20

*Standard 20: Organizations shall use a Deaf Interpreter when clinicians or clients identify the need, such as when Deaf clients have minimal language skills and there are potential health or safety risks. Organizations will use a Certified Deaf Interpreter, but when a CDI is not available, organizations will use a Deaf Interpreter who has successfully completed specialized training.<sup>22</sup>*

### Why is Standard 20 Important?

The terms *interpreter* and *sign language interpreter* typically refer to an individual who is hearing whereas *deaf interpreter* refers to a deaf individual. Deaf interpreters may work in tandem with hearing interpreters, or they may work alone. Typically, deaf interpreters are used in highly challenging situations because they have specialized training on different types of non-verbal communication such as gesture, mime, and drawing, and they may have additional expertise on deaf culture. Situations where a deaf interpreter may involve consumers who:

- Reflect characteristics of deaf culture that are not familiar to hearing interpreters;
- Use a foreign sign language;
- Use nonstandard signs or gestures such as home signs; or
- Are dysfluent and have minimal or limited communication skills.

The Registry of Interpreters for the Deaf (RID) has written a standard practice paper that further describes the role of a Certified Deaf Interpreter and situations where their services may be useful ([http://www.rid.org/UserFiles/File/pdfs/Standard Practice Papers/CDISPP.pdf](http://www.rid.org/UserFiles/File/pdfs/Standard%20Practice%20Papers/CDISPP.pdf)).

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### Questions to Ask

1. Does the agency inform clinicians working with deaf individuals of their right to request a CDI and provide information on the circumstances that may warrant the use of a CDI?
2. Does the agency provide front-desk staff with information on how to access a CDI when one is needed?

### Example Strategies for Implementing

Clinicians and interpreters can discuss the potential need for a deaf interpreter during pre- and post-session meetings. Sign-fluent clinicians with other organizations may be able to consult on specific cases.

Organizations should have contact information for a CDI available with other interpreter contact information. RID ([www.rid.org](http://www.rid.org)) maintains a directory of certified interpreters, including CDIs. The Colorado Commission for the Deaf and Hard of Hearing ([www.coloradodeafcommission.com](http://www.coloradodeafcommission.com)) may also be able to make a referral to a CDI.

## GUIDANCE TO IMPLEMENT STANDARD 21

*Standard 21: Organizations shall ensure a policy is in place to allow interpreters to access confidential information as clinicians determine pertains to the performance of their duties.<sup>23</sup>*

### Why is Standard 21 Important?

Medical and social history can strongly affect language and communication. As some of this information is considered part of a confidential medical record, interpreters will need to be able to review some confidential information in the course of their duties.

### Question to Ask

1. Do clinicians who work with deaf or hard of hearing clients have information on the relationship between biopsychosocial history and communication?
2. Does the organization have a process for staff to request access to medical records for business purposes?

### Example Strategies for Implementing

Organizations will need to determine a process that balances an interpreter's expertise in factors that affect communication with a clinician's discretion of what information is relevant. A clinician will need to determine whether behavioral health issues could potentially be affected by differences in communication styles. Pre- and post-session meetings with the interpreter, especially if the interpreter is familiar with behavioral health issues, would be helpful in determining whether additional information needs to be shared.

The information needed by an interpreter may vary depending on the setting. For example, for a clinical session, the interpreter will need to know the purpose and goals of the session, main concern, presenting problem, and assessment and diagnostic information. For a case management, vocational, psycho-



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educational, or group session, the interpreter will still need to know what the session will cover but will not need to know as much personal information as a clinical session.

### GUIDANCE TO IMPLEMENT STANDARD 22

*Standard 22: Organizations shall provide an area for interpreters to wait that is separate from consumers, such as a staff break room or lounge.<sup>24</sup>*

#### Why is Standard 22 Important?

Allowing an interpreter to remain alone with a client, even in a waiting room, can create a difficult ethical situation for the interpreter. This is particularly true with sign language interpreters, who are typically well-known in the deaf community and are more likely to have a pre-existing friendship with the client or someone known by the client. Allowing them to wait in a separate area from the consumer will help the consumer and interpreter maintain professional boundaries. It also prevents a consumer from initiating a conversation with their interpreter in the absence of a clinician; such conversations could include important psychosocial, medical, or other clinically-relevant facts, and the consumer may not repeat the same information during the session.

#### Example Strategies for Implementing

A formal, dedicated waiting area for interpreters is not necessary. Rather, any area can suffice as long as it is separate from the consumer waiting area and the clinician is able to find the interpreter when the appropriate time comes. Examples include a staff break room or an empty meeting room. Because clinicians and interpreters are encouraged to have pre-session meetings, the clinician's office may be a useful waiting area.

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# HEALTHCARE RECORDS

### GUIDANCE TO IMPLEMENT STANDARD 23

*Standard 23: Organizations shall ensure healthcare records include:<sup>25</sup>*

- a. Hearing status – deaf, hard of hearing, late deafened, etc.;*
- b. Use of personal hearing assistive technology (hearing aids, cochlear implants, etc.);*
- c. Preferred method of communication, as identified by the Colorado Communication Profile, including language and hearing assistive technology needs;*
- d. Preferred language for care;*
- e. Preferred language for written materials;*
- f. All spoken, signed, and written languages used, including if the deaf or hard of hearing client does not use sign language;*
- g. Presence of interpreters/communication service providers during any service delivery;*
- h. Preferred interpreter/communication service provider;*
- i. Any incidents where interpreters/communication service providers or assistive technology were not available;*
- j. Preferred method(s) of contact; and*
- k. Communication method used to secure informed consent.*

### Why is Standard 23 Important?

The healthcare record must include information on a client's communication preferences so that any person interacting with the client can prepare appropriately. This includes front desk and scheduling staff, who may not typically have access to a full medical record.

### Questions to Ask

1. Do agency health records include information listed above? Is access to the information set at the appropriate level, so front desk staff can secure the appropriate communication services?
2. Do agency health records for each point of contact include:
  - a. All spoken, signed, and written languages used, including if the client does not use sign language?
  - b. Accommodations provided (interpreters, hearing assistive technology, etc.)?
  - c. Incidents where interpreters, communication service providers, and/or assistive technology were needed but not available and the reason why they were not available?
  - d. Communication method used to secure informed consent?

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### Example Strategies for Implementing

Health records may already include information about hearing loss and communication styles in clinical notes or other portions of the document that are not accessible to scheduling staff or easily found. Moving this information to the demographics section of the records will make it more visible and more easily searched.

It is important to understand that situations may arise where the client's preferred interpreter is not the best interpreter for the situation. If an interpreter is too connected with the client or the client's social network, it may be unwise to use that interpreter, even if it is the client's preference. The clinician should handle this on a case by case basis. If the client's preferred interpreter is not the clinician's preferred interpreter, the record should clearly indicate this fact.

### GUIDANCE TO IMPLEMENT STANDARD 24

*Standard 24: Organizations shall update healthcare records with this information every six months or when client communication preferences change.<sup>26</sup>*

### Why is Standard 24 Important?

Just as other information in healthcare records can change with time, so too can communication needs. For example, a client's preferences may change over time due to the availability of new technology or due to changes in hearing acuity.

### Questions to Ask

1. Does the agency ensure that standard policies for updating healthcare records include requirements to update all of the communication access information included in Standard 23?

### Example Strategies for Implementing

Most organizations already have review processes in place. Thus, this standard merely adds a review of the items listed in Standard 23 into existing review processes.

# COMMUNICATION DURING SECLUSION & RESTRAINT

Please note: Nothing in this guidance is intended to preempt laws and regulations pertaining to the use of seclusion and restraint (e.g. Colorado Department of Human Services Rules 19.430 through 19.435). Seclusion and restraint rules exist to keep both staff and clients safe – the additional guidance below helps to explain strategies for seclusion and restraint that allow greater communication access and the potential for de-escalation, when possible and safe.

## GUIDANCE TO IMPLEMENT STANDARD 25

*Standard 25: Organizations shall document when deaf and hard of hearing clients are required to be secluded or restrained and, to the extent possible, that the techniques did not deprive the clients of the ability to communicate.<sup>27</sup>*

### Why is Standard 25 Important?

Basic seclusion and restraint processes are barriers to communication. Thus, caution must be taken when secluding or restraining deaf or hard of hearing clients, who may not be able to hear instructions or respond to commands. Organizations can create the opportunity to review and improve seclusion and restraint practices with deaf and hard of hearing clients by documenting and reviewing the techniques used and their outcomes.

### Questions to Ask

1. Within existing rules for documenting the use of seclusion and restraint, is there an opportunity to also include information on the impact to communication access?

### Example Strategies for Implementing

Documentation must show that:

- a. Seclusion and restraint procedures were not used in lieu of effective communication;
- b. Interventions prior to seclusion and restraint were not successful;
- c. A sign-fluent staff person or an interpreter was available for communication with the client.

Most organizations conduct administrative reviews when seclusion and restraint procedures are used. These reviews should include a determination of communication access and whether additional measures would have provided a greater degree of access.

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### GUIDANCE TO IMPLEMENT STANDARD 26

*Standard 26: Organizations shall ensure newly renovated or constructed rooms used for seclusion have windows that are of sufficient size and appropriately placed to allow for communication access between sign language fluent staff, interpreters, and clients.<sup>28</sup>*

#### Why is Standard 26 Important?

Several types of sign languages, including ASL, incorporate full body signals as an integral component of the language. Thus, communication requires that a person can be viewed from the waist and higher, but seclusion rooms often do not have windows that large due to safety reasons. Thus, when rooms are renovated or constructed, organizations should consider options that would allow sign language communication between staff and clients.

#### Questions to Ask

1. Do seclusion rooms allow for visual communication between clients and staff without the use of any auditory or verbal communication?
2. If a secluded client has an emergency need, how would he/she alert the staff? Can this be accomplished by a person who uses sign language as a primary mode of communication?

#### Example Strategies for Implementing

Although state regulations mandate windows in seclusion rooms, not all windows are conducive to visual communication. If a room with an appropriately sized window is not available for use by a deaf or hard of hearing client, video monitoring may be a viable alternative. Prior to renovating or newly constructing seclusion rooms, an organization should review state regulations from the Colorado Department of Public Health and Environment and the Colorado Department of Human Services. They may also wish to consult with a technical assistance center with expertise on access and disability issues, such as the Rocky Mountain ADA Center ([www.adainformation.org](http://www.adainformation.org)) or the Legal Center for People with Disabilities and Older People ([www.thelegalcenter.org](http://www.thelegalcenter.org)).

### GUIDANCE TO IMPLEMENT STANDARD 27

*Standard 27: Organizations shall ensure that in the event a deaf or hard of hearing client must be restrained, restraint techniques will balance the importance of client safety with the importance of communication access.<sup>29</sup>*

#### Why is Standard 27 Important?

Placing deaf or hard of hearing consumers in restraints, especially those who sign as their primary form of communication, presents unique safety hazards as they will no longer be able to express themselves, alert staff to physical pain, or otherwise indicate distress. Organizations must consider the safety implications of restraining someone that relies on their hands for communication.

#### Questions to Ask

1. What information is covered in training on restraints? Can this training include specific discussion of safety and communication access with deaf and hard of hearing consumers?

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2. Are staff familiar with multiple methods of restraints? How do staff choose among the different restraint methods?
3. Are staff familiar with any restraint techniques that do not restrict the movement of hands and wrists?

### Example Strategies for Implementing

Other states have codified seclusion and restraint of deaf or hard of hearing clients. Requirements in these states include leaving one hand free to sign and having a sign-fluent staff member with the client at all times. Staff may also consider leaving a client's hands and wrists with sufficient movement for fingerspelling. Organizations should ensure that evaluation for use of restraints includes consideration of whether these or other alternative strategies are possible.

## GUIDANCE TO IMPLEMENT STANDARD 28

*Standard 28: Organizations shall ensure that in the event that a person who uses sign language for communication must be restrained, a staff member or interpreter fluent in sign language will stay within the line of sight of the client continuously during the period of restraint.<sup>30</sup>*

### Why is Standard 28 Important?

Because sign language is a visual form of communication, a sign-fluent staff member or interpreter must be in the client's line of sight in order to give explanations or instructions. Because restraints may reduce a client's visual field, the staff member or interpreter must take extra care to remain visible to the client.

### Questions to Ask

1. How do staff members communicate with clients who are restrained?
2. Does the organization's policy on seclusion and restraint include requirements for continuous monitoring or checks?
3. Are staff members familiar with the effect of restraints on a client's visual or auditory field?

### Example Strategies for Implementing

Training on restraint procedures should address this standard, and these procedures for restraining deaf or hard of hearing clients should be reviewed when a facility begins serving a client who uses sign language for communication.

## GUIDANCE TO IMPLEMENT STANDARD 29

Standard 29: Organizations shall ensure that in the event that a person who uses hearing assistive technology for communication must be restrained, assistive hearing technology will only be removed when it presents an immediate safety issue and will be returned as soon as the safety issues is resolved.<sup>31</sup>

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### Why is Standard 29 Important?

Removing hearing assistive technology prevents effective communication. A consumer who relies on hearing assistive technology will not be able to understand explanations or directions being given by staff. In addition, staff should be aware if a client has unilateral hearing loss and take this into consideration when giving instructions to the client.

### Questions to Ask

1. How do staff determine whether use of a device presents a safety hazard during restraint?
2. If staff are authorized to use restraint procedures, how are they made familiar with the client's communication needs?
3. Does the organization have a procedure for removing eyeglasses during restraint? Can this procedure be adapted for hearing assistive technology?

### Example Strategies for Implementing

Types and purposes of hearing assistive technology should be included in trainings on restraint procedures so that staff will have the necessary information to balance the need for communication with the need for safety.

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# SCREENING, ASSESSMENT, AND EVALUATION

### GUIDANCE TO IMPLEMENT STANDARD 30

*Standard 30: Organizations shall ensure the Intake Addendum for Deaf and Hard of Hearing is completed with deaf and hard of hearing clients for the purposes of providing behavioral health services.<sup>32</sup>*

#### Why is Standard 30 Important?

The *Intake Addendum for Deaf and Hard of Hearing* was designed as an aid for clinicians who are familiar with deaf or hard of hearing issues but who are inexperienced in serving deaf or hard of hearing clients. The questions on the addendum will help clinicians explore appropriate communication access options as well as biopsychosocial aspects of hearing loss. The addendum is only one part of a complete client history but can serve as a starting point for clinicians to probe for further information. In addition, the addendum is intended only as an aid for clinicians and not as a replacement for training.

#### Questions to Ask

1. Do clinicians working with deaf and hard of hearing clients have training on the *Intake Addendum for Deaf and Hard of Hearing* and its purpose?

#### Example Strategies for Implementing

The *Intake Addendum for Deaf and Hard of Hearing* should be discussed in trainings for clinicians who serve deaf or hard of hearing populations. To make the addendum easily accessible to clinicians, a copy can be kept in a central location, such as an organizational shared drive or other location with job resources. A desktop reference manual for working with deaf or hard of hearing clients may also be useful.

#### Daylight Resources

A copy of the *Intake Addendum for Deaf and Hard of Hearing* is available from the Colorado Daylight Partnership toolkit, and additional questions about the addendum can be answered by Colorado Daylight Partnership staff.

### GUIDANCE TO IMPLEMENT STANDARD 31

*Standard 31: Organizations shall ensure assessment, evaluation, and psychological testing of deaf and hard of hearing clients includes gathering information about cultural identification and hearing acuity, including age of onset of hearing loss, etiological components, and language proficiencies.<sup>33</sup>*

#### Why is Standard 31 Important?

When gathering information and developing a treatment plan for deaf and hard of hearing individuals, it is important to take a systems perspective. Taking a systems perspective helps to illuminate the functional and dysfunctional relationships between the person and the systems, which can include biological systems as well as social systems, such as family, professional or work networks, and faith communities. Exploring these aspects of a client's life will help a clinician understand a client's preferred mode of communication,



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whether language fluency issues exist, and whether the client's hearing acuity has any effect on their behavioral health needs. In some cases, there may be no relationship between hearing acuity and the client's behavioral health needs; in this situation, the clinician will still need to ensure that communication preferences are included in the treatment plan.

### Questions to Ask

1. Do clinicians routinely explore cultural identification issues with clients?
2. Are clinicians familiar with the cultural model of deafness?
3. Are clinicians familiar with different types of hearing loss (pre-lingual deaf, late-deafened, hard of hearing, etc.) and the communication issues associated with each type?

### Example Strategies for Implementing

Clinicians who work with deaf or hard of hearing clients will need specialized training on the cultural model of deafness, types of hearing loss, and communication issues associated with different types of hearing loss. If such training is not available, organizations are encouraged to consult with or contract with other organizations that have this expertise. A list of organizations who have received this training from the Colorado Daylight Partnership is available at the Colorado Daylight Partnership website (<http://www.sparkpolicy.com/daylight/>).

### Daylight Resources

The Colorado Daylight Partnership Toolkit includes several items that will be helpful in implementing this standard:

- The *Intake Addendum for Deaf and Hard of Hearing* can be used in addition to the organizations usual intake process to guide clinicians in asking questions about hearing acuity and cultural identification.
- The *Decision Tree for Communication Access* will help staff explore possible options for providing communication access.
- The *Communication Access and Preference Profile for Deaf and Hard of Hearing (CAPP-DHH) Forms* were developed to identify the communication needs and preferences of deaf and hard of hearing people. The CAPP-DHH-Consumer Form also includes a written hearing screen that can be given to clients upon entry to the system or for an agency-survey.

## GUIDANCE TO IMPLEMENT STANDARD 32

*Standard 32: Organizations shall ensure clinicians who administer psychological tests to deaf and hard of hearing clients document the following: why a specific test was chosen, how the test was modified, and how the client's results on the test were affected by cultural and linguistic factors.<sup>34</sup>*

### Why is Standard 32 Important?

This standard asks that attempts to implement Standard 31 should be clearly recorded in the client's record. Recording this information will document the clinician's efforts to provide culturally and

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linguistically responsive services. As the clinician becomes more familiar with the individual client's needs, this information can be reviewed as necessary to make adjustments to the treatment plan. For additional information, refer to Standard 34 regarding evidence-based practices and Standard 40 regarding file reviews.

### Questions to Ask

1. How are psychological tests typically selected for use with individual clients? What information about this selection process is typically included in the client record?
2. Are clinicians familiar with cultural and linguistic factors that may affect results of a psychological test?
3. Are clinicians familiar with making modifications to psychological tests in order to accommodate communication and language access?

### Example Strategies for Implementing

Although some services can be provided by staff or clinicians with basic training on deaf or hard of hearing issues, the best practice for psychological tests is to have the test administered to clients directly by a clinician who is highly experienced working with deaf and hard of hearing clients rather than a less experienced clinician who consults with a deaf and hard of hearing expert. The knowledge required to appropriately modify tests and report results requires extensive familiarity with deaf and hard of hearing issues.

For example, the administration of a cognitive evaluation such as the Wechsler Adult Intelligence Scales Fifth Edition (WAIS-V) for a deaf adult would require a number of considerations that a less experienced clinician may not be adequately prepared to make. The test would need to be administered in ASL if the client uses ASL as his/her primary mode of communication, and the Verbal Scales would need to be used with caution and in most cases should not be considered at all for the IQ score since the scale relies heavily on English language comprehension. However, the Verbal Scale may be used to assess English language function. The examination report should include test modifications, such as whether an interpreter was used, any modifications to instructions, and why results of the test are not representative of intelligence due to cultural or linguistic factors.

Checklists and self-reported measures can also present challenges for deaf and hard of hearing clients. Often, an item analysis will need to be conducted after calculating scores. For example, if a parent of a deaf or hard of hearing child is given a questionnaire with the item "My child sometimes acts as if he doesn't hear me," then an item analysis would be needed in order to explain how this item may have affected the standardized score or how the examiner adjusted for the effect.

If a specialized clinician is not available within the organization, through telebehavioral health, or through other means, then an organization should consider a psychological test that does not heavily rely on language skills. For example, the Universal Nonverbal Intelligence Test (UNIT) does not rely heavily on language and can provide a representation of nonverbal intelligence.

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### Daylight Resources

The Colorado Daylight Partnership can make referrals to organizations that have staff experienced in administering psychological tests to deaf or hard of hearing clients.

# TREATMENT/CLINICAL BEST PRACTICES

### GUIDANCE TO IMPLEMENT STANDARD 33

*Standard 33: Organizations shall ensure providers work with deaf and hard of hearing clients to determine if they are best served in deaf specific programs or mainstream settings.<sup>35</sup> If deaf specific programs are best, organizations shall utilize them, including for residential and in-patient settings, whenever possible and ensure interpreters, as a service bridge, should be used as a last resort, rather than the first solution.*

### Why is Standard 33 Important?

Without cultural and linguistic understanding of deaf or hard of hearing populations, mental health and/or addiction issues can be difficult to separate from what is the norm for deaf or hard of hearing individuals. This can lead to misdiagnosis and inappropriate treatment. Clinicians must also be sensitive to the history of the deaf or hard of hearing populations so as not to perpetuate oppression and its effects on the client. Specialized providers are better able to assess the client's linguistic and cognitive level, possible barriers to treatment, impact of stigma, and norms within treatment settings.

### Questions to Ask

1. How does your organization work with the client to determine whether a specialized setting is necessary? Is there an opportunity for clients to request specialized settings?
2. Have you identified options for referring or providing specialized services, including through telebehavioral health?
3. Are you able to provide specialized services within your organization, through staff with language fluency, understanding of deaf and hard of hearing cultural issues, and understanding of communication adaptations needed in different treatment settings?

### Example Strategies for Implementing

Determining whether a client is best served in a specialized or mainstream program can occur per client request, as a result of discussion with the client on options, or based on observation of client communication and/or a communication assessment by a qualified provider (i.e. communication specialist, Deaf interpreter, sign-fluent provider). Clients with limited expressive and receptive language skills, cognitive deficits, or limited understanding of mainstream culture and language will likely benefit from visual aids and expansion of concepts which typically would not occur in a mainstream situation, even in the presence of an interpreter. A Deaf interpreter (DI) or Certified Deaf Interpreter (CDI) may be helpful in expanding concepts to promote the client's understanding for some cases, but in many situations it may be preferable to find a specialized setting. Specialized services may be easiest accessed through telebehavioral health, unless other providers in your community have the capacity to provide specialized settings. If the client needs and in-patient or residential setting, please contact the Colorado Daylight Partnership to find the right setting.

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### Daylight Resources

If an organization does not have the knowledge necessary to serve deaf or hard of hearing clients, it is recommended that they seek consultation or refer clients to specialized services. The Colorado Commission for the Deaf and Hard of Hearing maintains a list of providers who specialize in serving deaf and hard of hearing clients. The Mental Health Center of Denver and Arapahoe House also have specialized services for the deaf and hard of hearing. The Colorado Daylight Partnership can also help you identify the right specialized service provider for the needs of a specific client.

### GUIDANCE TO IMPLEMENT STANDARD 34

*Standard 34: Organizations shall use caution with evidence-based practices that are implemented without being adapted to the cultural and linguistic needs of deaf and hard of hearing clients since they have not been adequately researched for their effectiveness with deaf individuals and other linguistic minorities.<sup>36</sup>*

### Why is Standard 34 Important?

Evidence-based practices are typically evaluated for effectiveness with specific culture groups or populations, so caution should be taken when applying evidence-based practices to new groups, especially if language issues require translation or interpretation of materials. Written materials that are part of evidence-based practices are often not accessible to deaf clients who use English as a second language, and although visual methods are useful, they do not take the place of language-based communication.

### Questions to Ask

1. What evidence-based practices are used within the organization? What populations or groups have these practices been validated for?
2. Which staff have experience in adapting evidence-based practices?
3. Does the organization allow staff to adapt evidence-based practices with clients whose demographics and/or needs are not accounted for in the research?

### Example Strategies for Implementing

Some efforts to develop evidenced-based practices for deaf or hard of hearing individuals are underway:

- The Deaf Wellness Center at the University of Rochester Medical Center has some adapted materials available on their website (<http://www.urmc.rochester.edu/deaf-wellness-center/scholarship-research/grant-toward-equity/dialectical-behavior-therapy-studies.cfm>).
- The National Child Traumatic Stress Network also has treatment adaptations for trauma-focused Cognitive Behavioral Therapy ([http://www.nctsn.org/sites/default/files/assets/pdfs/Trauma\\_Deaf\\_Hard-of-Hearing\\_Children\\_rev\\_final\\_10-10-06.pdf](http://www.nctsn.org/sites/default/files/assets/pdfs/Trauma_Deaf_Hard-of-Hearing_Children_rev_final_10-10-06.pdf)).

When implementing an evidence-based practice with a deaf client, staff involved in adapting the practice need to be both familiar with the evidence-based practice and knowledgeable about serving deaf and hard of hearing clients.

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### Daylight Resources

The Colorado Daylight Partnership can provide additional resources and consultation on adapting evidence-based practices.

### GUIDANCE TO IMPLEMENT STANDARD 35

*Standard 35: Organizations shall utilize substance abuse treatment services found effective and to be promising practices for deaf and hard of hearing clients, which may include education and prevention services, continuing services, recognition and prevention of deafness-related enabling (be sure to include the client's family and friends in this process), vocational rehabilitation, and basic employment skills.<sup>37</sup>*

### Why is Standard 35 Important?

Standard 35 draws on research conducted in deaf specific substance abuse treatment settings, which identified a series of services most likely to be effective.

### Questions to Ask

1. Are staff trained in working with deaf and hard of hearing clients able to provide the recommended services (e.g. prevention, education, continuing services, vocational rehabilitation, basic employment skills)?
2. Does the staff person working with deaf and hard of hearing clients understand deafness-related enabling? Are they prepared to engage the client's family and friends in the treatment process?
3. Does the organization have experience with any other specialized populations? If so, did services need to be adapted, and what was the process for making these adaptations? Does that process apply for deaf and hard of hearing clients?

### Example Strategies for Implementing

Organizations that seeking to provide substance abuse services to deaf or hard of hearing clients should consult with organizations with previous experience serving deaf or hard of hearing experiences. One Colorado organization with this experience is Arapahoe House, which provides services for the deaf and hard of hearing at their Aurora, Denver, Thornton, Lakewood and Commerce City locations. National resources for effective treatment models include Deaf Off Drugs and Alcohol (DODA) in Ohio and the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals.

Arapahoe House  
303-657-3700 (voice phone)  
303-412-3636 (TTY)  
720-235-0946 (videophone)  
[www.arapahoehouse.org](http://www.arapahoehouse.org)

Deaf Off Drugs and Alcohol

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937-222-2400 (voice phone)  
937-641-8173 (video phone)  
[www.med.wright.edu/citar/sardi/doda](http://www.med.wright.edu/citar/sardi/doda)

Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals  
800-282-3323 (voice and TTY)  
866-928-5713 (video phone)  
[www.mncddeaf.org](http://www.mncddeaf.org)

### GUIDANCE TO IMPLEMENT STANDARD 36

*Standard 36: Organizations shall ensure treatment plans for each deaf or hard of hearing client that specify services necessary to meet the client's needs, including interpreters, technology support, other services to ensure full linguistic access, and culturally competent services.<sup>38</sup>*

#### Why is Standard 36 Important?

Treatment plans must demonstrate accommodations necessary to provide accessible treatment, both to ensure continuity of care and to plan for the contracting and payment processes needed to access communications providers and/or equipment.

#### Questions to Ask

1. What information is normally included in a treatment plan? How would this information be adapted when different communication preferences exist or if communication is achieved through a communication service provider such as an interpreter or CART?
2. Do treatment plans provide sufficient information to ensure a continuity of care for clients with differences in communication preferences?
3. Can communication access information in treatment plans be accessed by staff who handle contracting, billing, and budgeting for auxiliary services?

#### Example Strategies for Implementing

Implementation of this standard will require clinicians to be properly trained on what types of documentation should be included in the treatment plan for deaf and hard of hearing clients. Having desktop references may be useful for those clinicians who do not work with deaf or hard of hearing clients on a regular basis. Documentation should include needs at different points of contact, treatment plan goals, objectives, methods of service delivery. Documentation should also be included in the client's report of needs.

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### GUIDANCE TO IMPLEMENT STANDARD 37

*Standard 37: Organizations shall ensure every client shall have the right to participate in the treatment planning process, including the review of materials involved in the process that must be presented to the client in the appropriate language in a clear and understandable manner.<sup>39</sup>*

#### Why is Standard 37 Important?

Deaf and hard of hearing clients should be allowed to participate in their treatment planning in the same way that hearing clients participate in treatment planning. To promote equitable services, deaf and hard of hearing clients need direct communication or use of a communication access provider to make informed consent and to facilitate engagement in the treatment process.

#### Questions to Ask

1. How does the organization involve clients in their own treatment planning? Is this process accessible to deaf or hard of hearing clients?
2. What steps does an organization take to ensure that a client is participating in treatment planning?

#### Example Strategies for Implementing

Most organizations may already have processes for involving clients in their own treatment planning. For these organizations, implementation of this standard means ensuring that deaf or hard of hearing clients have the same opportunity to participate as hearing clients, whether through communication access providers, direct service providers, or other methods.

### GUIDANCE TO IMPLEMENT STANDARD 38

*Standard 38: Organizations shall have updated information about deaf and hard of hearing specialized services and resources, local and otherwise, to share with clients.<sup>40</sup>*

#### Why is Standard 38 Important?

Common barriers to behavioral health services include inadequate screening and audiological services, absence of supportive services that compliment behavioral health treatment, and lack of access to hearing aids. While it is not the responsibility of the behavioral health provider to ensure access to these other services, lack of access may result in ineffective, more costly, and more lengthy behavioral health treatment. For this reason, supporting the client out in the community is beneficial to the treatment process.

#### Questions to Ask

1. Does the organization have a list of deaf and hard of hearing community organizations? Is this list updated regularly?
2. Does the organization have any existing partnerships or contracts with organizations with expertise in deaf or hard of hearing issues?



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### Example Strategies for Implementing

This strategy can be implemented in part through working with statewide partners, such as the Colorado Commission for the Deaf and Hard of Hearing and the Colorado Daylight Partnership for ideas about resources to include in your list. A list of deaf or hard of hearing consumer advocates can also be provided. Also, share information and websites about organizations that provide technical assistance around the state, such as the Colorado Commission for the Deaf and Hard of Hearing, Colorado Association for the Deaf, and Colorado Chapter of the Hearing Loss Association of America.

However, it is also important to identify local resources. To identify local resources, it may help to outreach to partner organizations that have made a similar commitment to being an accessible organization.

### GUIDANCE TO IMPLEMENT STANDARD 39

*Standard 39: Organizations shall provide accessible client-related materials, including materials accessible to deaf and hard of hearing clients with limited English proficiency.<sup>41</sup>*

### Why is Standard 39 Important?

Written materials such as fact sheets, brochures, or forms may not be accessible to deaf or hard of hearing clients due to limited English skills, meaning that written materials will need to be translated into ASL or other language understood by the client. Concepts may need to be explained and expanded upon in order to ensure understanding of paperwork upon admission and for ongoing treatment. Clinicians should also consider whether the client's country of origin as those from outside the United States may have even greater difficulty understanding written English.

### Questions to Ask

1. What materials are provided to clients with limited English proficiency? How have these materials been adapted for non-English speaking populations?
2. Have any staff members been trained to work with limited English proficiency clients, and can these staff members provide insight on adapting materials for deaf or hard of hearing clients?

### Example Strategies for Implementing

Clinicians should review written materials in-depth with deaf or hard of hearing clients and not assume that such materials can be easily understood. In some cases where the consumer is language dysfluent, a deaf interpreter may need to work in conjunction with a hearing interpreter in order to help further explain unfamiliar concepts. Some video interpreting services are available through Purple ([www.purple.us/vri](http://www.purple.us/vri)) and through Professional Sign Language Interpreters ([www.pсли.net/PSLI/Services.html](http://www.pсли.net/PSLI/Services.html)).

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### GUIDANCE TO IMPLEMENT STANDARD 40

*Standard 40: Organizations shall ensure a clinical review of client records is conducted every 12 months to determine that the case has been properly managed. The review should include an assessment of involved collaterals and linguistic support services for clients who are deaf and hard of hearing, treatment plan modification if necessary, and cultural competency of services provided.<sup>42</sup>*

#### Why is Standard 40 Important?

Routine review of client records is an important part of the quality assurance processes. Making an extra effort to review the management of deaf or hard of hearing client records for compliance with the standards and quality of care, communication access, and culturally competency will help organizations identify where improvements can be made in patient care as well as gauge the level of implementation of these standards of care.

#### Questions to Ask

1. How often are client records reviewed? Is there an opportunity to include additional review requirements for clients who are identified as deaf or hard of hearing?
2. Does the organization's quality assurance process have provisions for other specialized populations, such as limited English proficiency? If so, how can these provisions be applied to the deaf and hard of hearing populations?

#### Example Strategies for Implementing

Reviews of deaf or hard of hearing client records should be coordinated with the organization's Quality Improvement Director and Cultural Competency Director. Reviews should also be incorporated into the peer review process. Supervisor of staff providing services can oversee that these elements are addressed in ongoing standard review process from point of access and through treatment.

### GUIDANCE TO IMPLEMENT STANDARD 41

*Standard 41: Organizations shall ensure a client whose preferred communication method is sign language has access to sign-fluent staff and/or an interpreter for all group activities including recreation, family therapy, individual therapy, and as requested by the client while in an in-patient, out-patient, day-treatment, or residential facility.<sup>43</sup>*

#### Why is Standard 41 Important?

Clients must be able to communicate with others at all times. Although the need for an interpreter is apparent to clinicians who wish to have one-on-one interactions with signing clients, the right to access is often overlooked in group or recreational settings. Organizations must be proactive in ensuring that interpreters or sign-fluent staff are present for all points of contact.

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### Questions to Ask

1. Which staff member is responsible for obtaining interpreter services for recreational activities, group therapy sessions, and other group activities? How is this person notified of the need of an interpreter or other communication access provider?
2. Does the organization have a process for discussing patient care in order to anticipate future communication access needs?
3. Does your organization ensure that an interpreter or other access provider is present at the beginning of an activity rather than waiting for a request after the activity has begun?

### Example Strategies for Implementing

In order to implement this standard, organizations will need to ensure that staff scheduling group activities are aware of the need for an interpreter as well as how to obtain interpreter services. If a group activity is not something that normally requires special scheduling, such as recreation time at a residential facility, advance arrangements may be needed to ensure that an interpreter is available during the activity or is available on short-notice if a need arises.

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### ADDITIONAL RESOURCES

- Alabama Mental Health Interpreter Training ([www.mhit.org](http://www.mhit.org))
- Arapahoe House ([www.arapahoehouse.org](http://www.arapahoehouse.org))
- Assistech ([www.assistech.com](http://www.assistech.com))
- Colorado Commission for the Deaf and Hard of Hearing ([www.coloradodeafcommission.com](http://www.coloradodeafcommission.com))
- Colorado Families for Hands and Voices ([www.cohandsandvoices.org](http://www.cohandsandvoices.org))
- Colorado School for the Deaf and the Blind ([www.csdb.org](http://www.csdb.org))
- Deaf Off Drugs and Alcohol ([www.med.wright.edu/citar/sardi/doda](http://www.med.wright.edu/citar/sardi/doda))
- Disability and Business Technical Assistance Center ([www.adainformation.org](http://www.adainformation.org))
- Dove Advocacy Services for Abused Deaf Women and Children ([www.deafdove.org](http://www.deafdove.org))
- Harris Communications ([www.harriscomm.com](http://www.harriscomm.com))
- Helen Keller Center for Deaf-Blind Youths and Adults ([www.hknc.org](http://www.hknc.org))
- Legal Center for People with Disabilities and Older People ([www.thelegalcenter.org](http://www.thelegalcenter.org))
- Marion Downs Hearing Center ([www.mariondowns.com](http://www.mariondowns.com))
- Mental Health Center of Denver ([www.mhcd.org](http://www.mhcd.org))
- Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals ([www.mncddeaf.org](http://www.mncddeaf.org))
- National Consortium of Interpreter Education Centers ([www.healthcareinterpreting.org](http://www.healthcareinterpreting.org))
- National Child Traumatic Stress Network ([www.nctsn.org](http://www.nctsn.org))
- Professional Sign Language Interpreters ([www.psli.net](http://www.psli.net))
- Purple Communications ([www.purple.us](http://www.purple.us))
- Registry of Interpreters for the Deaf ([www.rid.org](http://www.rid.org))
- Rocky Mountain ADA Center ([www.adainformation.org](http://www.adainformation.org))
- University of Rochester Deaf Wellness Center ([www.urmc.rochester.edu/deaf-wellness-center](http://www.urmc.rochester.edu/deaf-wellness-center))

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### Citations for Each Standard of Care

<sup>1</sup>This standard is drawn from the Massachusetts Department of Public Health Bureau of Substance Abuse Services (2010), which requires, “Program policy modifications must be initiated where feasible in all services and should be included as part of staff orientation and training when publicly funded.”

<sup>2</sup> This standard is drawn from many different sources that identify communication access as critical. For example:

- Michigan Department of Mental Health/Mental Retardation Division of Mental Illness Office of Deaf Services (2003) requires that “services must be available and accessible including effective communication access for consumers who are deaf, hard of hearing, or limited English proficient to enrolled consumers 24 hours per day/seven days per week” and that “a signing clinician or a qualified mental health interpreter will be used with consumers who are deaf and who rely on sign language as a primary or secondary communication system.”
- Tate and Adams' (2006) report for the Western Interstate Commission on Higher Education suggests that “health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.”
- Guthmann and Sandberg (1999) suggest that “accessible meetings, captioned video materials and the provision of interpreter services can help deaf and hard of hearing people access crucial aftercare services.”
- Guthmann and Graham (2004) suggest that accommodations for late deafened and oral deaf individuals as well as hard of hearing individuals can include such things as “good lighting, amplification, slowed or repeated spoken conversation, oral interpreting, captioning, use of computer technology and/or individual attention. In these cases, a program may want to use a laptop computer with someone inputting the information and sitting next to the client who is able to read the screen or if the technology is available, Computer Assisted Real-time Transcription (CART) services.”

<sup>3</sup> This standard is drawn from Tate & Adams (2006), who suggest that “health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.”

<sup>4</sup> This standard is drawn from many different sources, including:

UCSF Center on Deafness (2004) which suggests that organizations “prepare to spend extra time... each intervention will take longer than usual. This fact needs to be considered when planning schedules and evaluations.”

<sup>5</sup> This standard is drawn from UCSF Center on Deafness (2004), which suggests that staff be prepared to seek “referrals, consultation, and collaboration” through resources specialized in serving deaf and hard of hearing clients. It also suggests consultation with specialists because “understanding the impact of deafness on the history and functioning of a mentally ill person is a very complex matter.”

<sup>6</sup> This standard is drawn from Trychin (n.d.), who states that “it is very important that the office has prominently displayed signs informing people of the availability of these devices and services.”

<sup>7</sup> This standard is drawn from multiple sources that identify communication access as critical. For example:

- Tate and Adams (2006) suggest, “Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.”
- Mulley & Ng (1995) suggest that “a visual means of informing patients when it was their turn to see the doctor would help,” and “clearer signposting” is helpful when deaf and hard of hearing people are attempting to find their way through a building.
- Other portions of this standard are drawn from sources that identify physical environment changes. For example:
- Michigan Department of Mental Health/Mental Retardation Division of Mental Illness Office of Deaf Services (2003) requires that “At a minimum there needs to be adaptive equipment. Specifically, adaptive equipment needs to be provided for: 1) fire alarm; 2) door knock; closed captioning on the TV; and a TTY



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unless the consumer does not use one or has enough residual hearing that they ordinarily use a regular or amplified phone.”

- Trychin (n.d.) suggests that “telephone access equipment and services are necessary for people who are hard of hearing to call your office for an appointment, call your hot line service in case of emergency, or for enabling patients to make calls from your office, e.g., calling taxis, etc.”

<sup>8</sup> This standard is drawn from multiple sources:

- Michigan Department of Mental Health/Mental Retardation Division of Mental Illness Office of Deaf Services (2003) requires that there is “adequate room for private visits with relatives and friends, for small group activities, and for social events and recreational activities.” Additionally, it requires that in placements “occupied by deaf or hard of hearing consumers, a TTY must be provided present in order to allow the consumer to make and receive telephone calls.” However, TTY’s are no longer the only telecommunication option, and for this reason, the language of the standard remains open to multiple technology solutions.
- University of Massachusetts Memorial Health Care (2008a) found that including a poster with interpreter needs “on all inpatient doors, similar to NPO (nothing by mouth) status or isolation notification” helped increase the use of language services.
- Missouri Department of Mental Health Office of Deaf and Multicultural Services (2006), which requires that programs and facilities make their buildings accessible, including the use of “flashing lights, wakeup alarms (vibrators, fans, flashing lights), etc.” The portion of the standard on “secure storage” was developed by the Standards Work Group and is not based on any literature.

<sup>9</sup> This standard is drawn from many different sources that identify training as critical. For example:

- National Association of the Deaf Mental Health Committee (2003) recommends training as a component of creating a continuum of services for deaf and hard of hearing individuals.
- The settlement agreement in *Bailey v. Alabama Department of Mental Health and Mental Retardation* (2001) requires that staff training include “identifying the communication needs and preferences of persons who are deaf or hard of hearing... and sensitivity training in providing care and treatment.”
- Massachusetts Department of Public Health Bureau of Substance Abuse Services (2010) requires that “trainings that address awareness, knowledge, attitudinal changes and behavior will be made available on both a statewide and regional basis.”
- Missouri Department of Mental Health Office of Deaf and Multicultural Services (2006) recommends that “existing staff and programs will need to receive in-depth training and exposure to appropriate Deafness treatment models.”
- Michigan Department of Mental Health/Mental Retardation Division of Mental Illness Office of Deaf Services (2003) requires that “people who are trained to analyze communication do communication assessments.”
- Guthmann and Sandberg (1999) recommend that counselors “pursue supervision with a professional who is knowledgeable about multi-cultural counseling issues” and notes that “in assessing a deaf client, the interviewer may need to explain the phenomenon in addition to (or instead of) using the term ‘blackout.’”
- Guthmann and Graham (2004) note, “It is important for treatment providers to understand the parameters within which interpreters work.”
- Tate and Adams' (2006) suggest that “health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.”
- Trychin (n.d.) suggests, “It is essential that all office staff who come into contact with patients, e.g., secretary, billing clerk, nurse, etc. are adequately trained to: identify people who are hard of hearing, communicate effectively with people who are HoH, and use and troubleshoot assistive equipment.” Additionally, he notes, “Psychologists who test with persons who have hearing loss must take into consideration the many factors that can potentially influence the results obtained. Most standardized psychological tests rely on audition and verbal expression, and, as such, test results can be significantly affected by the person’s linguistic competency or comprehension of questions asked.”

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- <sup>10</sup> From revised Alabama Admin Code: 580.2.13-.03 (10): Staff who provide services primarily to specific subgroups (such as people who are elderly or deaf/hard of hearing) shall have either 2 years supervised experience with the specific subgroup or 2 specialized graduate courses related specifically to the subgroup or 12 continuing education credits of training in the specialty area to work with such subgroups or shall receive supervision by a staff member with the required training/experience.
- <sup>11</sup> This standard is drawn from the Michigan Department of Mental Health/Mental Retardation Division of Mental Illness Office of Deaf Services (2003), which states that "some recognized instrument, such as the Signed Communication Proficiency Inventory, or the Registry of Interpreter for the Deaf interpreter certification test should be used to measure a clinician's fluency in American Sign Language."
- <sup>12</sup> From revised Alabama Admin Code: **580-2-9-.18 (7)**: The majority of residential staff of a home serving primarily consumers who are deaf shall hold at least Intermediate Plus level fluency in Sign Language as measured by the Sign Language Proficiency Interview (SLPI) with at least one fluent person per shift. Staff providing clinical services shall have an advanced proficiency. Non-signing staff will engage in on the job training to learn American Sign Language.
- <sup>13</sup> This standard is drawn from multiple sources. For example:
- Missouri Department of Mental Health Office of Deaf and Multicultural Services (2006) requires organizations to "ensure that intake and other paperwork is completed in a manner that guarantees informed consent on the part of the Deaf consumers."
  - Michigan Department of Mental Health/Mental Retardation Division of Mental Illness Office of Deaf Services (2003), which states that signing clients should have an interpreter present for "interpreting any forms, permissions, and explanation of procedures, policies, or rules."
- <sup>14</sup> This standard is drawn from multiple sources, including:
- The Colorado Revised Statutes (2009) that require certification using the Registry for Interpreters for the Deaf certifications.
  - Code of Alabama, Chapter 580-3-24, Section 3: Professional Competencies and Knowledge, which states that interpreters must understand professional boundaries and must be able to explain confidentiality and privilege, including at a minimum, abuse reporting, the duty to warn, and, protections specific to Alabama statute.
- <sup>15</sup> This standard is drawn from several sources that reference the qualifications of an interpreter to work in mental health and substance abuse settings, including:
- Guthmann and Sandberg(1999), who define a qualified interpreter as one who is "certified by the Registry of Interpreters for the Deaf or the National Association of the Deaf and who is familiar with vocabulary and concepts related to substance abuse."
  - Alabama Department of Mental Health and Mental Retardation Office of Deaf Services (2003), which recommends the use of qualified interpreters as defined in Chapter 580-3-24 of the Code of Alabama. Qualifications for mental health and substance abuse interpreters include familiarity with psychopathologies, symptomology of illnesses, assessment methods, treatment methods, and other issues that require specialized vocabulary.
  - Northeastern University and NCIEC (2007), which lists interpreter qualifications.
- <sup>16</sup> This standard was developed by the Standards Work Group and not specified in any literature, but it is based on the need for interpreter confidentiality, such as those listed in the Code of Alabama, Chapter 580-3-24, Section 3: Professional Competencies and Knowledge.
- <sup>17</sup> This standard is drawn from the UCSF Center on Deafness (2004), which recommends that organizations "develop a strategy for locating and authorizing sign language interpreters."
- <sup>18</sup> This standard is drawn from Hamerding and Karlin (2003). Pre- and post-session meetings are "now considered the norm for professional collaboration in most settings where interpreters work. The pre-conference allows the therapist to brief the interpreter about therapeutic goals for that session and to give background information necessary to allow for accurate translation of concepts raised in therapy ... Debriefing after a

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session, or post-conferencing, allows the interpreter to share information of clinical importance that could not be brought up during the session."

<sup>19</sup> This standard was developed by the Standards Work Group and is not based on any literature.

<sup>20</sup> This standard is drawn from the University of Massachusetts Memorial Health Care (2008b). Interpreter evaluations include a detailed report of "patient and provider interaction, language skills and terminology."

<sup>21</sup> This standard is drawn from several sources concerned about the need for confidential quality interpretation, including:

- Tate and Adams (2006): "Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer)."
- University of Massachusetts Memorial Health Care(2008b): "Ensuring the quality of interpretation from vendors helps encourage providers to use professional, quality interpretation versus ad hoc interpreters such as family members."
- National Association of State Mental Health Program Directors (2002): "Using family members as interpreters may intimidate the individual needing services from providing critical information that may reflect poorly on the family member. In addition, family members generally lack needed mental health training. Because family members often lack objectivity about the individual, they may also, consciously or unconsciously, modify the individual's communications to reinforce the family member's perspective. Of course, family members may also be the source of past or current trauma experienced by some people, and using them as interpreters could mask critical information needed for assessment, diagnosis, or effective treatment."

<sup>22</sup> This standard is drawn from several sources; however the specific requirements around when to use a CDI were developed by the Standards Work Group and are not based on any literature. The CDI information that was based on the literature comes from:

- Hamerdinger and Karlin(2003), who distinguish between deaf interpreters and other interpreters: "Deaf interpreters are people who are themselves deaf and by virtue of their native fluency in American Sign Language and understanding of dysfluent language use are able to function as intermediate interpreters, relaying message between a deaf consumer with minimal or dysfluent language skills and a secondary interpreter working between English and American Sign Language. An interpreter is a person who works between the spoken (or in this case signed) forms of two languages providing communication facilitation between speakers of those languages."
- The Registry of Interpreters for the Deaf (n.d.), who have a specific certification for the title of certified deaf interpreter (CDI).

<sup>23</sup>This standard was developed by the Standards Work Group and is not based on any literature.

<sup>24</sup>This standard was developed by the Standards Work Group and is not based on any literature.

<sup>25</sup> This standard is drawn from Cambridge Health Alliance (2008), where they provided an example of improving information systems, including adding "fields to the existing patient registration system. These included recording the patient's primary language at home, preferred language for care and preferred language for written materials."

<sup>26</sup> This standard is drawn from the US Department of Health and Human Services Office of Minority Health(2001), which states that communication preferences, including those regarding sign language, should be "collected in health records, integrated into the organization's management information systems, and periodically updated." The timeline of every six months was developed by Standards Work Group members based on their organizations' current standards for review and updating of medical records.

<sup>27</sup> This standard is drawn from multiple sources. For example:

- The Centers for Medicare and Medicaid Services (2010)require a written and signed order for every instance of seclusion and restraint. The order must "state the events leading up to the need for restraint and the purposes for which restraint is employed. The order shall also state the length of time restraint is to be employed and the clinical justification for that length of time." Requirements for seclusion are similar: "The

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order shall state the events leading up to the need for seclusion and the purposes for which seclusion is employed. The order shall also state the length of time seclusion is to be employed and the clinical justification for the length of time."

- Some state departments of health and human services, such as that of Illinois, have adopted the CMS regulations into state regulations (see Illinois Compiled Statutes 405-5-2-108 and 405-5-2-109).
- Colorado Code of Regulations (2007) require that when seclusion and/or restraint are used, "documentation of less restrictive methods and the outcome shall be contained in the clinical record," and that "staff shall document efforts to assure that the use of seclusion/restraint shall be a brief as possible."

<sup>28</sup>This standard was developed by the Standards Work Group and is not based on any literature.

<sup>29</sup> This standard is drawn from recommendations by the National Association of State Mental Health Program Directors (2002), who state that "clear communication during the use of the intervention is critical and, to the maximum extent possible, disruptions to communication must be minimized," and recommend that "to the maximum extent possible and safe for the individual, staff should select or modify an intervention to permit the individual—especially Deaf individuals who communicate principally by signing—to keep their hands free."

<sup>30</sup> This standard is drawn from recommendations by the National Association of State Mental Health Program Directors (2002): "Interventions should be implemented in a way that keeps the individual's vision unobstructed. All people who are deaf or hard of hearing rely—to varying degrees—on sight to inform their understanding of situations. For an individual who is deaf and has no formal language, this may be his or her only method of receiving messages. Obstructing vision unnecessarily heightens fear, anxiety, and trauma related to the intervention. The person being restrained should have a constant, unobstructed view of his or her surroundings and of a staff person communicating in sign language as the intervention is being implemented and monitored."

<sup>31</sup> This standard is drawn from recommendations by the National Association of State Mental Health Program Directors (2002) concerning the need for communication during restraint. The recommendation states, "Assistive devices should be checked and accommodated as the intervention is being implemented. Staff should be aware that applying physical restraints may dislodge a hearing aid, for example, and lessen the ability of an individual who is hard of hearing to receive instructions or understand what is happening."

<sup>32</sup> This standard is drawn from multiple sources. For example:

- Michigan Department of Mental Health/Mental Retardation Division of Mental Illness Office of Deaf Services (2003) states, "For consumers who are deaf, mental health centers are strongly encouraged to have communication assessments done in order to help them tailor adaptations to meet the consumer's needs."
- Alabama Department of Mental Health and Mental Retardation Office of Deaf Services (2003) states, "Deaf consumers ITP [individual treatment plan] should indicate a communication assessment, how linguistic access is provided, and adaptive equipment needed to facilitate the highest level of independence the consumer can have."
- Missouri Department of Mental Health Office of Deaf and Multicultural Services (2006) states that "an independent language/communication assessment conducted by an ASL/Deafness specialist" must be performed in order to plan treatment.

<sup>33</sup> This standard is drawn from Trychin (n.d.), who states that "psychological tests which may be inappropriate to use with one individual may be appropriate for use with another," so gathering information prior to testing can increase test validity.

<sup>34</sup> This standard is drawn from multiple sources. For example:

- Guthmann and Moore (2007) note that "written tools are not always the most appropriate method for administration of assessments with many Deaf individuals."
- UCSF Center on Deafness (2004) instructs organizations to "adapt your mental status examination. English is at best, a second language for a culturally deaf person. When one puts sign language into written form, the result can appear fragmented, concrete, or confused. Distinguishing language limitation from confusion or thought disturbance is a complex clinical challenge, requiring special care and a professional who has had experience with deaf people."

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<sup>35</sup> This standard is drawn from multiple sources, including:

- Guthmann and Graham (2004), who note that “people who are late deafened, grew up using the oral methods of communicating, are hard of hearing and do not use sign language, or those who do not identify with Deaf Culture may all be appropriate for mainstream settings. These individuals will generally prefer to be served by programs for the general population alongside clients who can hear.... Although mainstream programs are successful for some individuals, many D/deaf people do not experience treatment in an effective way in this setting.”
- Missouri Department of Mental Health Office of Deaf and Multicultural Services (2006) which recommends that “efforts should be made to develop 'Deaf Only' residential placements, regardless of diagnosis” because “Deaf Only placements, have shown themselves to be more successful than 'integrated' settings... Interpreters, as a service bridge, should be used only as a last resort, rather than the first solution sought by providers.”

<sup>36</sup> This standard is drawn from the National Association for the Deaf's Mental Health Subcommittee of the Public Policy Committee (2008), which cautions that the five evidence-based practices endorsed by the Substance Abuse and Mental Health Services Administration “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 practices specifically mentioned include: Illness Management and Recovery, Assertive Community Treatment, Family Psychoeducation, Supported Employment, and Integrated Dual Diagnosis Treatment for Co-occurring Disorders.

<sup>37</sup> This standard is drawn from in-depth information in two sources: Guthmann (1995) and Leigh (2002). Both sources provide a specific array of substance abuse treatment activities that have demonstrated improved outcomes for individuals who are deaf and hard of hearing.

<sup>38</sup> This standard is drawn from the Missouri Department of Mental Health Office of Deaf and Multicultural Services (2006), which recommends that “individual treatment planning in all three DMH Divisions needs to include the unique needs of Deaf consumers,” with particular attention paid to “individuals' hearing loss and communication needs.”

<sup>39</sup> This standard is drawn from the Alabama Department of Mental Health and Mental Retardation Office of Deaf Services (2003), which states, “Every consumer shall have the right to participate in the treatment planning process, with material involved in the process presented in language appropriate to the consumer's ability to understand.”

<sup>40</sup> This standard is drawn from multiple sources, including:

- UCSF Center on Deafness (2004), which suggests that staff are prepared to help deaf and hard of hearing clients “by locating community resources that provide services for deaf and hard of hearing individuals” for purposes of “referrals, consultation, and collaborations.”
- Guthmann and Sandberg (1999), who suggest, “Access information from local resources about agencies in your area that serve deaf and hard of hearing persons.”

<sup>41</sup> This standard is drawn from a Missouri Department of Mental Health Office of Deaf and Multicultural Services (2006) guideline regarding materials given to consumers regarding illness and recovery: “Many treatment processes involve 'homework' in the form of reading and writing assignments, in which consumers learn about their illness and steps to enhance recovery. Since most Deaf people do not read or write English fluently, it is advised that this mode of treatment be avoided. Rather, it is recommended that ASL translations of such materials be made available (video), and consumer responses also be recorded in a video format. If films, videos or other media are used as part of the 'normal' treatment process, they MUST be captioned (legal requirement), but again, since reading may be a barrier for many Deaf consumers, an ASL translation (interpreter) may also be required to ensure full comprehension of the material being covered.”

<sup>42</sup> This standard is drawn from the Alabama Department of Mental Health and Mental Retardation Office of Deaf Services (2003): “A clinical review of direct service staff records should be conducted every 12 months to determine that the case has been properly managed. The review should include an assessment of involved

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collaterals and linguistic support services for people who are deaf or limited English proficient, and treatment plan modification if necessary."

- <sup>43</sup> This standard is drawn from the Michigan Department of Mental Health/Mental Retardation Division of Mental Illness Office of Deaf Services (2003): "Clients who are deaf and who rely on signing as a principal method of communication shall have an interpreter present for any clinical interaction, including psychiatric and general assessments, and psychological and general consultation. Ideally, this would mean a deaf consumer who depends on sign language would have an interpreter a minimum of 8 hours daily."