COLORADO DAYLIGHT PARTNERSHIP

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

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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Spark Policy Institute authored the document, incorporating input from key partners, including feedback from participants on the Colorado Daylight Partnership's Standards Work Group. This document would not have been possible without the extensive assistance and review from the following people.

Spark Policy Institute authors:

- Jewlya Lynn, PhD
- Quinn Lung, MPA
- Christina J. Kalinka, MA, EdM

Colorado Daylight Partnership's Standards Work Group members:

- Ric Durity, Project Director, Colorado Daylight Partnership, Mental Health Center of Denver
- Mary Sterritt, Project Coordinator, Colorado Daylight Partnership, Mental Health Center of Denver
- Cliff Moers, Colorado Commission for the Deaf and Hard of Hearing
- Rebecca Herr, Hard of Hearing Community Advocate
- Angie Lawson, Consultant, Colorado Daylight Partnership
- Susan Drown, Colorado Division of Behavioral Health
- Art Schut, Arapahoe House, Inc.
- Robert Radujko-Moore, Aspen Pointe
- Mary Pat Graham Kelly, Deaf Consumer Representative
- Rachael Moore, Community Representative

Standards of Care external reviewers:

- Neil Glickman, PhD, Clinical Director of Deaf Services, Advocates Inc., Framingham, MA
- Debra Guthmann, EdD, Director of Pupil Personnel Services, California School for the Deaf, Fremont, CA, and Founding Director, Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals, Minneapolis, MN
- Steve Hamerdinger, MA, Director, Alabama Department of Mental Health Office of Deaf Services, Montgomery, AL
- Roger C. Williams, LMSW, Director of Services for the Deaf and Hard of Hearing, South Carolina Department of Mental Health, Columbia, SC

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FOR MORE INFORMATION

For more information on the Standards of Care, please contact:

Dr. Jewlya Lynn

CEO/Research Director

Spark Policy Institute

Jewlya@SparkPolicy.com

www.sparkpolicy.com

Voice: 303-455-1740, ext 113

For more information about the Colorado Daylight Partnership, please contact:

Mary Sterritt, MSW, LCSW

Director, Colorado Daylight Partnership

Mental Health Center of Denver

mary.sterritt@mhcd.org

Voice: 303-504-6521

Video Phone: 720-949-7484

TABLE OF CONTENTS

INTRODUCTION AND PURPOSE

The Standards of Care to follow are intended to guide the delivery of mental health and substance abuse services to deaf and hard of hearing individuals. They address a wide range of issues, including administrative procedures, record keeping, communication access, and clinical practices.

Origin: 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.

In the Spring of 2011, the Standards were reviewed by seven organizations involved with the Daylight Learning Collaborative. These organizations began implementing the standards in both mental health and substance abuse settings and provided feedback to guide the August 2011 revisions. The revisions included changes to the content of standards and changes to improve clarity.

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.

Purpose: Adopting these standards is critical to successful mental health and substance abuse service delivery to deaf and hard of hearing Coloradans. This document is designed to provide general standards that can be incorporated into an organization's existing policy and practices. A separate guiding document will accompany these standards in order to provide more specific information and recommendations on how the standards can be implemented.

STANDARDS OF CARE

GENERAL

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.[1]
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:[2]
    a. Certified sign language interpreters or sign-fluent providers.
    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.
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.[3]
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.[4]
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 accessible services, including for consultation and/or direct service delivery.[5]
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.[6]

PHYSICAL ENVIRONMENT

7. Organizations shall ensure the physical environment at facilities where services are provided to deaf and hard of hearing clients includes:[7]
    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 or 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.

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:[8]

   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.

PROVIDER QUALIFICATIONS & TRAINING

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:[9]

   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.

10. Organizations shall ensure staff members who provide services in sign language are measured as proficient in signed language. A recognized instrument, such as the ASL Proficiency Interview, should be used to measure a clinician's competency in sign language.[10]

CONSENT AND RIGHTS

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.[11]

COMMUNICATION ACCESS THROUGH INTERPRETERS

12. Organizations shall perform due diligence when selecting interpreters, including confirming interpreters:[12]
    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.
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:[13]
    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.
14. Organizations shall have Healthcare Information Portability and Accountability Business Agreements with interpreters and interpreting companies prior to their involvement in any healthcare setting.[14]
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.[15]
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.[16]

17. Organizations shall ensure an interpreter will be present when either the consumer or clinician requests a sign language interpreter to facilitate communication, including when the clinician is a sign language fluent provider.[17]
18. Organizations shall ensure an ongoing evaluation of the effectiveness and quality of language services being provided through an interpreter.[18]
19. Organizations shall not use family and friends to provide interpretation services.[19]
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.[20]
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.[21]
22. Organizations shall provide an area for interpreters to wait that is separate from consumers, such as a staff break room or lounge.[22]

HEALTHCARE RECORDS

23. Organizations shall ensure healthcare records include:[23]
    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, 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.
24. Organizations shall update healthcare records with this information every six months or when client communication preferences change.[24]

COMMUNICATION DURING SECLUSION & RESTRAINT

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.[25]

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.[26]

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.[27]

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.[28]

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

SCREENING, ASSESSMENT, AND EVALUATION

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.[30]

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, age of onset of hearing loss, etiological components, and language proficiencies.[31]

32. Organizations shall ensure clinicians who administered 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, linguistic, and communication factors.[32]

TREATMENT/CLINICAL BEST PRACTICES

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. 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.[33]

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.[34]

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.[35]

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 accessible services.[36]
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.[37]
38. Organizations shall have updated information about deaf and hard of hearing specialized services and resources, local and otherwise, to share with clients.[38]
39. Organizations shall provide accessible client-related materials, including materials accessible to deaf and hard of hearing clients with limited English proficiency.[39]
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.[40]
41. Organizations shall ensure a client whose preferred communication method is sign language has access to sign-fluent staff and/or an interpreter all group activities including recreational, family therapy, individual therapy if a sign-language fluent provider is not present, and as requested by the patient while in an in-patient, day-treatment, or residential facility.[41]

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CITATIONS FOR EACH STANDARD OF CARE

[1] 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."

[2] 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."

[3] This standard is draw 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."

[4] This standard is drawn from the 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."

[5] 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."

[6] 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."

[7] 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 provided for: 1) fire alarm; 2) door knock; closed captioning on the TV; and a TTY 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."

[8] 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.

[9] 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."

[10] 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."

[11] 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."

[12] 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.

[13] 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.

[14] 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.

[15] 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."

[16] This standard is drawn from Hamerdinger 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 session, or post-conferencing, allows the interpreter to share information of clinical importance that could not be brought up during the session."

[17] This standard was developed by the Standards Work Group and is not based on any literature.

[18] 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."

[19] 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."

[20] 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).

[21] This standard was developed by the Standards Work Group and is not based on any literature.

[22] This standard was developed by the Standards Work Group and is not based on any literature.

[23] This standard is drawn from Cambridge Health Alliance (2008), who 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."

[24] 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.

[25] 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 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."

[26] This standard was developed by the Standards Work Group and is not based on any literature.

[27] 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."

[28] 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."

[29] 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."

[30] 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.

[31] 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.

[32] 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."

[33] 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."

[34] 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.

[35] 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.

[36] 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."

[37] 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."

[38] 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."

[39] 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."

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

[41] 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."

