November 2019

Deafness Mental Health Needs Assessment: A Model

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Abstract

The success of any new program often depends on an accurate needs assessment of the population to be served. Program planning is particularly difficult for low incidence disabilities, such as deafness. This paper presents a model to assist practitioners in community mental health program planning for deaf adults. The model is applied to a large metropolitan community in the southwestern part of the United States. Several issues emerge as a result of applying this model and we make recommendations for more effective mental health service provision based on these issues.

The past two decades have seen an expansion of social and rehabilitative services to deaf people as a result of major legislative mandates, such as the Rehabilitation Act of 1973 and its amendments; improved competencies and communication skills in professionals working with deaf clients; and expanded consumerism (Danek, 1987).

Although much progress is evident, the spectrum of human service programs, particularly less traditional services such as mental health services, has frequently not been available to deaf persons.

Accessibility is defined as the extent to which deaf people are able to utilize services to the same degree as hearing people. Too often, the deaf person has little choice of services, or little assurance that programs are staffed by professionals with expertise in deafness as well as other appropriate skills.

This issue of accessibility to services for deaf Americans is a complex one. Since deafness is both a low-incidence and an "invisible" disability, it is easy to overlook the special needs of deaf persons when planning human service programs, such as mental health services. These services are not utilized extensively by the general population and, therefore, are particularly likely to be inaccessible to deaf persons. Although these services are needed by limited numbers of people, they are no less important to those deaf people who need them.

Accessibility to mental health services is an emerging concern among professionals familiar with deaf persons' service needs (Langholtz & Heller, 1988; Sussman, 1988). Increased attention to this need has resulted in professional training programs at the pre- and post- service levels and large numbers of professionals expanding their expertise and focus to accommodate those deaf persons in need of mental health services. As a result, mental health services are becoming more available in the deaf community as efforts are being made to recognize the specific needs of deaf people (Mental Health System Reorganization Office [MHSRO], 1985).

Needs Assessment: Rationale

A systematic approach to assessing mental health needs of deaf people is the crucial first step in designing programs and services. Otherwise, efforts to provide services might be inadequate, possibly overlapping at one point while falling short in another.

Needs assessments are necessary to prevent the all too frequent occurrence of program failure. Program failures are most likely the result of the good intentions of community practitioners who provide less necessary services while not providing more urgently needed ones (Siegel, Attkisson & Carson, 1978). Additionally, program failures are sometimes the result of program implementation based on what we will refer to as "top-down" assessment, where programs begin in response to legislation or mandates at the state or federal level. Needs that are specific to a community are often not met by these federally mandated programs and, therefore, the program fails.

The purpose of this paper is to describe a model to assist practitioners in community pro-

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gram planning and to apply the model to a large metropolitan community. By using a model, professionals have a conceptual framework for planning and conducting needs assessments that effectively address the needs unique to their community and the population they wish to serve.

The model proposed in this paper incorporates a "bottom-up" approach that provides safeguards to insure accuracy in the assessment process. The bottom-up approach refers to "grass roots" program planning based on the needs of a specific geographic area. By presenting a bottom-up approach, overlaps and gaps can be prevented because the uniqueness of a particular community is considered.

No one model for a needs assessment is universally accepted. It is important, therefore, when initiating a needs assessment to consider the various options based upon the specific purpose and contexts. Kamis (1981, pp. 28-32) lists and describes four generic methods, each with advantages and disadvantages in procedures:

1. The field survey method, which involves a representative household survey of problems and needs.
2. The key informant method, which assesses the perceptions of needs by community leaders or professionals.
3. The rates-under-treatment approach, which infers needs from the pattern of on-going service utilization.
4. The social indicators approach, which infers needs from known associations between

social area characteristics (e.g. income, ethnicity, age) and the prevalence of social and health problems.

Description of the Needs Assessment Model

The following is a description of the model used in this paper to identify the mental health needs of prevocationally deaf persons in a moderately large county of about one million persons in the southwestern part of the United States.

This model used a two-tiered approach that combined social indicators and key informant methods to establish a "discrepancy" between needs and usage. "Discrepancy" in this paper refers to the comparison of hypothetical data obtained by extrapolation with actual usage patterns and other data gathered from sources in the community.

Step one. Since little data exists on the size of the deaf population in any given catchment area, it was first necessary to estimate a probable range of the prevalence of deafness in that area. For the deaf population, estimates were used. For purposes of this survey, we defined deafness as the inability to hear a normal conversation (Department of Commerce, 1986).

Figure 1 shows the distribution of the county population according to ethnicity. One unique characteristic of the county studied is a slightly greater number of hispanics than of anglos. The needs of hispanic deaf persons often extend beyond those of the general deaf population and

FIGURE 1

SUMMARY OF COUNTY CENSUS DATA
Ethnic Distribution

Other 1%
Black 7%
Anglo 45%
Hispanic 47%
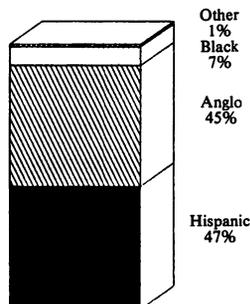
(Revised 1986) Note "Other" is < 1%.

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FIGURE 2

ESTIMATES OF THE DEAF POPULATION
ACCORDING TO AGE AND ETHNICITY

note bimodal distribution

Age
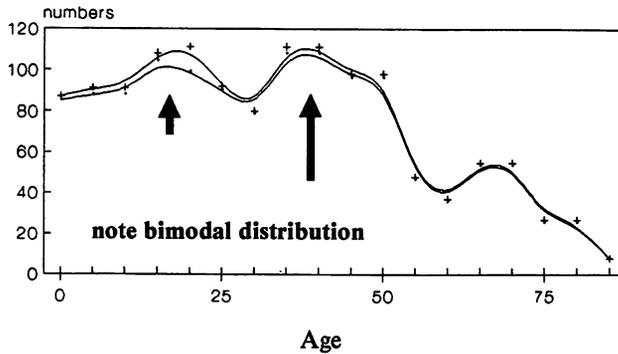
(extrapolated from county census data)

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should be considered within the framework of a "double minority" status (Sue, 1977). There is a very small number of black persons in the county and, therefore, we can expect black deaf persons in this area to be exceedingly rare. Overall, approximately 2,222 deaf people are estimated to be living in the county and, of these, 1,026 are hispanic and 1,009 are anglo as noted in Figure 2.

Next, it was necessary to estimate the number of deaf individuals who might need mental health services. Using the estimates of deaf persons in Figure 2, a range was determined for the number of deaf people possibly needing mental health services. This was calculated by using the National Institute of Mental Health (1984) estimates for the hearing population mental health needs (Robins et al., 1984). If we assume that deaf people need mental health services in numbers equal to the hearing population (and we do not believe there is adequate empirical evidence indicating otherwise), we can directly extrapolate from general population needs to the needs of the deaf population. For example, approximately 268 deaf people might need mental health services in any six month period (Figure 3).

FIGURE 3

POTENTIAL DEAF USERS OF MENTAL HEALTH SERVICES
(Within A Six Month Period and Lifetime Usage)

Age
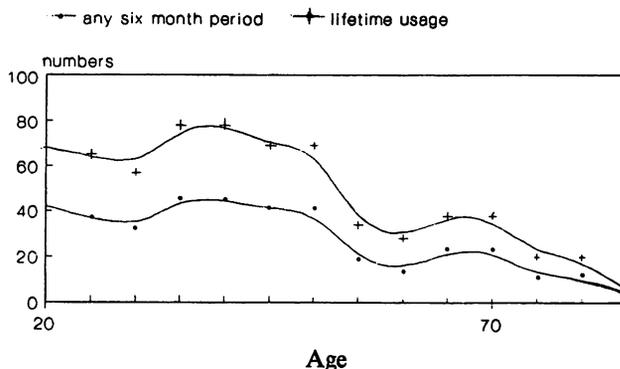
Based on NIMH estimates (1984)   (extrapolated for county data)

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FIGURE 4

LIFETIME POTENTIAL DEAF USERS OF MENTAL HEALTH SERVICES ACCORDING TO GENDER AND ETHNICITY

Gender within ethnic group

▥ male   ▨ female   ☐ total
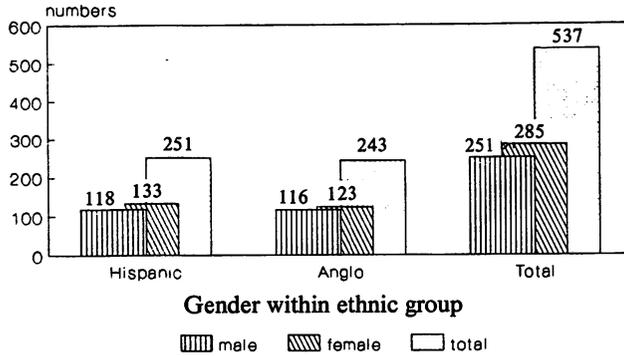
(blacks included in total: extrapolated from county data)

Approximately 395 to 537 people might require such services over a lifetime (Figure 3). While these newly established numbers are by no means exact and some experts caution again using extrapolated data (Hotchkiss, 1989), we believe this method offers the planner a range to consider for implementation of services and provides at least some basis for program development. Further demographic breakdown is also possible according to gender and ethnicity (Figure 4).

Step two. The next step should be to obtain the usage rate of existing mental health services. An exhaustive survey was not conducted for this paper due to time and financial constraints. Instead, a small number of representative mental health service providers from two rehabilitation facilities, two community mental health centers and two social service agencies in the county were contacted by telephone. Open-ended questions focused on numbers of clients being referred, where clients are referred from, program accessibility, kinds of services provided, services most often used, services not offered, numbers of clients being referred, where clients are referred from, services not available, and where agencies are referring clients when they are unable to accommodate the client directly.

Findings

Regrettably and surprisingly, usage numbers cannot be reported in this study because the agencies sampled did not maintain reliable records and the sample was limited. However, all respondents believed that deaf people were neither requesting nor receiving mental health services in numbers commensurate with their needs. Major concerns expressed by the respondents were:

1. The deaf community was unaware of existing services.
2. Outreach agencies were unable to work beyond their present capacities.
3. Mental health services were perceived by the respondents as largely inaccessible to deaf people; often there was no place to refer a deaf client for mental health services.
4. Front line staff at generic social service agencies were unable to identify those deaf persons in need of mental health services and thus could not make appropriate referrals.
5. When referrals were made, a gap existed between the referral agency and the receiving agency: the agency to which the client was referred frequently never received the client.

Discussion

While it is inappropriate to generalize findings or to draw widespread conclusions on the small numbers of key respondents utilized, several issues emerged as a result of following this model. First, it seems highly likely that the deaf community in this particular area was not utilizing

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services in numbers proportional to their needs. A directory of community services was outdated and did not specify services that were accessible to deaf users (i.e. through TDD's, interpreters, staff trained in deafness, etc.). Agencies contacted for this research were located by word of mouth.

Second, the question of who was responsible for outreach was a relevant one. Respondents observed that outreach agencies were restricted in their efforts due to various economic and personnel shortages. Inadequate staffing was, in fact, the reason given for rehabilitation agencies' inability to be more involved with outreach activities.

Third, there is a possibility that deaf clients for mental health workers may be "slipping through the cracks" virtually undetected. This may be due to the referring agency's inability to recognize a mental health problem and to distinguish between problems attributable to deafness and those due to true mental health needs.

Several reasons may account for this possible gap between the referring agency and the receiving agency. It is possible that among segments of the deaf population a stigma is attached to mental health problems and a mistrust of mental health agencies exists. This may possibly be due to several well-publicized cases of misdiagnosis and misplacement of deaf people in institutions for the mentally retarded (Stokoe and Battison, 1981). Since approximately half of the potential clients used for this model are also hispanic, it may also be that traditional hispanic reluctance to seek mental health services keeps clients from following up on referrals that are made (Ruiz & Padilla, 1977).

Next, and more importantly, the receiving agency itself may be inaccessible to the deaf person. If, for example, the client is in need of counseling, the fluency of the mental health professional in sign language, or whether he/she is knowledgeable of the cultural aspects of deafness may have an impact on whether or not the client shows up for counseling services. Hearing people who do therapy with deaf people must appreciate cultural differences, be sensitive to normal communicative and social behavior in the deaf community, and apply this knowledge in their clinical practice (Stokoe & Battison, 1981).

If an interpreter is used, the mental health professional, with no previous experience with deaf people and not knowing how to communicate with a deaf person or use an interpreter, may find it harder to establish rapport, confidence, and trust in the therapeutic relationship (Harvey, 1983). Sometimes the interpreter may be unclear or unaware of his/her boundaries and responsibilities, or have difficulty with transference issues (Goldberg, 1983, Taff-Watson, 1983). The deaf mental health client, who brings positive or negative feelings to the situation based on previous experiences with interpreters and/or mental health professionals, may not know what to expect from the therapist, may not know how to use an interpreter, or worse, may feel the interpreter is inadequate or cannot be trusted.

Finally, clients who could not afford private mental health services frequently had no appropriate agency to be referred to. Public community agencies either functioned in multiple capacities in order to provide what mental health services they could, or simply did not serve the client.

Recommendations

The following recommendations are offered in response to a number of issues raised in this paper. First, it is difficult for program planners to document exactly the probability of a population needing services and those that are using them. Although not perfect estimates, hypothetical numbers may be established for need and then estimates of usage derived from key informants or rates under treatment. In this way a broad discrepancy rate can be obtained for purposes of outreach and program planning.

Secondly, a well-maintained directory of services, either specifically for the deaf community or for the general population with additional notations for accessibility is needed. The local or state association of deaf people might actively involve itself in this process. When significant numbers of minority deaf persons exist as they did in this survey population, directories should be available in their language (e.g. Spanish).

Thirdly, all agencies, such as rehabilitation, mental health, and social services agencies must be proactive and take more initiative in outreach efforts. Designated outreach agencies cannot be solely responsible for linking the service providers to those in need of their services. An interagency agreement clarifying referral and outreach efforts can reduce the overall burden on any one agency.

Fourth, in-service training in the form of workshops and lectures by professionals in deafness needs to be made available to social service and

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rehabilitation generalists so that identification of potential deaf mental health referrals is possible. The local rehabilitation agency, along with the mental health agency, can sponsor such efforts. It is important that such workshops address the mental health needs of deaf persons, and possible misdiagnosis based on misinformation. Additionally, workshops should address issues related to interpreter use in mental health settings, as well as the psychosocial implications of deafness and the implications of minority group status in accessing mental health services (e.g. how the deaf hispanic person perceives and accesses mental health services).

Conclusion

This paper presented a model that can assist practitioners with community program planning for deaf persons. The model was used to assess mental health needs among deaf persons in a large metropolitan community in the south-

western United States with a sizable hispanic population.

Several issues emerged as a result of applying the model to an actual community. First, there is a need for increased awareness of existing mental health services by the deaf community. Additionally, the responsibility of all service providers in relation to mental health services is three-fold: Increased outreach efforts to aid in both the deaf community's awareness and the efforts of designated outreach agencies, better detection of potential mental health clients, and increased sensitivity to deafness and Deaf culture issues.

In summary, the availability of mental health services for deaf people should be a matter of need and not necessarily demand. Demand may be reduced due to many factors including the perception of a barrier-filled environment. Mental health services must be offered to deaf people on as broad a scale as those offered to the hearing population.

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