DEAF COMMUNITY LEADERS AS LIAISONS BETWEEN MENTAL HEALTH AND DEAF CULTURES

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Abstract

Providing mental health services to deaf people is usually a formidable task. Given the movement to more "ecological" perspective on mental health issues in deaf people, it seems that two important features of successful mental health service delivery to deaf people would include in-depth understanding of experiential and cultural differences among people in the deaf community and development of a sturdy "bridge" between the mental health service provider community and the deaf community. This paper will describe the evolution of attempts in Washington State, from 1984 to 1987, to provide more adequate mental health services for deaf people. On the basis of these efforts, a deaf leader liaison model was developed and is being proposed here as a cost-effective means of meeting the mental health needs of a deaf community.

Introduction

As is well known to those who have tried, successfully or otherwise, providing mental health services to deaf people is a formidable task. Mental health service providers have come a long way from the assumptions that deafness was merely a medical problem involving faulty mechanisms of the ear, or that deaf people experience more frequent or severe mental health problems relative to nondeaf people (Vernon & Andrews, 1989). Though the disability of deafness is currently recognized as a pervasive communication barrier, many practitioners still fail to take adequately into account the sociocultural implications of deafness as a different way of communicating or even living.

In a number of significant aspects, the deaf community comprises a range of individuals with hearing impairments ranging from hard-of-hearing people who use hearing aids and other assistive listening devices and are assimilated into the mainstream ("hearing") world to Deaf people who comprise a different culture complete with a separate language and lifestyle (Schroedel, 1984; Higgins, 1983; Glickman, 1986).

For many deaf people, deafness is more of an ethnic minority experience than a physical disability experience, and it is this critical distinction which may determine the effectiveness of mental health services in meeting the needs of deaf people.

Given this current view, it would seem that two important features of successful mental health service delivery to deaf people would be an in-depth understanding of experiential and cultural differences among people in the deaf community and development of a sturdy "bridge" between the mental health service provider community and the deaf community. Loosely defined, this "bridge" would incorporate both role and function aspects of mental health service delivery to deaf people, including advocacy, translation, and facilitation. This paper will briefly describe the evolution of attempts, in the three-year period from 1984 to 1987, to provide more adequate mental health services to the deaf community residing in the state of Washington, and then propose a model for more effective programs serving this population. Because of the continuing shortage of qualified [deaf or hearing] mental health professionals with expertise in deafness, a potentially cost-effective way of enhancing access of existing mental health services to deaf clientele may be to train recognized leaders of the deaf community to serve as liaisons—bridges—between the two systems. Properly selected/elected and trained, these liaisons can contribute in-depth understanding of the differences between mental health and deaf community systems, ability to "translate" these differences between systems, and ability to facilitate accommodation of those differences for achieving accessible/effective mental health services for deaf clientele. Even as increased numbers of qualified mental health professionals with expertise in deafness enter the field, as anticipated (e.g., graduates of the new M.S.W. and Clinical Psychol-

ogy Ph.D. programs at Gallaudet University), the proposed model can be adapted to incorporate those professionals and deaf leader liaisons (DLLs) as collaborators.

Washington State Experience

Prior to hiring a Coordinator of Statewide Mental Health Services for Hearing Impaired People in 1984, deaf community and state mental health professionals alike realized the need for more systematic mental health services to deaf people throughout the state of Washington. At that time, the state Division of Mental Health (DMH) awarded budget contracts to a total of 39 county mental health program administrators, who in turn awarded funds to designated mental health providers responsible for carrying out state-guided directives for mental health services. Because of the diverse demographics across counties, mental health services to specific—especially underserved—population groups (e.g., deaf people) varied greatly with respect to accessibility, quality, and effectiveness. Since deaf people were among the most underserved, a deaf mental health professional was hired as part of a contract between a speech/hearing agency in King County and the DMH. King County was selected as the central location of the MH Coordinator's office because of its size and concentration of deaf people in the urban areas of the county; however, the MHC was responsible for working with all of the county-designated mental health programs to develop accessible and cost-effective mental health services for this population across the state.

Questionnaire surveys of the county-designated community (outpatient) and institutional (residential, inpatient) mental health service providers revealed a significant lack of familiarity with the needs of deaf clientele as well as a desire for more education and training (Wax, 1985). Logically enough, these results led to the development of a training program combining curricula about mental health and deafness as well as guidelines for the use of sign language interpreters in mental health treatment (this part of the curriculum was developed and taught by Lisa Holmberg, Mental Health Interpreter Consultant). Also, the MH Coordinator was able to develop contracts with each of the designated mental health service providers stipulating that such training would take place at regularly scheduled intervals, to accommodate personnel and program changes. Consultation was also available to these providers as needed for particular deaf client situations.

During the same period, focused discussion group surveys of deaf community members across several (N = 6) of the most densely populated counties revealed both lack of knowledge about existing mental health resources and low utilization due to perceived lack of accessibility or availability of mental health specialists in deafness. Again the logical outcome of these survey findings was to design a series of workshops to educate deaf consumers about mental health and mental health services. Built into these workshops was a needs assessment process, to ascertain what deaf people perceive as most pressing mental health service needs. Particularly noteworthy is the fact that these workshops were poorly attended; those in attendance tended to be professionals, parents of deaf children, or deaf leaders already fairly knowledgeable about mental health services, or more precisely, the lack thereof. The intended audience of the "regular" deaf consumer never fully materialized at these workshops.

During this time, the DMH also had an office of specialists coordinating services to refugees, another underserved population. Because of its relative proximity to the Pacific Islands and the Asian mainland, Washington state has had a significant Asian population, many of whom were refugees from the war in Vietnam and subsequent political danger zones. While sharing concerns with these specialists about lack of attendance of deaf consumers at the mental health education workshops, the MH Coordinator discovered that they were experiencing similar problems providing outreach to their minority populations and had discovered that working closely with their leaders—in this case, Buddhist monks—was a particularly effective way of communicating about mental health services to the Asian refugee population. Since Asian people and Deaf people share similar characteristics of not wishing to be identified with mental illness and of tending to approach the "elders" or leaders of their communities with what would be described as mental health problems, the MH Coordinator developed the proposed model for improving rapprochement between mental health service providers and deaf consumers/clients.

Deaf Leader Liaison Model For Mental Health Service Delivery

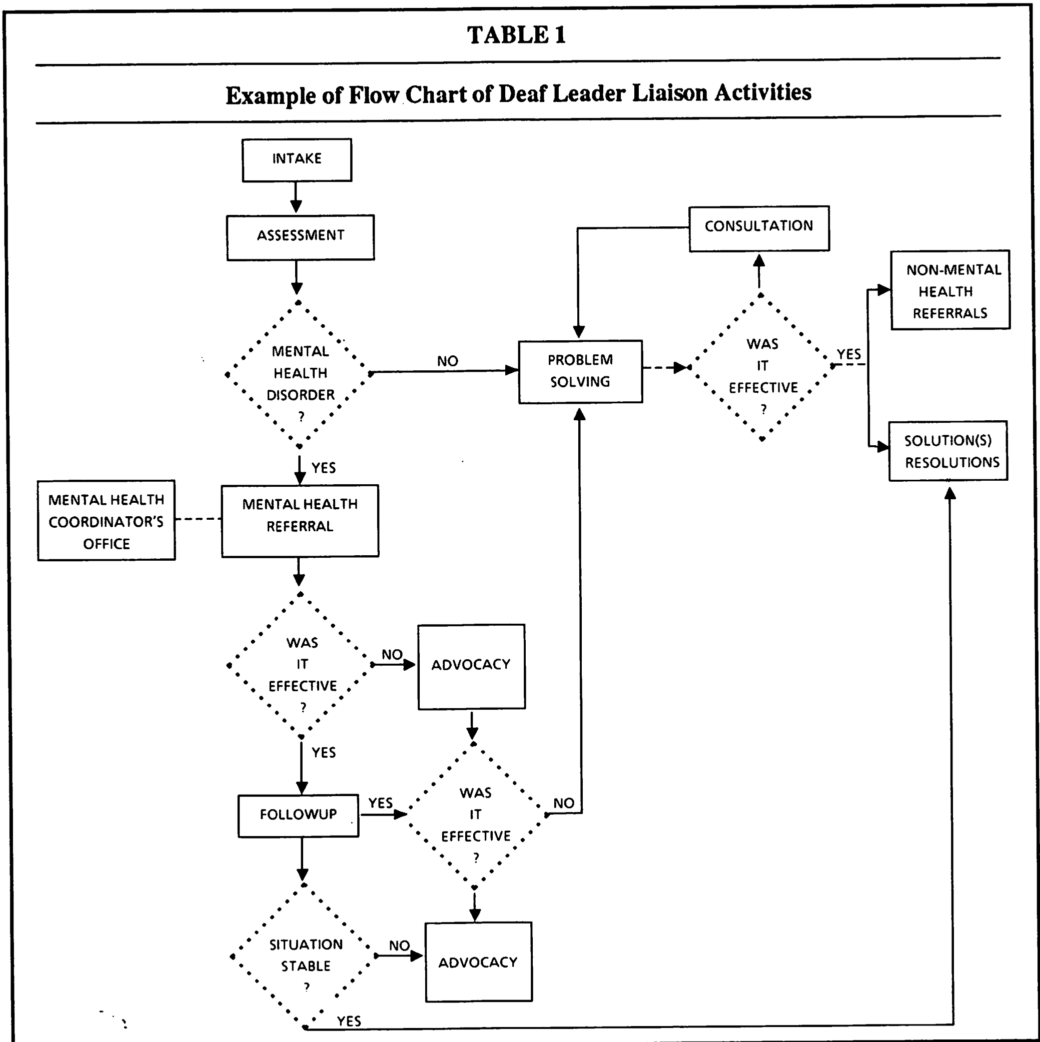
Given the assumption that the mental health program and service culture is significantly different from the deaf community culture (and specifically the Deaf Culture, comprised of about two million

people, Higgins, 1983; Padden & Humphries, 1988), it follows that some cross-cultural process is needed to facilitate access of existing services to this population. It would appear that a cost-effective method for providing such access would be to identify key people in the deaf community who are also educated about the hearing community and its resources; these people can then be trained in specific skills (e.g., listening/screening; problem-solving, advocacy) which they could translate into increased interaction between cultural systems. Logically, Deaf people who have attended college and/or obtained graduate degrees in mental health fields would make ideal candidates to serve as deaf liaisons, because of their presumably positive reputation and credibility as members of the deaf community and because of their knowledge of the mental health system and access to resources in the hearing community. There are other members of the deaf community who, because of their ability to use both sign language and the spoken English language, their pursuit of careers in mainstream work settings, or their otherwise fortuitous contacts in the larger hearing community, have ended up in leadership capacities within the deaf community and who would also make good candidates for this role.

It is important to point out that "obvious" leaders, such as the current president of Deaf clubs, or mental health professionals assigned the task of providing services to deaf people are not always the best candidates. Such leaders can be identified by a "key informant" approach (Warheit, Bell, & Schwab, 1970)—those who are named by most members of the deaf community as the person(s) most likely to

TABLE 1

Example of Flow Chart of Deaf Leader Liaison Activities



be approached for help with [mental health] problems, because of their perceived empathy and wisdom. These people can range from being the volunteer bartender at the local deaf club, to the elderly couple who provide temporary shelter to runaway teenagers and upset or abused spouses, to the well-liked and respected deaf alcoholism counselor (Froland, Pancoast, Chapman, & Kimboko, 1981). It is also important that the person be deaf, both to provide a model for interaction and communication to the prospective mental health service provider and to demonstrate the abilities of deaf people to act as informed consumers on their own behalf.

The deaf leader liaison (DLL) role will have several important functions:

- Help identify or screen potential mental health problem situations needing professional help
- Serve as consultant and advisor to the local mental health program and service providers
- Guide and facilitate access of potential deaf clients to mental health system resources when needed
- Serve as "translator" between deaf client and mental health professional(s) in terms of understanding cultural differences in perspectives or experiences (not to be confused with sign language interpreter services)
- Act as advocate on behalf of deaf clients experiencing difficulty obtaining access to needed services or treatment.

These functions can be identified from the suggested flow chart above (Table 1). For example, identifying/screening functions most likely would occur during the "intake" and "assessment" phase of a DLL's contact with individuals from the deaf community; the guiding/facilitating functions would most likely occur at the "referral" phase; the translating and advocacy activities would most likely occur as mental health resources are being utilized, and the consultation/problem solving functions would most likely occur during this phase as well as at other times, when providers may have specific questions or issues. After the DLLs have been oriented and trained, ongoing contacts between the MH Coordinator's office and the DLLs would probably most frequently occur when they have made referrals to the agencies where service is requested on behalf of deaf client(s). At that point, the MH Coordinator can reinforce the training and consultation activities with the agencies involved. Also noteworthy about the flow chart in Table 1 is that inherent within each question/decision point is a built-in mechanism for evaluation research, to determine effectiveness of the role and function of DLLs as well as of the process itself.

Proposed Curriculum Models For DLL Training

Intake and Assessment Skills (Table 2): Deaf community leaders approached by friends or relatives with what can be identified as mental health problems sometimes feel that these problems are beyond their scope. As a result they may feel helpless and frustrated. One way of increasing effectiveness of those leaders in dealing with these situations is to teach active listening skills as well as some tools for initial screening of the problem to ascertain the need for more professional assistance. Table 2 suggests some subtopic areas which could be reviewed with DLLs, such as active listening skills for empathy (Hackney & Cormier, 1979) and the importance of confidentiality. The latter is an especially significant consideration, because of the cohesiveness of the deaf community (e.g., Baker & Cokely, 1980). The DLL will be in a position to explain, credibly, the distinction between talking as supportive friends within the community, and the option of seeking/using confidential mental health services. By acting as role model for this distinction, the DLL can facilitate a "translation" of the issue of confidentiality between mental health services and the deaf community, for instance. With respect to assessment of presenting problem(s), DLLs can be taught to recognize the typical indicators of mental illness (e.g., Philadelphia Psychiatric Center, Table 3). It will also be helpful to teach problem-solving strategies and effective ways to use consultation (with the MH Coordinator and/or mental health service providers in local agencies), in order to prepare the way for possible referral(s).

Referral: To make appropriate referrals—that is, to steer deaf individuals to appropriate possible resources—DLLs need some information about different manifestations of the mental health system, such as type of agency, varieties of staff, and typical assessment/treatment procedures. With this information, DLLs can proceed to develop relationships with key providers in the local agencies and help explain or "translate" the system to the prospective client, who may otherwise be reluctant to find out for oneself. Conversely, the DLL can help

TABLE 2

Outline of Intake, Assessment, Referral, and Followup Skills for Deaf Leader Liaison Training

**Deaf Culture / Mental Health Culture:
Deaf Community Leaders as Liaisons**

INTAKE

A. **Active Listening Skills**
    1. Attention
    2. Reflection
        A. Cognitive Reflection
        B. Affective Reflection
        C. Cognitive-Affective Reflection
    3. Confirmation: Accurate Empathy
B. **Assuring and Protecting Confidentiality**
    1. Scope and Limits

ASSESSMENT

A. **Warning Signs of Mental Illness**
B. **Problem-Solving Strategies**
C. **Use of Consultation**

REFERRAL

A. **Understanding the Mental Health System**
    1. Public vs. Private
    2. Profit vs. Non-Profit
    3. Mental Health Assessment
    4. Mental Health Professionals
    5. Mental Health Intervention, etc.
B. **Relationship and Rapport-Building**
    1. Translation
    2. Facilitation and Resource-Sharing
C. **Advocacy**
    1. Negotiation
    2. Mediation
    3. Conciliation
    4. Arbitration

FOLLOW-UP

A. **Evaluation**
    1. Effectiveness: Is [Intervention] Appropriate? Working? Satisfactory?
    2. Adequacy: Is [Intervention] Enough?
    3. Efficiency: Is [Intervention] Timely? Too Costly?
B. **Advocacy Revisited**

TABLE 3*

Ten Warning Signs of Mental Illness

1. Gradual, Marked Personality Change
2. Confused Thinking, Strange or Grandiose Ideas
3. Prolonged Severe Depression, Flat Emotions, or Extreme Highs and Lows
4. Excessive Anxieties, Fears, or Suspiciousness
5. Withdrawal from Others, Friendliness
6. Abnormal Self-Centeredness
7. Thinking or Talking About Suicide
8. Numerous, Unexplained Physical Ailments, Sleeplessness, or Loss of Appetite
9. Anger, Hostility – Rage or Violent Behavior
10. Growing Inability to Cope with Problems and Daily Activities Such as School, Job, or Personal Needs

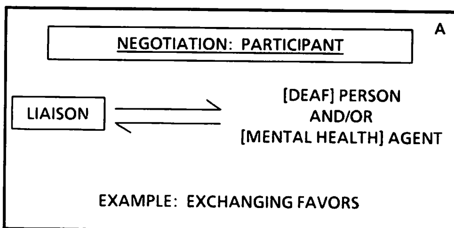
*Philadelphia Psychiatric Center, Philadelphia, PA

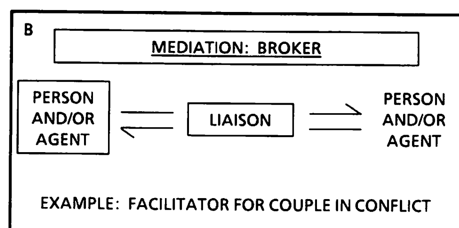
prospective client(s) "translate" mental health problems in the context of the deaf community culture, so that the provider can be more effective in formulating appropriate interventions. An illustration of a technique which can be used by DLLs to provide this kind of translation can be found in the work of Pedersen and Marsella (1981), using the "pro-" and "anti-counselor" roles.

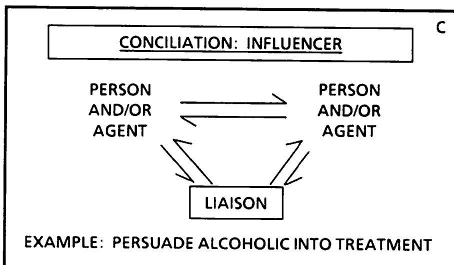
Often mental health service delivery to deaf people is hampered by discrepant financial and political priorities; consequently, DLLs need to be prepared to advocate on behalf of prospective clients

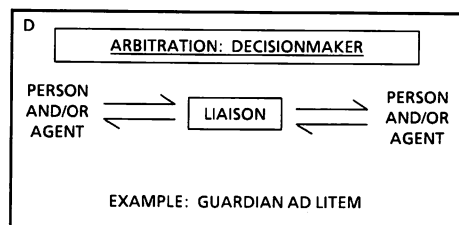
TABLE 4

Types of Bargaining For Advocacy Work









and community mental health needs. Advocacy skills include the ability to negotiate, mediate, conciliate, and arbitrate (Table 4), depending on the situation (Nierenberg, 1973; Zartman & Berman, 1982). To illustrate, if a DLL wants to establish a working relationship with a particular mental health provider/agency because of perceived benefits for deaf community clientele, he or she may try to negotiate a reciprocity of favors. Perhaps the DLL will offer a free workshop about deaf awareness for agency personnel in exchange for agency personnel attending a deaf club meeting and explaining about agency services (Situation A, Direct Participant in Negotiation, Table 4). DLLs often find themselves in the role of mediator, as when trying to help patch up things between fighting spouses (Situation B, Mediator, Table 4); in such cases, having active listening and clarification skills as well as ready suggestions for marriage counseling resources will be helpful for the DLL. In still other cases, a DLL may try to persuade a deaf person to seek alcoholism treatment services and will be working both with prospective treatment provider and prospective client and/or client's family; in these situations the DLL acts in the role of conciliator, who can—in contrast to the mediator who acts strictly as facilitator—exercise persuasion or influence upon the client's decision (Situation C, Conciliator, Table 4). Finally, there may be cases in which a DLL may be asked to serve temporarily as a legal guardian or guardian ad litem to a runaway deaf teenager, for instance, in order to ease family tension or until mental health resources take effect (Situation D, Arbitrator, Table 4). In these cases, authority and decisionmaking powers are vested in the DLL to protect the welfare of the client during that time.

Conclusion

Originally, the proposed DLL model was intended as a cost-effective means of using community people and resources to improve existing mental health service resources by making them more accessible and effective for deaf mental health clientele. Notwithstanding the need to demonstrate the cost-effectiveness of this concept, however, the DLL role can still serve a number of important purposes. Though conceptualized as an opportunity for deaf leaders to volunteer for community service in specifically utile ways, the skills required can increase the employment potential of such volunteers for paid positions with similar functions, such as case manager for deaf clients within the involved local mental health agency. Or when more [deaf] people graduate with mental health degrees and expertise in deafness, then these DLLs can work closely, perhaps in a paraprofessional capacity, with these professional experts in mental health. Hopefully, of course, some DLLs may be inspired to pursue further formal mental health education and training themselves—and be hired by those agencies to provide a broader spectrum of fully accessible mental health services to deaf clients.

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