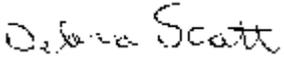
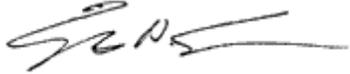


	MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES BULLETIN	
	COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF PUBLIC WELFARE	
NUMBER: OMHSAS-01-06	ISSUE DATE: 10/01/01	EFFECTIVE DATE: Immediately
SUBJECT: Accessibility of Community Mental Health and Substance Abuse Services for Persons Who Are Deaf, Hard of Hearing, Late Deafened, or Deaf-Blind		
BY:  Gerald F. Radke Deputy Secretary for Mental Health and Substance Abuse Services Department of Public Welfare	BY:  Stephen R. Nasuti Interim Executive Director Office of Vocational Rehabilitation Department of Labor and Industry	
BY:  Debra Scott Director Office for the Deaf and Hard of Hearing Department of Labor and Industry	BY:  Stephen H. Surovic Acting Deputy Secretary for Health Promotion and Disease Prevention Department of Health	

SCOPE:

Field Operations, Office of Mental Health and Substance Abuse Services (OMHSAS)
 County Mental Health/Mental Retardation (MH/MR) Administrators
 Base Service Unit (BSU) Programs
 Community Mental Health Service Providers
 Single County Authority (SCA) Administrators
 All Licensed Drug and Alcohol (D&A) Treatment Programs

PURPOSE:

This document is addressed to mental health and substance abuse services providers in Pennsylvania's county mental health and drug and alcohol service systems. It restates the legal and regulatory requirements, and provides recommended practices for meeting the accessibility needs of consumers/clients (children, adolescents, and adults) who are deaf, hard of hearing, late deafened, or deaf-blind. The Office of Mental Health and Substance Abuse Services (OMHSAS) and the Bureau of Drug and Alcohol Programs (BDAP), advise and recommend that County Mental Health/Mental Retardation Programs, Single County Authorities (SCAs), and mental health and drug and alcohol service providers use this document to initiate community interagency discussion, planning, and program implementation. This document will assist service providers in carrying out their responsibilities. All providers must know how the federal and state laws and regulations apply to the implementation of their services. These include:

1. Title II and III of the American Disabilities Act of 1990,
2. Section 504 of the Rehabilitation Act of 1973,
3. The Mental Health/Mental Retardation Act of 1966, and,
4. The Drug and Alcohol Abuse Control Act of 1972.

This bulletin is organized into five parts as follows:

- Part I Background: Incidence of Hearing Loss, Mental Illness, and Drug and Alcohol Services
- Part II Federal and State Statutes and Regulations
- Part III Implementing Approaches for Accessing Mental Health and Substance Abuse Services
- Part IV Recommended Practices to Meet Accommodation Needs of Persons with Hearing Loss
- Part V Resources and Attachments

PART I BACKGROUND:

Prevalence of Mental Illness and Substance Abuse in the General Population: According to epidemiological surveys in the U.S. Surgeon General's Report on Mental Health¹, "The current prevalence estimate is that about 20 percent of the U.S. population are affected by mental disorders during a given year." The report's supporting research states that "a subpopulation of about 5.4 percent of adults is considered to have a 'serious' mental illness (SMI)" and "Children and adolescents with serious emotional disturbances (SED) number approximately 5 to 9 percent of children ages 9 to 17." In addition, the research indicates "...about 15% of all adults who have a mental disorder in one year also experience a co-occurring substance (alcohol or other drug) use disorder, which complicates treatment." And "as many as half of people with serious mental illnesses develop alcohol or other drug abuse problems at some point in their lives."²

Prevalence of Hearing Loss in the General Population: The exact number of persons who are deaf, hard of hearing, late deafened, or deaf-blind in the United States is unknown, but the National Institute on Deafness and Other Communication Disorders estimates that approximately ten percent of the general population has a hearing loss.

Prevalence of Mental Illness and Substance Abuse in the Population with a Hearing Loss: Within the population of persons who have a hearing loss, the need for mental health or drug and alcohol services is at least as great as identified in the general population. Based on these figures, each service provider can estimate the number of persons with a hearing loss, who may also need mental health and/or drug and alcohol treatment services. For example, in a community of 50,000 people, 10,000 may need mental health treatment services in a given year. Approximately 1,000 of these people may experience a hearing loss, and about 150 of these individuals may also require drug and/or alcohol treatment.

Access to and Utilization of Mental Health and Drug and Alcohol Services by Persons with a Hearing Loss: Children, adolescents, adults, and the elderly who are deaf, hard of hearing, late deafened, or deaf-blind require services that are accessible and appropriate to the special and unique problems, issues, and concerns presented by this disability. However, persons with a hearing loss are often uninformed about the availability of mental health and drug and alcohol services and/or how to effectively access them. Also, under-utilization of such services is attributed in part, to the lack of professionals, who are:

1. Trained about the needs of individuals with hearing loss;
2. Skilled in the communication needs of persons with hearing loss, and
3. Able to apply effective communication skills to provide appropriate diagnostic and/or level of care assessments and therapeutic treatment procedures.

PART II FEDERAL AND STATE STATUTES AND REGULATIONS

Mental health treatment services administered under the Mental Health/Mental Retardation Act of 1966, and drug and alcohol services administered under the Drug and Alcohol Abuse Control Act of 1972, are subject to federal and state requirements related to accessibility. The federal laws include Title II and Title III of the Americans with Disabilities Act (ADA) of 1990, and Section 504 of the Rehabilitation Act of 1973. The regulations implementing §504 of the Rehabilitation Act mandate that all programs receiving federal assistance are fully accessible regardless of an individual's disability.

By state statute, the Commonwealth of Pennsylvania "assure[s] within the State the availability and equitable provision of adequate mental health and mental retardation services for all persons, who need them" subject to the availability of funding, MH/MR Act of 1966, §201 (50 Pa.C.S. §§4201, 4509(5) and the PA Drug and Alcohol Abuse Control Act of 1972, §10 (71 Pa.C.S. §1690.110)). OMHSAS and BDAP recognize that "all people" as articulated in this assurance, includes people who are deaf, hard of hearing, late deafened, and deaf-blind.

Most notably, Title II of the Americans with Disabilities Act, 42 U.S.C. §12101 *et seq.*, provides that people who are deaf, hard of hearing, late deafened, or deaf-blind cannot, "by reason of such disability," be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. §12132. The definition of a public entity in Section 12131 of Title II includes:

- "Any State or local government" and
- "Any department, agency, special purpose district, or other instrumentality of a State or States or local government."

Thus, Title II prohibits the Commonwealth's and local government's mental health and drug and alcohol service systems from

discriminating against people who are deaf, hard of hearing, late deafened, or deaf-blind in assessment, diagnosis, evaluation and other forms of mental health or drug and alcohol services that are provided to other citizens. Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §794, further bolsters the rights afforded under Title II by providing that all programs receiving federal assistance are fully accessible regardless of an individual's disability.

Requirements similar to those applied to the Commonwealth and local governments under Title II are applied to private entities under Title III of the ADA. Such entities include doctors' offices, pharmacies, hospitals, and social services agencies. Thus, when such private entities contract with the Commonwealth to provide mental health or drug and alcohol services, or even when they provide such services independently of the Commonwealth, they shall not discriminate against any individual "on the basis of disability in the full and equal enjoyment of [their] goods, services, facilities, privileges, advantages, or accommodations." 42 U.S.C. §12182.

Although Title III does not apply to religious organizations or entities controlled by religious organizations (42 U.S.C. §12187), such entities must meet similar requirements under § 504 of the Rehabilitation Act, when they receive federal funds for their mental health and drug and alcohol programs.

Regulations developed by the United States Department of Justice (DOJ) and other federal agencies to implement these federal statutes specifically address the obligations of the Commonwealth and those who work with it to remove communication barriers to mental health treatment services for individuals who are deaf, hard of hearing, late deafened, or deaf-blind. Furthermore, the Commonwealth is committed to providing equitable services for these individuals.

Discrimination or inequity in the provision of mental health or drug and alcohol services for persons who are deaf, hard of hearing, late deafened, or deaf-blind, can take many forms. For example, discrimination may occur when a service provider/agency fails to:

- Provide and maintain a direct communication system³ using current assistive technology, thus insuring accessibility to persons who are deaf, hard of hearing, late deafened, or deaf-blind;
- Inform a consumer/client who is deaf, hard of hearing, late deafened, or deaf-blind, at the first point of entry into the service system that the consumer/client is entitled to equally appropriate, effective services under Title II;
- Provide a qualified interpreter or other auxiliary aid or service for a consumer/client when such would be necessary to enable the consumer/client "to obtain the same result, to gain the same benefit or to reach the same level of achievement as that provided to others," 28 C.F.R. §35.130 (b) (1) (i-iii);
- Ask the consumer prior to the initiation of services, what will facilitate communication and honor the consumer's choice; or
- Effectively inform the consumer/client in his/her preferred communication mode of the right to appeal a denial of service or accommodation and how to initiate such an appeal.

Therefore, providers of mental health or drug and alcohol services need to assure accessibility to services and effectively meet the accommodation needs of persons with a hearing loss.

PART III IMPLEMENTING APPROACHES FOR ACCESSING MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

The State Mental Health Plan, the State Drug and Alcohol Plan, the Federal Block Grant application, the County Mental Health Plan Guidelines, and contracts/contractual agreements include guidelines and direction to identify and meet the needs of special populations. Based on the legal and regulatory requirements identified in this bulletin (Part II), OMHSAS and BDAP are committed to improving access to county administered mental health and drug and alcohol services for persons who are deaf, hard of hearing, late deafened, or deaf-blind. To effectively improve access to services, OMHSAS and BDAP will:

1. Seek, invite, and encourage the participation of consumers who are deaf, hard of hearing, late deafened, or deaf-blind, as well as family members, and parents of children and adolescents, in the program/service assessment, planning, implementation, and evaluation process.
2. Plan, develop, and implement training initiatives with the collaboration of consumers who are deaf, hard of hearing, late deafened, or deaf-blind on issues related to the mental health and drug and alcohol service needs of individuals who are deaf, hard of hearing, late deafened, or deaf-blind.
3. Recruit persons who are deaf, hard of hearing, late deafened, or deaf-blind to participate in the development of policies and training programs, and to serve as trainers.
4. Use professionals familiar with the specific needs of individuals who are deaf, hard of hearing, late deafened, or deaf-blind in the development of policies and information materials, as well as staff training.

The County MH/MR Programs and the Single County Authorities (SCAs) must ensure that their contracted service providers comply with the legal requirements related to accessibility. Therefore, OMHSAS and BDAP recommend that County MH/MR programs, SCAs, and mental health and drug and alcohol service providers implement the measures listed above (#1 – 4) at the local level. In addition, accessibility to services can be improved by:

- Ensuring that mental health and drug and alcohol professionals and staff use effective manual communication skills (signing), which can be accomplished in one of two ways:

1) Evaluate the signing skills of professionals and staff to meet the proficiency standards set by the Sign Communication Proficiency Interview (SCPI) at the advanced level or above, or

2) Obtain a qualified certified interpreter(s) and use team interpreting⁴ when necessary.

- Ensuring that mental health and drug and alcohol professionals and staff are trained so they can implement services that match the special communication and treatment needs of persons who are deaf, hard of hearing, late deafened, or deaf-blind. Training topics should include, but are not limited to: definitions, deaf culture, cultural differences of individuals with a hearing loss, the languages used by persons who are deaf, hard of hearing, late deafened, or deaf-blind, protocol for using interpreters, improving sign language skills, psycho-social effects of hearing loss and behavioral characteristics, and the effective use of auxiliary aids and communication equipment (such as ALDs, amplifiers, and TTYs).

Additionally, service providers should initiate actions to acquire technical assistance capability to educate and inform mental health and drug and alcohol professionals and staff about the unique needs of persons who are deaf, hard of hearing, late deafened, or deaf-blind. Also, service providers should work on expanding that capacity to include other needed services that are identified by the local community, such as printed and videotape resource materials.

PART IV RECOMMENDED PRACTICES TO MEET THE NEEDS OF PERSONS WITH A HEARING LOSS

This section provides recommended practices for assuring accessibility to services and meeting the needs of persons with a hearing loss⁵. These practices can be used to implement the legislative and regulatory requirements cited in Part II (Federal and State Statutes and Regulations), as well as Part III (Implementing Approaches for Accessing Mental Health and Substance Abuse Services) of this bulletin. By applying these practices, every agency, program, and service provider can strategize, plan, develop, and implement effective approaches to meet the needs of persons who are deaf, hard of hearing, late deafened, or deaf-blind.

As stated in Part II (Federal and State Statutes and Regulations) of this bulletin, accessibility to services is required for persons who are deaf, hard of hearing, late deafened, or deaf-blind by provisions in the ADA (Titles II and III) and §504 of the Rehabilitation Act of 1973. When implemented, the following recommended practices would assist agencies, programs, and service providers and their staffs maintain compliance with applicable laws and regulations. These recommended practices would also facilitate in applying and implementing the established principles and values of service philosophies [Community Support Program (CSP), the Child and Adolescent Service System Program (CASSP), and the Bureau of Drug and Alcohol (BDAP) Treatment Philosophy and Principles].

- Assessment
 - Assess the needs (service needs and accommodation needs) of the individual (child, adolescent, adult) to be served.
 - Identify the individual's communication needs, level of reading skills, comprehension level, the preferred choice of service provider, evaluation and treatment options, and the level of family involvement.
 - Ask the individual to identify his/her level of hearing loss and how he/she wants it to be addressed (i.e., deaf, hard of hearing, late deafened, deaf-blind.)⁶
 - Give the consumer's accommodation preferences and personal views (identified during assessment) primary consideration in treatment planning and service delivery.
- Development of Effective Mental Health and Drug and Alcohol Treatment Services
 - Develop effective services for persons who are deaf, hard of hearing, late deafened, or deaf-blind by joining with neighboring county MH/MR and drug and alcohol programs/providers for cost-effective options (i.e., interpreter services contracts).
 - Develop effective services for older adults who are deaf, hard of hearing, late deafened, or deaf-blind through collaboration with agencies on aging.
 - Develop effective services for children and adolescents with emotional disturbances, who are deaf, hard of hearing, late deafened, or deaf-blind, and their families through collaboration with all child-serving systems, such as education, juvenile justice, child welfare, etc.
 - Contract with providers of specialized services for interpreters and auxiliary aids that meet the consumer's needs as stated under Title II of the ADA.
- Reasonable Accommodation Access
 - Ensure appropriate communication access, based on the consumer's preference.
 - Make reasonable accommodations by using available technology (i.e. auxiliary aids).
 - Ensure the availability of assistive listening devices (ALDs)⁷ or computer assisted real time transcription (CART) for those persons, whose communication access requires this equipment.
 - Ensure that clinicians use effective manual communication skills (signing) for those persons, whose preferred method of communication is signing. Since sign language interpretation during the complex interaction between clinician and consumer/client requires a level of proficiency that ensures accurate diagnosis and appropriate treatment, this can be accomplished in one of two ways:
 - Evaluate the clinician's signing skills to meet the proficiency standards set by the Sign

- the child's disability, and where collaborative effort among multi-systems is needed.
- Hearing children who have parents who are deaf, hard of hearing, late deafened, or deaf-blind.
- Persons with a hearing loss who are experiencing social isolation, vocational adjustment problems, or difficulties with activities of daily living over their life span. These include persons who have experienced gross sensory, communication, and social deprivation due to misdiagnosis and/or long term placement in residential programs and/or institutions.
- Persons having difficulty adjusting to changes resulting from gradual hearing loss related to aging.
- Persons experiencing difficulty adjusting to traumatic or sudden hearing loss/late deafened from accidents, medications, disease, tumor, heredity, or other causes.
- Persons impacted by improved hearing resulting from successful cochlear implants or lack of improved hearing due to the failure of cochlear implants.

PART V RESOURCES AND ATTACHMENTS

There are agencies, organizations, and advocacy groups in Pennsylvania that are willing to work with the mental health and drug and alcohol systems to meet the challenge of providing appropriate and accessible services to persons who are deaf, hard of hearing, late deafened, or deaf-blind. A list of resources is attached.

Information about the Department of Labor and Industry, Office for the Deaf and Hard of Hearing (ODHH) and the Office of Vocational Rehabilitation (OVR) is included that may be used as resources to develop accessible programs. For instance, each District Office of OVR employs at least one Rehabilitation Counselor for the Deaf and Hard of Hearing (RCDHH)¹² to assist with employment evaluations and assessments. Although the OVR Bureau of Blindness and Visual Services (BBVS) does not have a Rehabilitation Counselor or social worker that deals strictly with individuals who are deaf-blind, providers may contact the BBVS District Office for assistance and referrals to the counselor or social worker, who coordinates rehabilitation services for persons who are deaf-blind.

Attachment A	List of Acronyms
Attachment B	Definitions: Part 1, Related to Deaf, Hard of Hearing, Late Deafened, Deaf-Blind; Part 2, Bulletin Terminology
Attachment C	Resource List
Attachment D	Sign Communication Proficiency Interview (SCPI) Skills Assessment Evaluation Tool
Attachment E	Section 504 of the Rehabilitation Act
Attachment F	ADA Communication Accommodation Project: (Published by Gallaudet University, Washington, D.C)
Attachment G	Core Principles of The Child and Adolescent Service System Program (CASSP) and The Community Support Program (CSP)

¹ Mental Health: A Report of the Surgeon General, Published by the U.S. Department of Health and Human Services, Public Health Service, Chapter 2, Section 3, December 1999

² *ibid.*, Mental Health: A Report of the Surgeon General, Chapter 4, Section 5, December 1999

³ The use of a direct communication system is determined by the needs of the population served by the service provider and the consumer/client's preference of communication method, such as, TTY, Braille text, TeleBraille, Pennsylvania Relay System, (PRS) and telephone amplification devices.

⁴ Team interpreting: See Attachment B Part 2 Definitions

⁵ A Task Force identified the specific accommodation needs of persons with a hearing loss and developed these recommended practices to assure accessibility to services. The Task Force included staff from DPW (OMHSAS and Office of Medical Assistance Programs), Department of Labor & Industry (Office of Vocational Rehabilitation and Office for the Deaf and Hard of Hearing), service providers, advocates, representatives from PSAD and SHHH, and individuals who are deaf, hard of hearing, or late-deafened.

⁶ See Definitions Attachment B – Part 1

⁷ Auxiliary Aids/Assistive Listening Devices: See Attachment B Part 2 Definitions, Bulletin Terminology

⁸ SCPI: An evaluation tool to assess an individual's level of communication proficiency when communicating using sign language and receptive skills. Required to meet Level 4, Advanced or Level 5, Superior. (Certified interpreters are exempt from this requirement.) See Attachment D for description of the SCPI Assessment tool.

⁹ Contact the Department of Labor and Industry, Office for the Deaf and Hard of Hearing or their Website at www.dli.state.pa.us to obtain the list of Certified Interpreters.

¹⁰ See Cultural Competency in Attachment B Part 2 Definitions, Bulletin Terminology. Used in the context of this bulletin, cultural competency refers to understanding cultural differences relating to ethnicity, race, religion, etc., in addition to understanding the impact of the individual's hearing loss across their life span.

¹¹ *ibid.*, Mental Health: A Report of the Surgeon General, Chapter 8, Section 6, December 1999. See also, Mental Health: Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General, Page 36.

¹² The RCDHH is not an interpreter, but he/she is an important contact person for planning a comprehensive rehabilitation treatment program for an individual who is deaf, hard of hearing, late deafened, or deaf-blind and is involved with OVR or may be referred to OVR. Information on the Client Assistance Program is available from OVR.

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