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Abstract

With the exception of a few long-standing programs, the existence of inpatient psychiatric services for deaf and hard-of-hearing people has generally waxed and waned over the years, as evidenced, for example, by changes noted in sequentially published directories of mental health services for this population (Long, High, & Shaw, 1987; Willigan & King, 1992; Morton & Christensen, 2000). A panel presentation consisting of psychiatric inpatient program directors was developed for the most recent ADARA conference in Monterey, California. The purpose of this presentation was for directors from geographically and historically diverse programs to describe characteristics of their respective programs, and to comment on present as well as future implications of this level of care for deaf and hard-of-hearing people. Four psychiatric inpatient program directors were able to participate directly in the panel presentation (Tovah Wax, Deaf Services Unit, Dorothea Dix Hospital, Raleigh, NC; Barbara Haskins, Head of Treatment Team, Western State Hospital, Staunton, VA; Timothy Mason, State Director of MH Services f/t Deaf, Springfield Hospital Center, Springfield, MD; and Wendy Ramirez, Service Director, Rockland Psychiatric Center, Orangeburg, NY).

Current Program Characteristics

Table 1 reflects a summary of key program characteristics for four psychiatric inpatient programs: Dorothea Dix Hospital, Western State Hospital, Springfield Hospital Center and Rockland Psychiatric Center, with additional contribution by Marie Savoy-McAdory, who could not personally attend the conference. Some noteworthy observations about these programs are:

1. Some programs were established as a result of threatened or actual legal actions regarding accessible mental health care for deaf and hard-of-hearing state residents. The Rockland Psychiatric Center and St. Elizabeth's hospital units were established as an extrapolation of the pioneering efforts of Rainier and Altschuler (1966; 1967) and Robinson (e.g., 1973), respectively, concerning psychiatric services and deafness. Western State Hospital's deaf unit was established as a proactive response to ongoing litigation in the neighboring state of Maryland (Haskins, Table 1).

Table 1. Psychiatric Inpatient Program Characteristics

Program Name & Director/Representative	Brief History of Program	Size (# Beds)	Target Population
Deaf Services Unit Dorothea Dix Hospital Raleigh, NC Tovah M. Wax, Program Director	Founded as part of settlement agreement between NC Association of the Deaf and the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services. Established in 1994.	17	Deaf, HOH, Deaf-Blind adults (over 18), Residents of NC State, CO-ED
Deaf Unit Rockland Psychiatric Center Orangeburg, NY Wendy Ramirez, Service Director	Established as part of a research project run by Dr.'s John Rainer and Kenneth Altschuler. Created in 1963.	22	All Deaf (nationally), ages 18-85, CO-ED; Primarily NYC residents
Deaf Unit Springfield State Hospital Center Springfield, MD Timothy Mason, State Director of Mental Health Services of the Deaf	Established as a result of a lawsuit and decree enacted by the state ("Doe Decree"), in 1985.	20	All Deaf in state of MD
Mental Health Center for the Deaf Western State Hospital Staunton, VA Barbara Haskins, Head of Treatment Team	Federal grant awarded to Western State Hospital to establish a unit for deaf in 1970's. When grant ended, deaf were "mainstreamed". General assembly of VA spurred by Maryland lawsuit to establish distinct Deaf Unit in 1987.	24	Deaf, HOH, Deaf-Blind adults (over 18) of VA State, CO-ED

Table 1. Psychiatric Inpatient Program Characteristics, continued

Program Name	Services Provided	Staffing	Communication Modes/Methods	Auxiliary Services
Deaf Services Unit Dorothea Dix Hospital	"Traditional" (Acute) "Psychosocial Rehabilitation" (Chronic)	Psychiatrist, Psychologist, Unit Nurse Mgr, Social Worker, Ther. Rec. Spec., Nurses, HCT's, Interpreters	Signing Staff; Interpreters; Visual Media	Audiology Rehab Services Medical Services Religious Services
Deaf Unit Rockland Psychiatric Center	Individual, Group, Family Therapy Meds, Psych Assessment ADL's, Cognitive Remediation, Social Skills, Training, Consultations	Psychiatrist, Social Worker, Team Leader, Nurse Supervisor, Rehab Counselor, Case Manager, Psychologist, Rec. Therapist, Nursing Staff, Interpreters	Signing Staff; Interpreters	Medical Clinic Secure Unit "Treatment Mall" Religious Services
Deaf Unit Springfield State Hospital Center	Psych Assessment, Meds, Psy. & Soc. Wk. Svcs., Rec. & Occ. Therapy, Voc. Svcs., Addictions Svcs., Nursing, Art Therapy, HIV/AIDS Education	Psychiatrist, Social Workers, Art Therapist, Communication Specialist, Psychodramatist, Rec. & Occ. Therapists, Psychologist (contract), Nursing Svc.	Communication Specialist Consult; Interpreters, Some Signing Staff	Dental & Vision, Audiology, Speech, Forensic, Medical/Surgical
Mental Health Center f/t Deaf Western State Hospital	"Treatment Mall", Meds, PSR, Indep. Living Skills, Psych. Assessment	Psychiatrist, Psychologist, Social Worker, Nursing Staff, Occ. Therapist, Language Therapist, Neuropsychologist	Some Signing Staff; Interpreters; Assistive Devices; Tactile Signing	Substance Abuse Services, Forensic Assmt. Voc. Rehab.

2. All of the programs were established as separate units or services with specialized multi disciplinary staffing and resources for deaf and hard-of-hearing patients. The number of beds range from 16 to 22, and only one of these programs serves deaf and hard-of-hearing patients of all ages; the populations served by the remainder are 18 years and older. Although the NY program serves people from other states, it and the other state-based programs serve primarily residents from their home state.
3. All of the programs have staff sign language interpreters and/or contracts with interpreter agencies or businesses, notwithstanding the presence of other staff that use sign language [although admittedly with varying degrees of fluency]. Some programs have a communication specialist on staff (e.g., Springfield State Hospital), while most of the others have consultative or collaborative access to auxiliary audiology/speech/language services. Almost all mention the use of visual assistive devices as well.
4. Although explicitly described only by Western State Hospital, the deaf units offer a "treatment mall" of multi disciplinary services that most often include substance abuse, vocational, forensic treatments, and community mental health outreach, in addition to the more customary acute inpatient psychiatric services.

Intra-Contextual Factors Affecting Current Program Functioning

Positive Factors: The importance of an explicitly stated sign language and communication policy within the unit was identified most frequently as a positive influence. When a state mental health coordinator was available, the facilitation of collaboration with community providers and other parts of the state mental health system was also considered beneficial. Paradoxically, the fact that units existed under the protection of distinct legislative mandates also provided a sense of security and continuity. Having deaf professional staff, a strong multi disciplinary clinical team, and coherent programming were all also mentioned as contributors to an effective deaf unit.

Negative Factors: Isolation from the rest of a hospital system reinforcing the isolation of deaf people in general was mentioned as a probable deterrent to optimal inter-relationships with other programs or services. The perception from other hospital units that the deaf unit was "overstaffed" or had special protections, along with the observation that the

unit appeared to be regarded more positively from within than from outside (from other hospital areas), were also identified as having adverse effects.

Between- or among-shift tensions (e.g., inconsistent applications of program expectations or consequences), as well as different levels of staff commitment or involvement, were also offered as threats to the integrity of unit functioning.

Extra-Contextual Factors Affecting Current Program Functioning

Positive Factors: Probably the most important sustenance for deaf inpatient units is the perceived or actual support from and collaboration with the surrounding deaf communities and related advocacy groups, as well as consistent interaction with state offices or commissions on deafness, and regional mental health offices focused on deaf clientele. Maintaining credibility (e.g., willingness to make referrals) and "presence" or visibility, through training and consultation activities within the hospitals involved and across the state was another important influence upon the continued success of deaf psychiatric inpatient units.

The ability to advocate successfully for managed care recognition and/or accommodation of specialized services for deaf psychiatric patients was also perceived as critical to the survival of the program by covering the increased costs for sign language interpreting services and specialized providers. Geographic proximity to deafness-related educational centers (e.g., Gallaudet University or any of its regional affiliates) was also considered beneficial with respect to training and other collaborative activities.

Negative Factors: Although mentioned by the panelists, budget constraints was not considered a primary negative factor; instead, the lack of qualified professionals in the field was cited as a major frustration, as was the lack of more adequate representation by deaf professionals in key positions within the state or regional mental health systems. Probably related indirectly to budget considerations, other major concerns were the perceived or actual unwillingness of existing community agencies to accommodate needs of deaf clients/consumers and the lack of aftercare or follow up resources in the community. Also a source of frustration was the lack of specialized services for [other] age groups of deaf or hard-of-hearing people not served by the existing psychiatric inpatient unit; the most frequently mentioned of such specialized needs were services for children and adolescents, forensic services, and more adequate services across the continuum of treatment for substance abuse.

Because funding of hospital programs is so often based on "numbers" of admissions and/or discharges, the relatively small size of deaf

units often result in perceived or actual pressures to scale back funding. Overcoming resistance or negative assumptions from other hospital staff about the specialized (often labor-intensive and often not "cost-effective") needs of deaf patients is often another challenge faced by these units. In some cases, personnel policies or procedures can mitigate against needed exceptions for recruiting (e.g., requiring national as opposed to statewide searches), hiring (offering competitive salaries and benefits) and retention (providing "reasonable accommodation") of specialized and qualified staff.

Projections Regarding the Future of Inpatient Psychiatric Programs for Deaf/Hard-of-Hearing People

It was the perception of most of the panelists that the continued existence of deaf inpatient units would most likely depend on continued state and/or federal laws or mandates. There may also be a decline in the need for psychiatric inpatient services, as community resources become more available and "deaf-friendly" (e.g., the impact of the Olmstead decision), and as managed-care-related admission and discharge criteria become more stringent. Staffing and operation of inpatient units for deaf people may also be affected by technology, which may reduce the need for specialized providers or services (e.g., teletherapy, video relay interpreting, cochlear implants).

On the other hand, deaf service units offer unique opportunities for supervision and training of new or interested professionals in mental health and deafness; by becoming accredited as an internship site, or by affiliation with graduate mental health programs, deaf inpatient units can provide a fertile ground for building specialized clinical skills and conducting clinical research with a unique population. Panelists also indicated that in some cases their units have expanded the range of services to include outpatient consultations (e.g., psychological testing) and treatment.

Overall, it is likely that deaf psychiatric inpatient services will continue to be needed to some extent, especially if the spectrum of services can be expanded to include other age groups, attention to co-morbidity (e.g., multiple mental health diagnoses), and more politically attuned funding strategies.

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