Communication is the Key:

Review of Deaf Mental Health Services in British Columbia

by

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(Ministry for Children and Families, Ministry of Health,
Ministry of Attorney General, Ministry of Education)

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EXECUTIVE SUMMARY

This is a review of the needs, existing resources, and recommendations for future directions of mental health services for Deaf children and adults as well as their Hearing family members who reside in large and small communities throughout BC.

Method
We gathered information by reviewing relevant literature and previous reports; consulting with a Community Advisory Committee; and interviewing over 160 community members, family members, and service providers individually and in small groups.

Target Population
In BC about 8000 children and adults from all ethnic and family backgrounds are Deaf. Although all Deaf people face tremendous communication barriers in a world designed for people who hear, this small population is very diverse in terms of pattern of deafness, communication preferences, signing skills, speaking skills, educational experiences, literacy, and abilities. Almost two thirds of the Deaf population (about 5000 BC residents) communicate primarily through American Sign Language (ASL) and are more or less oriented toward Deaf culture and involved in the Deaf community.

About 90% of Deaf children are born to Hearing parents and about 90% of children born to Deaf parents are Hearing. This means there are more than 30,000 Hearing residents of BC who have one or more Deaf children, Deaf parents, or Deaf siblings. Because communication is the main issue, Deafness involves all family members.

Mental Health Issues
The incidence of severe and persistent mental illness in the Deaf population is about the same as is found in the Hearing population (1-3%). However, the incidence of serious mental disturbance may be as much as four times higher in the Deaf population (40%) than is found in the general Hearing population (10%). There is a high incidence of severe stress and trauma disorders caused by lack of communication, family disconnection, isolation, daily systemic discrimination, physical abuse, and sexual abuse. Stress and trauma impact directly on the lives of Deaf individuals and ripple outward to affect their Deaf and Hearing family members, friends, and other loved ones.

Access Issues
Except in rare circumstances, mental health services within the mainstream system are not accessible to Deaf individuals because of:

- inability to meet the communication needs of Deaf persons
- lack of awareness or understanding of Deaf mental health and social issues, and
- insensitivity to Deaf culture.
Entitlement to Deaf Mental Health Services

Deaf individuals and their families require specialized mental health services provided by service providers who have fluent communication and understanding of Deafness as well as training and experience in the field of mental health. Deaf individuals are entitled to these services because the Canadian Charter of Rights and Freedoms guarantees equality of access. Further, the BC government has made a commitment to help victims and their families heal from serious abuse at Jericho Hill School for the Deaf that went on for many years.

Praise For Existing Mental Health Resources

In BC, Deaf individuals and their families have been accessing specialized mental health services since 1991. Deaf mental health services are provided by the Deaf, Hard of Hearing and Deaf-Blind Well Being Program. Respondents to this community consultation process praised services offered by the Well Being Program:

- Services are good, accessible, responsive, and important.
- Confidential individual and family therapy is a service that is saving lives.
- Deaf community support workers provide an essential service.
- Psychoeducational workshops, and socially oriented support groups are beneficial.
- Deaf-Blind respondents appreciate the opportunity to attend workshops specifically set up to meet their access needs.

Other mental health related resources that received praise during this community consultation were:

- Provincial School for the Deaf, Provincial Resource Programs, and Victory Hill student residence
- Deaf Service Agencies
- The Deaf community
- Those mainstream service agencies that have made an effort to meet the needs of their Deaf clients
- Family and friends

Concerns About Existing Mental Health Resources

The main concerns identified in this community consultation were:

- The model of providing therapy through interpreters is not the preferred practice
- Cuts to service that occurred in 1999 were viewed with alarm
- Some respondents did not know about the existence of the Well Being Program
- Some agencies would like to work more closely with the Well Being Program
- There are service gaps (e.g. few services in the Interior and the North, and few services to school age Deaf children and their families)
- Developing mental health services is very challenging (especially for Deaf service providers) in the context of historical abuse issues combined with systemic inequities in Hearing service systems.
- Mainstream service providers still do not show enough understanding of the need to match Deaf clients with service providers who are sensitive to Deaf issues
Recommendations

1. Support the Well Being Program to be a strong 'Centre of Excellence'. Services will include:
   - Psychoeducational workshops, courses, and socially oriented support groups
   - Therapy services for individuals and families
   - Training and consultation to mainstream service providers
   - Deaf Community Support Workers for children, youth, families and adults
   - A resource library for service providers, Deaf individuals and families throughout BC
   - Mental health interpreting

2. Organize service delivery according to four macro-regions: Lower Mainland, Vancouver Island, Interior, and the North. In collaboration with the local resources in these macro-regions, work toward the development of adequate satellite services.

3. Shift the mandate of Deaf mental health services back to a focus on promoting wellness and building healthy families and communities. This family and community focus will be inclusive of:
   - all ages (from the early years when Deafness is first identified through to Deaf seniors)
   - all ethnic and cultural backgrounds (including Aboriginal people and recent immigrants)
   - diversity in communication and literacy
   - all disabilities, including Deaf-Blind, developmental disabilities, and mental illness
   - both genders and all sexual orientations
   - diverse social problems ranging from life’s transitions, stress at school and work, as well as family violence, addiction, and post trauma reactions to abuse

4. Establish a Community Advisory Committee made up of Deaf and Hearing representatives from throughout the province to give feedback to the Well Being Program and other agencies and government programs who are providing Deaf mental health related services.

5. Place priority on hiring signing service providers who have the required combination of mental health expertise, ASL fluency, sensitivity to Deaf culture and understanding of Deaf diversity issues.

6. Encourage Deaf Service Agencies to network and to develop collaborative partnerships with each other and with mainstream health and social services when ever possible.

7. Support the Deaf Service Agencies to keep up to date on accessible technology including TTY technology, video conferencing, tele-psychiatry and the Internet.

8. Deaf mental health services need to be governed within systems that are sensitized to Deaf issues, and that acknowledge and proactively address the systemic barriers and stresses facing employees and potential employees who are Deaf. In other words, Deaf individuals should have equal opportunities to be hired and fully included in the workplace, as well as equal opportunities for professional development and career advancement. Supports should also be put in place to prevent discrimination, back-stabbing, and other pressures and/or to deal with these common problems if they occur.
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1 Introduction

This review considers the mental health needs of individuals who are unable to access mainstream mental health services because of communication and/or cultural barriers related to Deafness. The unique issues facing Hearing family members who have one or more Deaf children, siblings, or parents are also considered in this report. Readers who are unfamiliar with Deafness are referred to the Glossary of Terms in Appendix A for an orientation to Deaf issues.*

The review addressed the following questions:

1) What is the scope of the target population "Deaf individuals and their families"?

2) What are the mental health needs of Deaf individuals and their families (as differentiated from the broader range of social and educational needs)?

3) What mental health services funded through government are available to Deaf individuals and their families in large and small communities across the province?

4) How are these services perceived by Deaf individuals, family members, service providers, and associates in terms of strengths, gaps, concerns, and impediments to service access?

5) What future directions are recommended to ensure adequate access to mental health services by Deaf individuals and their families in the short and long term?

6) What role should be played by the Greater Vancouver Mental Health Services (GVMHS)** Well Being Program (Well Being Program) in supporting the network of mental health services for Deaf individuals and their families?

7) What collaboration and partnership roles should be undertaken by the provincial and federal governments in addressing the mental health needs of Aboriginal Deaf individuals, their families and their communities?

* This report capitalizes the word “Deaf”, as preferred by members of the Deaf Empowerment Movement who view Deafness with a strong sense of cultural pride.

** Effective April 1, 2000 GVMHS will amalgamate with the Vancouver/Richmond Health Board (V/RHB) and will operate as the Vancouver Community Mental Health Services of the V/RHB
2 Personnel

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Anita Harding, Independent Contractor

2.4 Community Advisory Committee
Anita Harding, Chair
Lisa Anderson, Greater Vancouver Association of the Deaf
Susan Charnoff, Western Institute for the Deaf and Hard of Hearing
Patti Dobie, Well Being Program
Janice Jickels, Medical Interpreting Services
Jeannie Stultz, Appointed family member representative, Kelowna
Greg Warren, Northern Interior Association of the Deaf, Prince George
Lois Wood, Island Deaf and Hard of Hearing Centre, Victoria
Sunshine, Appointed Deaf representative, Penticton
(Two other appointed committee members did not wish to be named)
3 Method

We gathered information from literature, documents and community consultation:

- Review of relevant literature and documents 1989 - 1999
- Information provided by the Well Being Program
- Feedback from members of the Advisory Committee
- Focus Groups for Deaf community members in Kelowna (3 parents also participated in this group), Nanaimo, Prince George, Victoria, Vancouver (2 groups), and a Focus Group for Deaf First Nations Individuals on Vancouver Island
- Interviews with small groups of: Therapists, Therapists/Interpreters, Parents (4 groups), Teens, Service Providers (4 groups), Deaf-Blind Consumers
- Individual interviews with service providers and community members

In total, we interviewed 76 Deaf and 85 Hearing stakeholders in various communities throughout BC as shown in Table 1.

<table>
<thead>
<tr>
<th>Place</th>
<th>Well Being Program Staff, and Contracted Service Providers</th>
<th>Service providers from mainstream agencies who have some contact with deaf consumers</th>
<th>Service Providers who mainly serve deaf individuals and families (Government and Non Government)</th>
<th>Community Members (Deaf individuals and Hearing Family Members)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deaf</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>1</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
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<td>30</td>
</tr>
<tr>
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<td>0</td>
<td>1</td>
<td>7</td>
<td>8</td>
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<td>76</td>
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<tr>
<td>Hearing</td>
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<td></td>
<td></td>
</tr>
<tr>
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<td>1</td>
<td>1</td>
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<tr>
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<tr>
<td>Pr. George</td>
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<td>4</td>
<td>12</td>
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<tr>
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<td>11</td>
<td>41</td>
</tr>
<tr>
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<td>15</td>
<td>21</td>
<td>27</td>
<td>85</td>
</tr>
<tr>
<td>TOTAL</td>
<td>26</td>
<td>15</td>
<td>34</td>
<td>86</td>
<td>161</td>
</tr>
</tbody>
</table>

More information about the process followed in reviewing the literature, selecting the advisory committee, organizing the focus groups and interviews, the limitations of the community consultation process, and a description of how the data were organized, coded, sorted, and analyzed is in Appendix B.*

* Appendices B to K are supplementary Appendices that are available on request from the Ministry for Children and Families
4 Description of Deaf Individuals and Their Families

4.1 Scope

The scope of this review encompasses individuals who have been Deaf since birth or childhood and their families. Figure 1 shows that about one out of every thousand children (about 4000 individuals in BC) are born deaf or become deaf during early childhood. About two out of every hundred children (about 80,000 individuals in BC) are born Hard of Hearing or become Hard of Hearing during early childhood. More and more people acquire a hearing loss as they age.

Generally speaking, the much larger population of people who are Hard of Hearing or who acquire a hearing loss later in life is not within the scope of this review of Deaf Mental Health Services.* However, there is no exact cut-off between who is Deaf and who is Hard of Hearing. The “grey area” in the figure above is intended to show this blurred gradation between being Hard of Hearing or Deaf. For purposes of space and convenience, all Deaf and Hard of Hearing individuals who face significant barriers to spoken communication will be collectively referred to as “Deaf”. Therefore the scope of this review probably encompasses a population that is double the size of the severely and profoundly Deaf population (or about 8000 BC residents). See supplementary Appendix C for a referenced review of the demographics of Deafness.

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*A number of respondents pointed out that many Hard of Hearing and late Deafened individuals face significant mental health problems such as poor adjustment to hearing loss, communication anxiety, social isolation and failure at school and work. Further research is needed to review the mental health needs and access issues facing individuals who are Hard of Hearing or have acquired a hearing loss.
4.2 Diversity

This small population of about 8000 BC residents who are Deaf is very diverse. Deaf individuals vary greatly in terms of causes and type of deafness; pattern of deafness as measured on an audiogram; age of becoming Deaf; communication preferences; signing and speaking skills; educational experiences; and orientation toward, involvement in, and attitudes about Hearing culture and Deaf culture.

Deaf people show as much variation in intelligence as is found in the Hearing population. However, at 30%, the rate of educationally significant disabilities (in addition to Deafness) is two times higher in the Deaf population than the 15% rate usually estimated for the Hearing population. This includes about 5% of the Deaf population (about 400 individuals in BC) who are both Deaf and Blind. Low literacy is prevalent throughout the Deaf population, and more than 60% of Deaf students leave school with less than a Grade 5 reading comprehension ability. At the other end of the spectrum, a significant minority of Deaf individuals are university graduates (about 1-2%).

Deafness cuts across all ethnic and racial groups. About 23% of the Deaf population are immigrants or children of recent immigrants (about 2000 individuals) and about 5% of the Deaf population are Aboriginal (about 400 individuals).

4.3 Deaf/Hearing Family Relationships

About 90% of Deaf children are born to Hearing parents and about 90% of children born to Deaf parents are Hearing. Communication dynamics between Deaf and Hearing family members affect the entire family.

"Deafness is very unique, particularly for children who use Sign Language . . . Deafness involves the entire family because communication becomes an issue. Our concern is that the family may be overlooked when only providing services to the child. In actual fact, the entire family is disabled because they cannot communicate with their family member. For this reason, sometimes it is the other family members that need the services, not the Deaf child." (letter to Ministry for Children and Families from the Family Network for Deaf Children, 1999)

Multiplying the estimated population of up to 8000 Deaf people in BC by a factor of 4 gives a ‘best guess’ estimate that there may be more than 30,000 Hearing people in BC who have a Deaf child, Deaf parent, or Deaf sibling. Many families have more than one Deaf family member (e.g. families with two Deaf parents or families with Deaf siblings and cousins). This is partly because of the high rate of marriage between Deaf people, and also because some causes of Deafness are genetic.
4.4 The Deaf Community

A focus on Deaf mental health issues easily obscures the positive aspects of participating in a Deaf Community that proudly celebrates Deafness as a cultural and linguistic difference. In BC, as elsewhere throughout the world, Deaf people form a closely-knit minority group of people who socialize together, participate actively in Deaf Associations, compete in Deaf sports events, attend Deaf cultural events, have a strong sense of Deaf history, and enjoy Deaf jokes, Deaf poetry, and Deaf creative arts. The visual language of American Sign Language (ASL) and a visual perspective on life strongly link members of the Deaf community together.

Most Hearing parents have a strong desire for their Deaf child to become oral and associate mainly in “the Hearing World”. However over time, Deaf children tend to become more and more involved in the Deaf community. The majority of individuals with profound Deafness (some researchers say as high as 85-90%) and a small minority of individuals who are Hard of Hearing (perhaps as many as 2-3%) eventually come to use signing as their most comfortable form of communication.

Table 2 below shows that the ‘best guess’ estimate of the population of BC’s Signing Deaf Community may be as many as 5000 children and adults.

<table>
<thead>
<tr>
<th>TABLE 2: Best Guess Estimate of the Size of BC’s Signing Deaf Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999 population estimates according to region</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Vancouver Island/Coast</td>
</tr>
<tr>
<td>Mainland/Southwest</td>
</tr>
<tr>
<td>Thompson/Okanagan</td>
</tr>
<tr>
<td>Kootenay</td>
</tr>
<tr>
<td>Cariboo</td>
</tr>
<tr>
<td>North Coast</td>
</tr>
<tr>
<td>Nechako</td>
</tr>
<tr>
<td>Northeast</td>
</tr>
<tr>
<td>Total B.C.</td>
</tr>
</tbody>
</table>
5 Deaf Mental Health Issues

The incidence of severe and persistent mental illness appears to be about the same in the Deaf population as is found in the Hearing population (Brauer et al, 1999). This means that in BC there may be up to 200 Deaf individuals (1-3% of the total Deaf population) who live with a serious chronic mental illness such as schizophrenia, bi-polar disorder, or organic brain disorders.

However, the psychological, social, and linguistic consequences of growing up Deaf in a world designed for people who hear mean that Deaf children are at high risk for emotional and behavioural disturbance. The incidence of serious mental disturbance may be as much as four times higher in the Deaf population (40%) than is found in the general Hearing population (10%) (Ridgeway, 1998). This means there may be up to 3000 Deaf individuals in BC (40% of the estimated Deaf population) who are struggling with severe mental disturbance such as personality disorders, anxiety, anger, depression, and frequent suicidal ideation.

The main mental health issues facing Deaf individuals are severe stress and trauma disorders related to the consequences of physical and sexual abuse, lack of communication, family disconnection, isolation, and daily systemic barriers that lead to discrimination and marginalization. These themes were confirmed during the community consultation interviews.

“I had a very tough life with a lot of hurt. All my life there was so much pain. No one loved me. There was suffering, and pain, and no love from my parents. I was sent to Jericho Hill School . . . where I was abused by three people there. But I was also raped at home by relatives and in a hotel by a man. My mother abandoned me there. I have no idea where she was. All I have ever wanted is a good life, with love, but I was beat up and hurt by my mother . . . . You don't have to hurt me because I'm stupid or dumb or Deaf . . . . My mind is in isolation . . . . They took me to the school, then they took me to another place, and to foster homes, and then to Jericho. All the time there was isolation, too much moving. Now, my mind is gone.” (Community Consultation, 1999)

“Deaf are always oppressed. We can do, but we are not given opportunities . . . . Parents are ashamed and treat their Deaf children like pet dogs. Being ignored in these ways is not the Deaf child’s fault.” (Community Consultation, 1999)

“Deaf clients have been hit from so many different directions. There is systemic lack of power and control over their lives, education issues (education abuse seems to be a uniquely Deaf issue), difficulty trusting Hearing people, isolation within their family of origin, estranged relationships with family members, anger and bitterness toward family members. There is the experience of being pathologized all their life and labelled by their families and teachers as ‘you are bad’, ‘bad girl’, ‘you have problems with anger’. Then some Deaf clients have been so traumatized by severe abuse on top of all that. They just have no way of coping or dealing with all that has happened to them. Either they aren't coping at all, or the ways they learn to deal with their life circumstance are socially unacceptable: drinking, gambling, promiscuity, anger, violence, drugs and boundary issues that affect the entire Deaf community, and make it into one big incestuous family.” (Community Consultation, 1999).

Deaf mental health issues are reviewed in supplementary Appendix D.
6 Access to Mental Health Services

Except in rare circumstances, the mental health services within the mainstream system are not accessible to the Deaf community because of:

- inability to meet the communication needs of Deaf persons
- lack of awareness or understanding of Deaf mental health and social issues
- insensitivity to Deaf culture.

Communication barriers are a major problem. Staff at mainstream service agencies are not fluent in ASL. Because of literacy barriers and slowness, typing or writing notes back and forth is ineffective and misunderstandings are frequent. Communicating through Hearing parents, children, friends, or staff who can sign a little is completely inadequate. In mainstream settings Deaf clients are often refused service, treated inappropriately, diagnosed incorrectly, or referred on to other inaccessible services. Mainstream service providers tend to focus on Deafness as the pathology to be addressed, and are likely to minimize, or completely miss the real difficulties being presented. A detailed review of access barriers identified in the literature is in supplementary Appendix D.

The community consultation process confirmed that these complaints about barriers are not simply memories of the way it used to be. Access continues to be difficult for Deaf children, adults, and their families:

“There was no information out there to help make a decision. . . There is no toll free number that young couples with Deaf kids can phone and find out where to get the information, or to access counsellors, or what ever is needed to be referred to resources to get guidance. Our daughter is Deaf! What do we do? We went through the back roads and we got bounced around and it was confusing.” (Community Consultation 1999)

“The trauma of dealing with the day to day issues of a child you can’t communicate with, and then advocate is massive. It was a struggle since the day he was born. We had to fight, fight, fight all the time to get services. We had to struggle every day, and we had to push and push for counselling.” (Community Consultation 1999)

“Deaf children and adults continue to be told “You can’t be part of the team.” These issues create a sea of clients who graduate from school with a perception of being unworthy, unimportant, invisible, in poverty, experienced with victimization, and dealing with ableism issues. Emotional issues and lack of counselling block all they do, and prevents success in all they do in education and work. There is denial, hostility, suicide, and gut wrenching stories.” (Community Consultation, 1999)

“There’s no where to go for help with mental health problems. We have nothing.” (Community Consultation, 1999)

“I look in the telephone book and see that Hearing have all kinds of services. But I wonder, where is Deaf service?” (Community Consultation, 1999)
7 Entitlement

The main recommendation for addressing the combination of high mental health needs and formidable access barriers faced by Deaf individuals and their families is to develop specialized mental health services provided by service providers who:

- are Deaf themselves and/or have fluent communication and understanding of Deaf issues and Deaf culture
- are trained and experienced in the field of mental health

These recommendations are expanded in supplementary Appendix D.

In BC, there are two main reasons why Deaf individuals and their families are entitled to specialized mental health services that provide communication fluency and sensitivity to Deaf issues. The first reason is the BC government’s commitment to respond to serious abuse at Jericho Hill School for the Deaf that went on for many years:

"The terrible consequences for the students and their families did not end when they left the school. Their suffering continued and continues still. The government recognizes that the consequences of abuse affect us all. They have an impact not only on the justice system, but on all aspects of society as well . . . we will help victims and their families heal the wounds of the past and prevail over the pain that was inflicted on them"

(Attorney General Ministerial Statement, June 28, 1995)

The second reason is that equality of access is a fundamental human right in democratic Canadian society. In 1983, Judge Rosalie S. Abella made these observations about equality of access to public services in Ontario for people with disabilities (including Deaf people).

“The failure to grant equality of access derives usually from an uninformed rather than a malevolent public. But . . . To be unconcerned with the needs of our contemporaries, is to be destructive of the future of the community. Those members of minorities who now watch the seemingly effortless movements through the community of others, may one day themselves become intolerant in their frustration. Ultimately, if we do not act, we will have to deal with their bitterness, impatience, anger, and cynicism . . . The circle will become vicious, the problems insoluble, the social lines drawn, and all members of the public victimized by the sense that solutions are not possible . . . Once issues have been brought to our attention, we must respond intelligently, effectively, and sensitively . . . It is not enough to provide a service . . . It may be accessible to some, but not to others. It must therefore be changed, drastically if necessary, to make sure that it is accessible in fact as well as in theory”.

In 1995 Thomas Berger observed:

“This is not simply a cultural issue. Deafness is not akin to a deficit that can be resolved through English-language training. As more than one deaf person has said, “I can’t learn to hear.” It is an inherent inequality . . . It is difficult to overemphasize how isolated the deaf can be: isolated from their own parents, but also from the helping professions . . .”
8 Deaf Mental Health Resources

During the community consultation process there were a total of 659 positive comments identifying mental health and mental health related resources that are sensitive to and accessible to Deaf individuals and their families.

8.1 Well Being Program (298/659 comments = 45.1%)

When the provincial government began funding the Well Being Program in 1991, BC became a role model for the rest of Canada, and joined England, Sweden, and several American States in showing international leadership in the provision of accessible Deaf mental health services. The Well Being Program has coordinated Deaf mental health services in British Columbia since 1992. Counselling services were funded through contracts administered initially by the Ministry of Health and currently by the Ministry for Children and Families. Funding has been provided through inter-ministry agreements between the Ministry for Children and Families, the Ministry of Health, the Ministry of Education and the Ministry of Attorney General.

Through a subsequent, 1996 cost-sharing agreement between the partner ministries, the Well Being Program received base annualized funding of $657,000, for Deaf mental health services. At that time, it was projected that this funding level would cover service demand in future years. In 1996 and subsequently, the partner ministries also provided additional one-time funding lifts to support anticipated strong shorter-term service demands for the next few years that would be related to the Jericho Hill abuse investigations and the Jericho Individual Compensation Program.

Subsequent program experience however has been different than the 1996 projections. Service demands have continued to be stronger than anticipated as more former students and other members of the BC Deaf community and family members have come forward and requested mental health services. Since 1998, the annual cost of these services has remained fairly stable at approximately $1.2 million. (Characteristics of the demand for Deaf mental health services are discussed later in this review, followed by projected ongoing service costs).

Well Being services include individual, family and group therapy, mental health interpreting, assertive case management, and community mental health support to Deaf, Hard of Hearing and Deaf-Blind clients. The Well Being Program contracts on a client by client basis with 5 signing therapists, 28 non-signing therapists, and about 25 mental health interpreters. The Well Being Program also supports four (3.5 Full Time Equivalent) community support workers who are Deaf themselves.

To date, the Well Being Program has served about 1000 Deaf individuals and family members (see Appendix E), including over 300 therapy clients during the 1999/2000 fiscal year. About 70% of services are provided to Deaf adults. The remaining services are provided to Deaf children and their Hearing family members, or to Hearing family members of Deaf adults.
As can be seen in Table 3, the Well Being Program provides well over 90% of its services to the Lower Mainland and Vancouver Island.

<table>
<thead>
<tr>
<th>Macro-Regions</th>
<th>Distribution of Therapy (according to clients served in each macro-region)</th>
<th>Community Support Workers</th>
<th>Distribution of BC Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower Mainland/South West</td>
<td>67%</td>
<td>71% (2.5 FTE)</td>
<td>57%</td>
</tr>
<tr>
<td>Vancouver Island/Coast</td>
<td>24%</td>
<td>29% (1.0 FTE)</td>
<td>18%</td>
</tr>
<tr>
<td>Interior of BC (Thompson, Okanagan, Kootenay)</td>
<td>8% occasionally outreach</td>
<td></td>
<td>16%</td>
</tr>
<tr>
<td>Northern BC (Cariboo, North Coast, Nechako, North East)</td>
<td>1% occasionally outreach</td>
<td></td>
<td>9%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Respondents to the Community consultation commented that the services offered by the Well Being Program are good, accessible, responsive, and important.

“The Well Being Program has taken mental health/deafness from being completely off the map, to being on the map” (Community Consultation, 1999)

They praised confidential individual and family therapy, especially therapy provided by therapists who sign. Therapy is seen as a service that is preventing suicides; decreasing isolation; treating depression, anger and emotionality; and helping clients to develop communication skills, learn about mental health, gradually heal from abuse, resolve problems, improve relationships with families, increase self esteem, socialize, and become employable.

Respondents also praised support from Deaf community support workers, and there were many comments about the benefits of psycho-educational workshops, and socially oriented support groups. Deaf-Blind respondents appreciated the opportunity to attend workshops specifically set up to meet their access needs.

Several therapists commented positively on the opportunities for professional development and collegial support that have been provided by the Well Being Program. The Access Directory, videos and newsletters produced by the Well Being Program were also identified as helpful resources.
8.2 Deaf Mental Health Related Resources (275/659 comments = 41.7%)

Most of the other half of the comments about mental health resources available to Deaf people were about the mental health related supports provided by the various Deaf education programs and Deaf service agencies in BC.

8.2.1 Deaf Education Programs

A number of respondents commented on the importance of attending school in a Deaf environment for Deaf children and youth to feel mentally healthy. In BC, there are about 170 Deaf students (about 10% of the population receiving Deaf educational support services) attending either the Provincial School for the Deaf (at South Slope Elementary School and Burnaby South Secondary School), the Provincial Resource Program in Langley School District or the Provincial Resource Program in Sooke School District. About 30 Provincial School for the Deaf students who live outside of Vancouver reside at the Victory Hill Residence during the week and return home on weekends.

These Deaf education programs aim to be culturally-based settings where Deaf students have opportunities to develop positive relationships with teachers, teaching assistants, and child care workers who are Deaf themselves, and where the Hearing staff can sign. Respondents praised psychoeducational workshops for students, ASL training for parents, and a youth group at Victory Hill Residence. In the Fall of 1999 Victory Hill Residence piloted an outreach program in which parents and children from rural areas came to live in the dormitory for a week so that children could attend school and parents could receive support and ASL instruction. Other pilot projects are in the planning stages.

“... despite the scandal at Jericho and other schools for the Deaf, the schools and residential programs are integral to Deaf identity and culture. Unlike the First Nations experience, residential schools for the Deaf have helped create a culture . . .” (Moore, 1999)

8.2.2 Island Deaf and Hard of Hearing Centre

Respondents on Vancouver Island identified the Island Deaf and Hard of Hearing Centre (IDHHC) as an important mental health related resource. Respondents commented positively on IDHHC’s Family and Community Enhancement Program, their educational support group for Deaf parents, community support workers (one is funded by the Well Being Program), psychoeducational workshops (partially funded by the Well Being Program), the interpreting coordinating service, vocational counselling and support from both the Victoria and Nanaimo offices.
8.2.3 Other Deaf Services

Other Deaf programs and service agencies that were identified more than once as providing mental health related support to Deaf individuals and their families are listed here according to how frequently they were mentioned:

- Western Institute for the Deaf and Hard of Hearing - Prince George
- BC Deaf Children's Society
- Deaf Blind Organizations
- Family Network for Deaf Children
- Medical Interpreting Services
- Private Practice Service Providers who can sign
- Prince George Interpreter’s Association
- Jericho Individual Compensation Program
- Greater Vancouver Association of the Deaf
- Western Institute for the Deaf and Hard of Hearing - Vancouver
- Elks Centre for Deaf and Hard of Hearing Children
- Sooke Parent Support Group
- ASL Program Douglas College

8.3 The Deaf Community (34/659 comments = 5.1%)

Despite all the problems related to ripple effects of abuse, respondents talked about how much they value their Deaf community and the vital importance of support from Deaf peers for communicating fluently; feeling supported, understood, and accepted; developing a proud Deaf identity; socializing; and making friends. To many Deaf people, the Deaf community is their second family, for better or for worse.

8.4 Mainstream Service Agencies (30/659 comments = 4.5%)

Respondents mentioned support from several mainstream agencies that have made an effort to meet the communication needs of Deaf individuals and their families. Some Mental Health Service Agencies, Community Living Centres, Ministry for Children and Families offices, First Nations Health Centres, Respite Services, School Districts and Hospitals have funded interpreting, contracted with Deaf support workers, or provided other supports that are sensitive to the needs of Deaf clients.

8.5 Family and Friends (22/659 comments = 3.6%)

Those Deaf individuals who have support from family and close friends have access to another informal resource that is essential for health and well being: Respondents identified wives, sisters, husbands, children and friends as people they turn to when they have mental health problems.
9 Problems With Deaf Mental Health Resources

During the community consultation process, respondents made a total of 927 comments about problems with existing mental health resources available to Deaf individuals and their families.

9.1 Concerns about Well Being Program Services (359/927 comments = 38.7%)

The Well Being Program has conducted two client satisfaction surveys (included in the document review found in supplementary Appendix D). However, this is the first time since the Well Being Program was established that there has been such a broad-based community consultation. Therefore it is not surprising that many people were as forthright with comments about various problems and gaps as they were about the strengths of this important resource.

9.1.1 Therapy Issues

Therapy services are much appreciated, and some see individual therapy as the foundation of Deaf mental health services. However, therapy services were also a major area of concern. There are a number of issues related to finding the right match, but the main issue is that, from the point of view of Deaf consumers, the model of providing therapy through interpreters is not the preferred practice.

“The therapy itself is good as far as it goes, but it is hard to explain to my therapist about Deaf culture . . . communication and lack of cultural awareness means that things are not fully comfortable and this has caused problems.”
(Community Consultation, 1999)

“Deaf take longer to build trust, especially if working with an interpreter.”
(Community Consultation, 1999)

“Clients go to therapy and don’t disclose their history because of the presence of an interpreter.” (Community Consultation, 1999)

See supplementary Appendix F for a detailed discussion of therapy issues.

9.1.2 1999 Service Cuts

The 1999 service cuts were the second major area of concern. Ever since 1991, the Well Being Program has received supplementary funding in response to a steadily increasing demand for therapy services. In May 1999, the Well Being Program began to realign service delivery to match with base funding. Therapists were directed to cut services to clients by two-thirds. A more stringent intake criteria for new clients was established (clients must be dealing with acute sexual abuse issues, suicidal or actively depressed, or angry and violent). Support for workshops and support groups that were being piloted on Vancouver Island and at the Victory Hill Dormitory was also discontinued.
These service cuts were protested vehemently during this community consultation. Clients who had made some progress reported feeling lost and in trouble again. Several interpreters reported an increase in assignments in emergency settings related to suicide attempts and other self-destructive behaviours. Some respondents to this community consultation felt revictimized and viewed the cuts as yet another indication that the government is unfair and cannot be trusted.

“...their decision is discrimination to Deaf, Deaf-Blind and Hard of hearing people. The government thinks they can get away from their responsibility for mess(ing) up deaf people’s lives through lousy money from JIC (Jericho Individual Compensation) and cut money for therapy ‘because the client should finish deal with their problems in five years.’ I tell you that it will be very serious for many Deaf people if therapy is cut. Even since now, I know some deaf have not had chance to get therapist, on waitlist, and some get so bad they had to go to hospital psychiatric ward because they feel danger or feel like kill self. But not all hospital staffs understand deaf culture, need ASL or how to call interpreter. It is your responsibility (and government and hospitals) to know how to deal with deaf and deaf-blind clients . . . Hearing people have lots of choices, we don’t . . . I am so angry when Deaf community finally gets some good services and fair treatment, we got cut off again” (letter to the premier, July 1999)

9.1.3 Lack of Awareness About the Well Being Program

In contrast to these concerns about service cuts, the third major complaint about the Well Being Program came from stakeholders who had no knowledge of the Well Being Program prior to being invited to participate in this community consultation process. Other respondents had heard about the Well Being Program, but were not aware of what it was for. A few individuals thought that the Well Being Program was part of the Jericho Individual Compensation Program.

“Word of mouth is not enough. . . I am the head of this resource and I don’t know the Well Being Program exists. If I don’t even know about the Well Being Program and what it does, how would the parents know, who would direct them to it?” (Community Consultation, 1999)

9.1.4 Lack of Networking and Collaboration

The fourth area of concern was frustration expressed by several Deaf service agencies was that there is not as much opportunity to network and collaborate with the Well Being Program as they would like to have.

“Well Being Program should be overwhelmed and excited (that our agency is here). Maybe we aren’t professional enough and that is why they aren’t in touch with us more?” (Community Consultation, 1999)

“Well Being Program haven’t reached out or brought themselves (to our community) enough to support our development of services and our professional development.” (Community Consultation, 1999)

In these times of limited resources, uncertainties about funding, and competition between agencies over scarce government resources, it is no wonder that networking, partnering, and collaboration have been limited.
9.2 Service Gaps (340/927 comments = 36.7%)

Respondents in this review noted that it is difficult for Deaf people who live outside of the Lower Mainland and Southern Vancouver Island to access mental health and mental health related resources. Lack of outreach is one problem. Shortages of skilled service providers is another problem. There are very few interpreters, or other service providers who can sign living in the Interior and Northern BC. Even where local interpreters are available, there are concerns about level of skill, problems related to confidentiality, and interpreters wearing multiple hats (e.g. interpreting for the same client at school and in the therapist’s office; providing a combination of social service and interpreting services to the same clients).

Other gaps include:
- There are very few resources to refer clients on to for advocacy and support
- The needs of Deaf individuals who have complex or multiple issues (e.g. Deafness as well as blindness, disabilities, social isolation, mental illness, or drug and alcohol issues) tend to fall through the service cracks
- There is a lack of culturally-based services for Deaf individuals and family members from different ethnic backgrounds (See supplementary Appendix G for comments from the Deaf First Nations Focus group)
- There are gaps in mental health services for Deaf children, Deaf youth and their families. This gap includes a lack of preventative communication support programs such as ASL instruction. Although previous reviews (Ombudsman, 1993 and Berger, 1995) strongly recommended that sign language training be provided for parents, most ASL courses are expensive and are not ‘family friendly’. There is very little ASL instruction for families once their children are past pre-school and there is almost nothing available outside of Vancouver (with the exception of an in-home signing program for families offered by the Nanaimo Island Deaf and Hard of Hearing Centre)
- It is difficult for Deaf individuals to get help in emergencies

9.3 Abuse in the Community and Discrimination in the System
(142/927 comments = 16.6%)

Developing mental health services is very challenging in the context of historical abuse issues combined with systemic inequities facing Deaf people who work in Hearing systems. First, there are the long standing abusive dynamics that have fractured the small and closely-knit Deaf community.

"The Deaf and Deaf-Blind community of BC is full of many damaged, traumatized individuals. When Jericho Hill Provincial School for the Deaf failed to protect and nurture its residents and students, it failed them as individuals and caused long term damage to their social community. Many Deaf people have left school with no functional literacy skills in English and emotional scars that make them, for the most part, unemployable. Some Deaf individuals have internalized that sexual, physical, and emotional abuse were 'normal' and have continued to live and act as if that were so, causing ongoing damage to their friends and families. The whole community has suffered and many still need help." (Community Consultation, 1999)
Bullying, back-stabbing, and safety issues impact on all community members. Deaf service providers are under a great deal of stress within their own community.

These abusive dynamics ripple right into the programs that have been set up in response to the abuse issues at Jericho Hill School for the Deaf. In particular there are complaints about the Deaf Access Office and the Jericho Individual Compensation Program that are related to a perceived lack of community input into how these programs were originally set up and disagreement over the way they operate now.

A related issue is that Deaf service providers continue to be at a huge disadvantage in relating to or working in mainstream service agencies and management structures. Communication barriers, cross-cultural differences, and unequal balance of power dynamics make it very difficult for Deaf service providers to work on an equal playing field with Hearing colleagues.

“Deaf/Hearing conflicts are upsetting the whole community. It’s a mess.”
(Community Consultation, 1999)

During the community consultation process we listened to many concerns from service providers about the atmosphere of distrust, oppression, misunderstandings, in-fighting, and unresolved problems that exist in this field. In a community that is crying out for skilled professionals, burn-out of existing service providers is disturbingly high.

9.4 Concerns about Mainstream Agencies and Programs (74/927 comments = 8.0%)

There are continued concerns that, even when an interpreter is present, mainstream mental health services do not serve Deaf consumers well. Employee Assistance Programs and local Mental Health intake teams may not understand the need to match Deaf clients with service providers who can meet Deaf client’s needs for fluent communication and cultural sensitivity. Similarly, protection investigations that involve Deaf children and children of Deaf parents are problematic because Ministry for Children and Families personnel do not have a background in Deaf issues. For example, social workers are not always aware of the need to arrange interpreters.
10 Suggestions for the Future of Deaf Mental Health Services

Participants in this community consultation process were unanimous that Deaf individuals and their families need and are entitled to access community oriented "Deaf-sensitive" mental health services that provide for fluent communication and sensitivity to Deaf issues. There were 1644 ideas for how current services could be improved.

10.1 Principles of Best Practice

605/1664 comments (36.3%) seem to describe desired principles of best practice for delivering Deaf Mental Health Services.

10.1.1 Signing Service Providers (183/605 comments = 30.2%)

Participants in this community consultation want Deaf mental health services to be provided by service providers who have mental health expertise, are fluent in American Sign Language, and understand Deaf cultural issues. Service providers could be Deaf, Hard-of-Hearing, or Hearing so long as they are sensitive to Deaf issues (See Appendix F). If everyone can sign, then Deaf and Hearing service providers can work comfortably together in a bilingual/bicultural environment.

10.1.2 Inclusive of Diversity (163/605 comments = 26.9%)

Respondents want Deaf mental health services to have the flexibility and ability to be inclusive of and sensitive to the wide diversity that is characteristic of the Deaf population. Deaf mental health services need to be able to reach:

- all ages from cradle to grave
- all cultural, religions, and ethnic backgrounds including First Nations and recent immigrants
- wide variation in method, style, fluency of communication, literacy, and educational background
- all disabilities including Deaf-Blind, developmental disabilities, and mental illness.
- both genders and all sexual orientations (men, women, gay, lesbian, bi-sexual, trans-sexual)
- wide variation in social problems including family issues, abuse, addiction, violence, stress in the work-place, and life transitions

One way to be inclusive of diversity is to train generalists so that each service provider is capable of responding to a wide range of needs. Another way to be inclusive of diversity is to have a pool of service providers and consultants with various areas of specialization to choose from. The shortage of skilled service providers makes this latter alternative difficult to act upon.
10.1.3 Outreach and Individual Advocacy (128/605 comments = 21.2%)

Respondents suggested that Deaf mental health services need to be advertised through flyers, brochures, and/or newsletters distributed to Deaf individuals, parents of Deaf children, educators of Deaf students, Deaf service agencies, mainstream mental health and social services, disability service agencies, and First Nations band offices and health centres.

"Put out a letter with everything offered and phone numbers. We are only a handful of people. It should be easy to send a newsletter to all people with deaf children to give the knowledge of what services are available. They know who is enrolled in what programs." (Community Consultation, 1999)

Several respondents suggested that the Access Directory should be distributed free of charge to everyone who is Deaf, to all parents of Deaf children, to all service providers who work with Deaf clients, and to all Deaf service agencies. (At present this excellent resource is provided free only to consumers who request a copy. Service providers and service agencies must purchase their copies).

Deaf mental health services need to be able to reach out to clients who face access barriers such as long term isolation, complex needs, or transportation problems. Provision for home visits, itinerant services, assertive case management, and moving the Well Being Program office closer to the Sky Train were all suggested several times.

A big part of improving the mental health of Deaf individuals and their families is providing information and individual advocacy so that Deaf individuals can gain access to educational, vocational, and social services that are perceived to be so easily available to Hearing people.

"Sometimes I get stuck and can’t figure out what to do. I found therapy very helpful and then I was ready for the next step. I wanted to join a women’s support group and attend the women’s drop in program at the women’s centre in our community. However, there were no interpreters at the women’s centre and so I felt isolated and left out, and I could not take part.” (Community Consultation, 1999)

Supplementary Appendix H is a summary of discussions about educational, vocational, social, and other more general access issues that came up during the community consultations. Poverty and unemployment are major social issues facing the majority of Deaf adults.

10.1.4 Family Centred (39/605 comments = 6.4%)

Respondents want Deaf mental health services to serve Deaf individuals in the context of their family. Early intervention, family counselling, and communication training are required to help Hearing parents and Deaf parents raise healthy, happy children in an atmosphere of safety, acceptance, and fluent communication. Families of children older than age five have a critical need for increased services.
10.1.5 Privacy and Trust (31/605 comments = 5.1%)

Deaf consumers need to have full trust that their rights to privacy will be respected and that service providers will not cross boundaries by working with mental health clients in dual roles and other contexts (e.g. a mental health interpreter should not also be working with a client in both a mental health setting and a school setting).

10.1.6 Wellness (31/605 comments = 5.1%)

There were a number of suggestions that Deaf mental health services need to be provided in a pro-active context that focuses on health and wellness. Deaf people should not be forced to pathologize their social problems, develop chronic mental health disorders, or wait until a problem escalates into a crisis in order to get service.

10.1.7 Reconciliation and Safety (30/605 comments = 5%)

A number of respondents suggested that Deaf mental health services need to somehow actively support community reconciliation while remaining neutral from "Deaf politics". Some respondents are hopeful that a structured process will be developed so that offenders and victims can reconcile. Other respondents want a community redress process that focuses on building wellness instead of revictimizing claimants by the court-driven focus on proving damage. Other respondents are very concerned about the safety of the next generation of Deaf children and urged Deaf mental health services to play a strong role in stepping in to stop current cycles of abuse, and in preventing any reoccurrence of another “Jericho tragedy.”

10.2 Model of Delivering Deaf Mental Health Services

In the Community consultation, 537/1664 suggestions (32.3%) were related to how services could be delivered more equitably to Deaf individuals and family members who live throughout BC.

10.2.1 Centralized Office with Satellite and Outreach Services
(196/537 comments = 36.5%)

The main suggestion is for the Well Being Program to be set up as a strong central office that will:

• continue to provide direct service in the Lower Mainland
• support the development of satellite and/or outreach services on Vancouver Island, Northern BC, and the Interior of BC.

Island Deaf and Hard of Hearing Centre already has the beginnings of a satellite service in that the Well Being Program already funds one community support worker position, and Ministry for Children and Families funds IDHHC’s Family Enhancement Program. IDHHC also coordinates interpreting services on Vancouver Island, and there are several skilled mental health interpreters. There are also four signing therapists who live on Vancouver Island. This makes it feasible to develop satellite services on Vancouver Island fairly quickly.
For the immediate future, the only practical way to serve the Interior and Northern communities with signing service providers is through regularly scheduled outreach services. A small mobile team could travel into these communities to provide direct service and to support the development of local services where ever possible. Western Institute for the Deaf and Hard of Hearing in Prince George and some private contractors in Kelowna are possible places to start developing satellite services. However, poor service that perpetuates abusive dynamics or quickly causes new service providers to burn out is likely to be worse than no service. To maintain the high quality of services that the Well Being Program has become known for, local service providers must have the necessary personal and professional qualifications, and have access to adequate supervision, collegial support, and professional development opportunities.

10.2.2 Community Advisory Committee (101/537 comments = 18.8%)

A community advisory committee is seen to be needed to help advise service delivery. Respondents suggested that the committee or board should be a bi-cultural committee made up of a diverse group of Deaf and Hearing representatives from throughout the province. In addition to representatives from Deaf associations, Deaf service agencies and government, the Advisory Committee should include appointees who are survivors of abuse; Hearing family members; or Deaf community members from different cultural backgrounds. Several respondents suggested that Advisory Committee members should receive training in how to participate and work together effectively as a bilingual/bicultural group. As satellite services are developed in Macro-Regions, smaller Advisory Committees that are linked to the Provincial Committee could be developed.

Participants in this consultation process appreciated being asked for their input. There were suggestions that Deaf mental health services be regularly reviewed through a community consultation process (e.g. annually). There were also suggestions that individual client progress be reviewed regularly by a clinical supervisor (e.g. every 6 months) to ensure that long term therapy remains accountable to demonstrate benefit.

10.2.3 Networking and Collaboration (85/537 comments = 15.8%)

Respondents to this review recognize that, because the Deaf population is small and widely scattered throughout BC, services need to be provincially focused and delivered in macro-regions, rather than regionally. Respondents emphasized the importance of supporting Deaf service agencies to network, collaborate, and develop partnerships with each other and with mainstream health and social services.

10.2.4 Professional Development (80/537 comments = 14.9%)

Respondents suggested that a commitment to professional development could help overcome the shortages of skilled service providers. Service providers who have only part of the required set of skills and experience need to be supported and encouraged to get the training needed to fill in their gaps. Hearing therapists and community support workers may have mental health skills and
experience but require training in American Sign Language and Deaf cultural issues. Deaf service providers may have ASL skills and experience in Deaf culture but require mental health training. All service providers may require training to broaden their ability to serve individuals, families, and communities and to be able to serve clients who have a variety of mental health issues and are of varying ages, cultures, sexual orientations, and abilities. Professional development can be provided through mentoring arrangements, as well as courses and conferences.

10.2.5 Make a Long term Commitment (38/537 comments = 7.1%)

Respondents recognized that Deaf Mental Health services require a long-term commitment and funding from the BC Government. As one respondent said emphatically: “We are not a five-year plan” (Community Consultation, 1999)

10.2.6 Governance (37/537 comments = 6.9%)

Administrators working in Government services and Deaf service agencies were asked to give suggestions related to the governance and management of Deaf mental health services (i.e. Governance of the Well Being Program or alternative models). These key informants had such a wide range of opinions about how Deaf mental health services should be governed, that there are no definitive answers to the question of governance.

- There were suggestions to continue the status quo by following the current plan for the Well Being Program to operate as one of the Vancouver Community Mental Health Services of the Vancouver/Richmond Health Board.

- There were also suggestions to amalgamate the Well Being Program with the various programs administered through the Victory Hill Residence, and/or to amalgamate with the Deaf Access Office.

- There were suggestions to set the Well Being Program up as a stand-alone agency; either as a Government “Deaf Services” Office, or as a Non-Profit Deaf Mental Health Service Agency.

- There were suggestions that Deaf Mental Health Services be divided into regions and attached to existing Deaf service agencies or to a local Community Mental Health office.
10.3 What Deaf Mental Health Services Should Be Provided

During the Community consultation, 522/1664 comments (31.4%) were related to the types of services that should be provided.

10.3.1 Community-based Psychoeducation (143/522 comments = 27.4%)

Psychoeducational workshops, short courses, or socially oriented support groups are needed to provide mental health information and build interpersonal skills. Many topics are suggested (see Appendix I). As can be seen, Deaf issues and abuse issues are not the major focus. There is a general thirst for information of all kinds. If strong ground rules for safety and mutual respect are built in, these events also help community members prepare for reconciliation by providing opportunities for Deaf individuals to interact in structured, positive, and safe environments.

10.3.2 Family-based Psychoeducation (105/522 comments = 20.1%)

Families need support to make informed choices, build communication between Deaf and Hearing family members, and deal with the myriad of predictable dynamics related to Deaf-Hearing cross cultural issues and developmental transitions. Respondents emphasized that family oriented instruction in ASL and Deaf studies will prevent many mental health problems, and help resolve problems of family disconnection. Several respondents also suggested that providing interpreting support for Deaf individuals to access major family events (such as weddings, funerals, and community gatherings) might go a long way toward preventing mental health problems. Parenting courses and support groups are considered to be vital for Deaf parents and very important for Hearing parents and Hearing siblings. Children of Deaf Adults (CODA) groups are a road to health and understanding for Hearing children of Deaf parents.

10.3.3 Therapy (66/522 comments = 12.6%)

The third major suggestion was for individual and family therapy from qualified counsellors to continue. Some respondents see therapy as the foundation of Deaf Mental Health services and note that many Deaf individuals have not yet accessed services. Other clients need long-term therapy to maintain gains, and many Deaf clients need to be able to re-access therapy at various points of readiness, transitions, or stressful situations throughout their lives.

80% of the Deaf population is unemployed and don’t have access to EAP funds or to other community services such as lay-counselling centres. The Government must provide them with service. (Community Consultation, 1999)

“This is a client group with chronic, on-going needs. Access to fifteen therapy sessions per year per client for ever would work.” (Community Consultation, 1999)
10.3.4 Educate Mainstream Service Providers (56/522 comments = 10.7%)

Several respondents suggested that mainstream service providers who work in education, health, social services, and the judicial system need to be able to access Deaf Sensitivity Training at the point that they begin interacting with a Deaf client.

“Develop a sensitization package in the form of a video tape and provide it to mainstream service providers at the point of contact with a deaf client. The package needs to provide awareness about communication issues, minority cultural issues, literacy issues, and interpreter issues. Then, there needs to be on-going access to a mental health professional who is aware of deaf issues.” (Community Consultation, 1999)

10.3.5 Community Support Workers (49/522 comments = 9.4%)

More Community Support Workers are needed to:
- provide role modelling and community support to Deaf children and youth
- provide assertive community treatment, support with activities of daily living, and one-on-one intervention for clients who have complex mental health needs such as isolation, on-going abuse issues, high-risk behaviours, disabilities, Deaf-blind issues, or mental illness.
- help clients develop daily living skills, interact more effectively with mainstream services, and manage stress and frustration.

10.3.6 Media and Technology (40/522 comments = 7.7%)

Respondents would like psychoeducational videos and books about Deaf issues and American Sign Language to be easily available to Deaf individuals, parents of Deaf children and service providers through a lending library or libraries.

TTY's, fax machines, toll-free lines, video conferencing, tele-psychiatry, and Internet services such as email, web-sites and discussion groups can all facilitate communication with Deaf individuals and their families throughout the province. Although technology does not replace personal contact in this face-to-face culture, it can supplement and reinforce direct interaction.

10.3.7 Groups (39/522 comments = 7.5%)

There were a number of cautions about group therapy. Therapeutic groups can only be offered in situations where there is great sensitivity to issues of trust and confidentiality in a small community where there is a lack of boundaries, and may be a lack of safety related to historical abuse issues.

10.3.8 Mental Health Interpreting (24/522 comments = 4.6%)

Mental Health Interpreters are needed whenever one or more people who do not sign fluently are part of the communication equation. This includes individual counselling situations where the therapist cannot sign, family counselling, and meetings with non-signing service providers.
11 Recommendations For Implementation

The following recommendations are intended to follow from the many excellent suggestions made by participants in this review. Many of these recommendations are similar to recommendations found in previous reports that have not yet been implemented.

1. **Support the Well Being Program to be a strong 'Centre of Excellence'** that plays a central role in developing Deaf mental health services in the province of BC. As a Centre of Excellence, the Well Being Program will become a more highly visible centre of resources and new developments. Services would include:

   a. **Psychoeducational workshops, courses, and socially oriented support groups** for Deaf adults and for families with Deaf children (including ASL instruction). Several workshops, courses and groups have already been successfully piloted and evaluated. Training the Trainers and Distance Education approaches could be used to offer these successful programs in other locations around the province.

   b. **Therapy services for individuals and families.** Costs could be saved by capping services after the first six months or year of therapy at a lower, maintenance level. Costs could also be saved by making it easy for clients to discontinue therapy and then re-access their maintenance sessions when needed. (Returning to long term treatment would require a new intake procedure and re-negotiation of therapy goals with the clinical supervisor).

   c. **A training video and follow up consultation for mainstream service providers** who are working with Deaf clients, perhaps for the first time. The video, handouts, and follow up support would build awareness about Deaf issues, Deaf culture, communication, literacy, working with interpreters, and resources in the community.

   d. **More Deaf Community Support Workers** who can work with children and youth as well as with Deaf adults who are socially isolated and/or have other complex needs.

   e. **A resource library** that can be accessed by service providers, Deaf individuals and their families throughout BC. The library could loan some materials and distribute others free of charge to BC residents (such as the Access Directory and videos produced by the Well Being Program). The Sexual Health Resource Network Library at Sunny Hill Hospital might be a model for how this library could be set up.

   f. **Mental Health Interpreting services** arranged when needed in psychoeducation settings, therapy, meetings with mainstream service providers, and to support Deaf community support workers to do their work.
2. **Organize service delivery according to four macro-regions.** This recommendation recognizes that the Deaf population of BC is too small in numbers and too complex in nature to make any regional model of service delivery practical.

<table>
<thead>
<tr>
<th>Table 4: Service Delivery Organized in Macro-Regions</th>
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<tbody>
<tr>
<td>Macro-region</td>
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<tr>
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</tr>
<tr>
<td>Northern BC (Cariboo, North Coast, Nechako, North East regions)</td>
</tr>
<tr>
<td>TOTAL</td>
</tr>
</tbody>
</table>

To achieve geographic equity, there is a need to develop measurable service delivery targets in each macro-region that relate to the distribution of BC's population and work toward the development of adequate satellite and outreach services in collaboration with local resources.

To enable the Well Being Program to effectively work with local resources in the macro-regions to support the development of satellite and outreach services, it will be essential to develop a clear inter-agency negotiation process with lines of communication, clarification of roles, and a set of understandings about negotiation procedures. Although the goal will be to work closely with, and sub-contract with local resources whenever possible, the Well Being Program will play an central role in providing consultation, training, and sharing of information in all four macro-regions.

The only two regions that have adequately skilled personnel who live and work within those macro-regions are the Lower Mainland and Vancouver Island. It seems likely that - at least in the immediate future - the only effective way to serve the Interior and Northern BC will be through regularly scheduled outreach services. Level of need in the Interior and the North will need to be assessed and a service delivery plan will need to be piloted over the next year.

3. **Shift the mandate of Deaf mental health services from a relatively narrow focus on treating mental illness to a broader, preventative focus on promoting wellness and building healthy families and communities.** In effect, this is a shift back to the original vision of the Well Being Program (to provide services in a way that would reduce stigma and would encourage Deaf individuals to care for their own mental health). This family and community focus needs to be sensitive both to the needs for early intervention with families of newly identified children and to the needs for safety and reconciliation in the Deaf community.
A family and community focus will aim to be inclusive of:
   a. all ages (from the early years when Deafness is first identified through to Deaf seniors)
   b. all ethnic and cultural backgrounds (including First Nations and recent immigrants)
   c. diversity in communication and literacy
   d. all disabilities, including Deaf-Blind, developmental disabilities, and mental illness
   e. both genders and all sexual orientations
   f. diversity of social problems ranging from life’s transitions, stress at school and work, as well as family violence, addiction, and post trauma reactions to abuse

4. **Establish a Community Advisory Committee** made up of a diverse group of Deaf and Hearing representatives from throughout the province to give feedback to the Well Being Program and to other government programs and Deaf service agencies who are providing Deaf mental health related services. Follow the suggestions in this report to develop criteria for membership on the Community Advisory Committee. Work with Deaf service agencies and Deaf associations to select and train committee members. Develop a plan for regular community-based evaluation of Deaf mental health services. Encourage macro-regions to develop local advisory groups as their services develop. These groups will send a representative to Advisory Committee Meetings held 3-4 times per year.

5. **Place priority on hiring signing mental health service providers** who have the required combination of mental health expertise, ASL fluency, sensitivity to Deaf culture and understanding of Deaf diversity issues. Any service providers who only have part of the required set of skills should be required to make a commitment to get the training needed to fill in their gaps. Incentives, training programs and mentoring opportunities will need to be provided. Work with post secondary training programs to provide practicums, internships, and coop placements to qualified students.

6. **Encourage Deaf Service Agencies to develop collaborative partnerships**, and/or to network and collaborate with each other and with mainstream health and social services wherever possible. Here are some examples of exciting opportunities for collaboration between service agencies:
   a. The Well Being Program, Victory Hill Residence, and BC Deaf Children’s Society could work together to develop family-friendly Deaf studies and ASL instruction; and to develop other outreach psychoeducational services for families.
   b. Deaf Service Agencies could collaborate with Telus to adapt the training program provided to Message Relay Centre operators to meet the needs of mainstream service providers who are encountering a Deaf client for the first time.
   c. Deaf Service Agencies could collaborate with The Federal Government, Friendship Centres, the BC Aboriginal Network on Disability, and Deaf service agencies to develop culturally supportive ways of providing mental health services to Deaf Aboriginal individuals, their families and communities.
d. Deaf service agencies could share locally developed psychoeducational programs with other agencies in other communities (e.g. Island Deaf and Hard of Hearing Centre has developed a psychoeducational support group for Deaf parents, life skills workshops and a community inclusion group. The Well Being Program has developed a multicultural Deaf group, a variety of workshops, and videotapes).

e. Deaf mental health services, mainstream health and social service agencies, and agencies that serve Deaf clients who have complex needs could schedule regular meetings for mutual exchange.

f. With inter-agency collaboration, it may be possible to redesign programs such as the Deaf Access Office in ways that are more acceptable to Deaf individuals and their families.

g. The Well Being Program, the Jericho Individual Compensation Program, Victims Services, and the Justice Institute could collaborate to develop a Deaf-sensitive community reconciliation process.

h. To keep everyone informed, Deaf Service Agencies could each write monthly columns and submit them for publication in all the other Deaf service agency newsletters in the province.

7. **Support Deaf Service Agencies to keep up to date on accessible technology** including TTY technology, video conferencing, tele-psychiatry and Internet services. For example, representatives from the Well Being Program can work with the Ministry of Health to make sure that the planned mental health teleconferencing services are fully accessible to Deaf individuals and their families. Deaf Service Agencies can also partner with researchers, curriculum developers, and educators at BC’s universities and colleges to deliver psychoeducational programs and professional development courses via Distance Education.

8. **Lastly, it is important to address the governance of Deaf mental health service contracts** (and all contracts for Deaf services) with particular sensitivity to governing and managing services in ways that are sensitive to input from the Deaf community, as well as the community pressures and systemic barriers facing service providers who are Deaf. Deaf mental health services need to be governed within systems that are sensitized to Deaf issues, and that acknowledge and proactively address the systemic barriers and stresses facing employees and potential employees who are Deaf. In other words, Deaf individuals should have equal opportunities to be hired and fully included in the workplace, as well as equal opportunities for professional development and career advancement. Supports should also be put in place to prevent discrimination, back-stabbing, and other pressures and/or to deal with these common problems if they occur.
12 Cost Implications

12.1 Base Funding

A summary of the Well Being Program budget is shown in Table 5:

<table>
<thead>
<tr>
<th>Table 5: Well Being Program Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Income</strong></td>
</tr>
<tr>
<td>Base Funding</td>
</tr>
<tr>
<td>Inter-Ministry One-Time/Carry Over</td>
</tr>
<tr>
<td><strong>TOTAL FUNDS</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Expenditures</strong></td>
</tr>
<tr>
<td>Well Being Program Staffing/Office Costs</td>
</tr>
<tr>
<td>Contracted Therapy, Psychoeducational Groups and Special Projects throughout BC</td>
</tr>
<tr>
<td><strong>TOTAL EXPENDITURES</strong></td>
</tr>
</tbody>
</table>

Since 1996, the Well Being Program has been provided with base funding of $657,000 that is divided into two parts:

- $527,000 covers staffing, a sub-contract with Island Deaf and Hard of Hearing Centre, and all expenses related to running and administering the program.
- $130,000 is designated for therapy, workshops, and special projects.

As of the year 2000, staffing at the Well Being Program includes: one coordinator position, a half-time intake worker, a staff therapist (new position just filled in April, 2000), a staff interpreter, 2.5 Community Support Workers, an office manager, and an office assistant. As is shown in Table 5, base funding has never met the demand for service. Ever since 1996 the partner Ministries have supplemented base funding with additional one-time funding lifts to pay for therapy and mental health interpreting.

This review has found that the demand for Deaf mental health services has grown steadily, even though the Well Being Program has not been extensively advertised. Since the Well Being Program is filling a huge void, demands for psychoeducation, therapeutic support for, (and consultation about) Deaf children, adults, and their families will continue to grow. Referrals will continue to come from the following sources:
- Self referrals from Deaf children, adults and families with significant mental health problems (including former residents of Jericho Hill School) residing throughout BC
- Referrals from government programs, including Child Protection Services, Addiction Services, Community Living Services, and mainstream mental health services
- Referrals from the Jericho Individual Compensation Program and individuals involved in civil litigation (e.g. the current class action suit)
- Referrals from the Provincial School for the Deaf, Victory Hill Residence, Provincial Educational Programs, and Mainstream School Districts

Budgeting needs to shift away from demand-driven “one time” infusions of funding, and move to a more reflective, long-term developmental strategy that:
- recognizes the complex mental health issues facing Deaf individuals and their families
- acknowledges the rights of Deaf individuals to have equitable access to mental health and mental health related services
- accepts the high level of on-going need in the Deaf population
- provides for long term planning and development of Deaf mental health services throughout BC.

Judging from the ever growing demand, the upset caused by the attempts to reduce services in 1999, and the many needs identified during this review, it is obvious that there is a real need for the base funding of $657,000 to be substantially increased. In fact, even with as much reallocation of funds toward psychoeducational workshops, courses, and socially oriented groups as possible, $1,286,000 (the amount of funding provided for 1998/99) is probably the minimum amount of base funding required to maintain existing levels of service. If these funds could be guaranteed on an on-going, annual basis, it will become possible to do some realistic long-term planning and budgeting in accordance with the suggestions and recommendations made in this report.

12.2 Satellite and Outreach Services

The next priority is to begin to work toward the goal of achieving equitable delivery of Deaf mental health services to the Interior and Northern macro-regions. If the approximately $72,000 that is projected to remain at the end of this fiscal year could be carried over to 2000/2001, then these funds could be applied to address this goal. Well Being Program staff or contractors could travel to the Interior and Northern macro-regions to assess the level of need, develop a practical plan, and then pilot outreach and/or satellite service delivery. Base funding would need to be increased the following year in order to sustain the Deaf mental health services that are being developed in the Interior and the Northern macro-regions. This is outlined in Table 6.
<table>
<thead>
<tr>
<th>Table 6: Projected Budget For Well Being Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
</tr>
<tr>
<td>Base Funding From Previous Year</td>
</tr>
<tr>
<td>$657,000</td>
</tr>
<tr>
<td>Additional On-going Base Funding</td>
</tr>
<tr>
<td>Additional On-going Funds for the Advisory Committee</td>
</tr>
<tr>
<td>One Time Carry Over</td>
</tr>
<tr>
<td><strong>TOTAL INCOME</strong></td>
</tr>
<tr>
<td><strong>Expenditures</strong></td>
</tr>
<tr>
<td>Well Being Program*</td>
</tr>
<tr>
<td>Outreach/satellite services to Interior and Northern Macro-regions</td>
</tr>
<tr>
<td>Community Advisory Committee</td>
</tr>
<tr>
<td><strong>TOTAL EXPENSES</strong></td>
</tr>
</tbody>
</table>

*Separate budgets will need to be developed for the Centre of Excellence, direct delivery of mental health services in Vancouver, and satellite services on Vancouver Island

Applying these carry-over funds to piloting new services would be far preferable than attempting to achieve geographic equity by subtracting services from the Lower Mainland or Vancouver Island. Such a strategy would run the risk of setting up the macro-regions to compete with each other over resources that are just barely meeting this high level of need. Another re-alignment “by subtraction” attempt will strain the community’s trust in the government’s will, and will decrease collaboration between macro-regions. There is a danger that Deaf mental health services throughout BC would become fragmented and weak just as they are beginning to bear fruit.

Instead, the preferred strategy is to gradually add new funds to build up services in the Interior and the Northern macro regions in the directions indicated in this report over time. In subsequent years, there will be a need for a gradual increase of funds to allow for continued development of satellite services in the Interior and Northern BC and to maintain services in the Lower Mainland region and on Vancouver Island.

### 12.3 Advisory Committee

Each meeting of the Community Advisory Committee can be expected to cost over $2500.00 (cost of interpreters and transportation). The cost of three or four face to face meetings per year will be about $10,000 per year.
12.4 New Initiatives

A number of the recommendations made in this review are to develop new initiatives for meeting the mental health needs of Deaf individuals and their families. Some examples of these recommended new initiatives include:

- Distance education and video conferencing in the Deaf Community
- Training Programs for Hearing and Deaf Parents
- ASL instruction and Deaf studies that match with the needs of families
- Deaf Awareness video for mainstream service providers
- A Deaf resource library for BC
- Deaf Diversity Training
- Building a Deaf-Hearing Bilingual/Bicultural Committee
- Deaf mental health mentoring
- Culturally-based outreach to Deaf First Nations individuals and their Communities
- Assertive Case Management in the Deaf Community
- Reconciliation in the Deaf community
- Deaf Professional Development

Contractors and sub-contractors could be encouraged to develop proposals to carry out one or more of these types of new initiatives per year. There are many opportunities for partnerships and shared funding arrangements with Municipal and Federal Governments; foundations that support community development and research; as well as corporate sponsors. (For example, corporations connected with communication (telephones, television) have often supported new initiatives in the field of Deafness).

“With a combination of support and funding our lives will become better from today on. We will transform our lives and become healthy.” (Community Consultation, 1999)
13 References


See Supplementary Appendix D for a comprehensive review and complete list of 1989-1999 documents relevant to Deaf Mental Health Issues in BC.
Appendix A:

Glossary of Terms
Appendix A: Glossary of Terms

American Sign Language (ASL): The visual-spatial language of BC’s Deaf Communities. About 10-13% of Deaf individuals (mostly Deaf children of Deaf adults) learn ASL as their first language, and about 85% of Deaf individuals eventually come to use ASL as their primary and most comfortable mode of communication. There is great diversity in fluency in ASL amongst members of the Deaf community. There are also local and regional variations and dialects.

Audiogram: A graph showing amount of hearing loss across the various sound frequencies.

Bi-Cultural/Bi-Lingual (Bi-Bi): An educational philosophy that promotes the development of fluency in ASL, fluency in reading and writing English, and an understanding of both Deaf and Hearing cultures.

Children of Deaf Adults (CODA): Hearing children of Deaf adults.

Cochlear Implant: A surgically implanted electronic device that transmits sound information through multiple electrodes or channels. Cochlear implanting infants and children is very controversial (see oral-manual controversy below).

Culturally Deaf: Deaf (as well as some Hard of Hearing, and a few Hearing individuals) who live with a Deaf cultural perspective, sign fluently and prefer to participate in the Deaf community. Common life experiences that may lead a person to become culturally Deaf are: growing up Deaf, growing up in a Deaf family, attending a Deaf school or resource room, socializing in the Deaf community, marrying a Deaf person.

Crab Theory: The tendency of members of an oppressed group to use criticism, pressure, gossip, and in-fighting against group members who appear to be too successful or who appear to be becoming too much like the members of the dominant group.

Deaf: A broad term referring to all people who have hearing levels in the severe to profound range. Instead of ‘person-first’ use of language recommended by disability activists, members of the Deaf Community prefer ‘Deaf-first’ language in the same way that other cultural descriptors are used (i.e. Deaf individuals, English people, the Chinese community).

Deaf Access Office: A small (one employee) office set up by the BC Government in 1992 with the mission of improving access to government services for the Deaf population. The office is part of the Ministry of Children and Families, is located in Vancouver, and is accessed by calling the Child Help line.

Deaf and Hard of Hearing: A broad, neutral term referring to all people who live with hearing loss of any level.

Deaf and Hard of Hearing Agencies: Non-profit organizations providing some combination of social, educational, and/or vocational services and individual advocacy for Deaf and Hard of Hearing consumers. The main Deaf and Hard of Hearing service agencies in BC are: Western Institute for the Deaf and Hard of Hearing (WIDHH) in Vancouver (small
branch office in Prince George). Island Deaf and Hard of Hearing Centre in Victoria and Nanaimo. BC Deaf Children's Society in Vancouver.

**Deaf Associations**: Social and cultural organizations developed and run by members of the Deaf community. The main Deaf Associations in BC are: Greater Vancouver Association of the Deaf, South Vancouver Island Association of the Deaf, Mid Island Deaf Association, Okanagan Association of the Deaf, Northern Interior Association of the Deaf.

**Deaf-Blind**: Individuals who are both Deaf (or Hard-of-Hearing) and legally blind. This includes about 3% of Deaf children and about 5% of Deaf adults.

**Deaf Community**: A focus on Deaf mental health issues easily obscures the joy of participating in a community that celebrates Deafness as a cultural and linguistic difference. The visual language of ASL and a visual perspective on life link members of the Deaf community and are the heart and lungs of Deaf events, Deaf clubs, Deaf sports, Deaf creative arts, Deaf jokes, and Deaf pride.

**Deaf Culture**: A distinct culture whose members highly value Sign Language, Deafness, a visual world view, and congregation of Deaf people. Members of Deaf culture strongly object to the view held by most Hearing professionals, that Deafness is a deficit, disability or pathology. Members of Deaf culture also strongly object to oralism and mainstreaming.

**Deaf Empowerment Movement**: A civil rights movement in which Deaf people are asserting their linguistic, cultural, and human rights to equal and active participation in society. This movement objects to oralism, educational policies that promote mainstreaming, medical and surgical intervention in Deafness, and other policies and practices that view Deafness as a disability to be fixed.

**Deaf Interpreter**: A Deaf person who relays signed, spoken and/or written information into gestures/mime, concrete images to support the understanding of Deaf individuals who are not fluent in ASL or English (e.g. new immigrants who are Deaf, Deaf people who have been isolated from Deaf culture, Deaf people with disabilities).

**Deaf Member Families**: Nuclear families with one or more Deaf members. The communication dynamics associated with Deafness impact on the entire family.

**Deaf Politics**: As in any community, there are many controversies within the Deaf community related to what core values are most emphasized, who the leaders are, how resources should be shared, how insiders should relate to each other and to outsiders, etc.

**Gallaudet University**: The only Deaf university in the world is the cultural, intellectual and research centre of the North American Deaf community, including the Canadian Deaf community. Many of the leaders in BC's Deaf community are graduates of Gallaudet University.
GVMHS Deaf, Hard of Hearing and Deaf-Blind Well Being Program: A mental health program established in 1991 to serve Deaf, Hard of Hearing, and Deaf-blind individuals and family members throughout BC who cannot access mainstream mental health services because of communication and/or cultural barriers.

Hard of Hearing: People who have a hearing loss but who have enough hearing to use a voice telephone and to understand spoken language by listening carefully in a quiet environment usually with a hearing aid or other assistive listening device. A Hard of Hearing individual might have a mild, moderate or severe hearing loss.

Hearing: People who are not Deaf or Hard of Hearing.

Hearing Aid: An electronic device fitted into the outer ear, that amplifies sounds in various frequencies.

Hearing-Can-Sign: Hearing people who are fluent enough in ASL to be able to converse more or less comfortably with Deaf people and who have developed some understanding of Deaf culture. Common ways to become a Hearing-Can-Sign person are: growing up in a family with one or more Deaf members, developing a close friendship with one or more Deaf individuals, and/or spending the equivalent of about two years in a full-time ASL and Deaf studies program.

Hearing impairment: A broad term used by many Hearing professionals to refer to all people who live with hearing loss. Members of the Deaf community object to the use of the term 'hearing impaired' because they view Deafness as a difference, not an impairment.

Intervenor: A one-to-one worker who supports orientation, mobility, comprehension, literacy, emotional, behavioural and informal communication support related to activities of daily living. An intervenor does not replace the need for professional interpreters in formal situations.

Jericho Hill School for the Deaf (JHS): BC's provincial school for the Deaf that was established in the 1930s. The original campus was located on a hill overlooking Jericho Beach in Vancouver and housed an elementary school, a high school, and four dormitories for Deaf students (as well as similar facilities for blind students). In 1979 the school was downsized and all children aged 5-19 were moved into one school building and one dormitory building. In 1991 the school program was relocated to Burnaby School District. In 1999 the name was changed to the Provincial School for the Deaf. The dormitory remained at the original Jericho Hill location until a new residence (Victory Hill) was built in 1997.

Late Deafened: Individuals who become severely or profoundly Deaf during their adult years.

Oral Deaf: Individuals who are developmentally Deaf but communicate primarily through speech and speech reading.

Oral/Manual Controversy: A century old debate on how Deaf children should be educated. Oralists claim that developing the ability to speak and to understand spoken language will enable Deaf children to function in the Hearing world. Manualists claim that developing fluency in sign language is what will enable Deaf children to develop language and literacy, general knowledge, and participate fully in their community.
Oralism (Aural Rehabilitation, Auditory-Verbal Rehabilitation, Speech reading): A philosophy of education that promotes learning to listen, speech-read, and speak. Oralists object strongly to the use of sign language, especially in the early years of a child's life, because they believe that the ease of signing will create a dependency on visual communication that will interfere with the Deaf child's oral development.

Pidgin Signed English (PSE or Contact Signing): A bridging combination of ASL vocabulary and English word order. Many English speaking, non-native signers use PSE when they sign. Native signers usually shift into this code when signing with non-native signers to meet them 'half-way'.

Provincial Resource Centres for the Deaf: There are two provincially funded resource centres for educating Deaf children located in Langley School District and Sooke School District.

Provincial School for the Deaf: An elementary school and a high school for Deaf students that were established as "schools within schools" at South Slope Elementary School and Burnaby South Secondary School.

Message Relay Centre (MRC): A special operator who enables callers using a voice telephone to call and have a conversation with someone who has a telephone device for the Deaf (TTY) and vice versa.

Sign Language Interpreters: Hearing people who are fluent signers and have additional training in the techniques and ethics of interpreting from Sign Language to spoken English and vice versa. Sign Language Interpreting is a highly demanding profession that requires at least four years of intensive training, and has various levels of certification, based on fluency and technical skills. Sign Language interpreters are essential for Hearing and Deaf people to interact fluently and equally with each other.

Signed English Systems (Signing Essential English, Signing Exact English, Manually Coded English): Signing systems that have been developed by educators of Deaf children with the purpose of teaching English visually. In each of these systems, ASL signs have been adapted to match the grammatical structure and word-usage patterns of English. The attempt to make a visual/spatial language match, sign for sign, with an auditory/sequential language is quite a stretch that many ASL signers strongly object to.

TTY: (TDD) A telephone device for the Deaf based on the teletype code in which the user types words that are transferred through the phone lines and can be read by another TTY. TTY's have been in use since about 1980.

Victory Hill: The residential program for students who attend the Provincial School for the Deaf in Burnaby.
Appendix B:

Method
Appendix B: Method

Steering Committee
The Interministry Jericho Coordinating Committee set the framework for the review. Clement Meunier (Ministry of Children and Families) and Wayne Fullerton (Ministry of Health) provided liaison between the steering committee and the review process by working closely with the researchers, attending meetings, observing focus groups, exchanging ideas, and editing the report.

Researchers
Linda Hill and Pat Nelson independently submitted research proposals in September, 1999. At the request of the Interministry Jericho Coordinating Committee, we combined our proposals and collaborated in carrying out this review.

Deaf Community Consultant
We asked decision makers in the Well Being Program, Greater Vancouver Association of the Deaf, Deaf Children’s Society, and Western Institute for the Deaf and Hard of Hearing (Vancouver office) to suggest credible candidates who had experience in areas related to Deaf mental health and who were well connected to the Deaf community. A short list of candidates who were acceptable to all four organizations was compiled. Anita Harding was selected as the Deaf community consultant from this short-list.

Advisory Committee
We established an Advisory Committee that was made up of a combination of individuals appointed by the Inter-ministry Jericho Committee and representatives from these organizations:

- Greater Vancouver Association of the Deaf
- Island Deaf and Hard of Hearing Centre
- Medical Interpreting Services
- Northern Interior Association of the Deaf (with input from Western Institute for the Deaf and Hard of Hearing - Prince George Branch)
- Western Institute for the Deaf and Hard of Hearing
- Well Being Program
- Ministry of Children and Families
- Ministry of Health

In total there were 13 committee members as shown in the table below:

<table>
<thead>
<tr>
<th>Table 1: Advisory Committee Members</th>
</tr>
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<tbody>
<tr>
<td>Service Providers</td>
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<tr>
<td>-------------------</td>
</tr>
<tr>
<td>Deaf</td>
</tr>
<tr>
<td>Hearing</td>
</tr>
<tr>
<td>TOTAL</td>
</tr>
</tbody>
</table>

Within this relatively small group, we attempted to ensure a wide representation from various parts of BC, various organizations, and various cultural backgrounds.
**Literature and Document Review**
To provide a base for the community consultation process, Linda Hill reviewed literature and documents such as previous reports from 1989-1999 related to Deaf mental health issues. In this qualitative meta-analysis of documents, statements related to mental health issues and/or counselling were entered into a database (Microsoft Works). Each of the resulting 1600 comments was then sorted into a major category (problems, resources, recommendations, and principles of best practice). Next the statements were coded into themes and sub-themes and counted. The number of comments relative to a theme indicates the relative importance of that theme. Once all comments had been coded and sorted, and counted, summary paragraphs were written. The results of the review are in Appendix D.

**Community Consultation Process**
Vancouver, Vancouver Island, Okanagan, and Prince George were chosen as the four community consultation sites. The focus groups were organized by local community organizers who were also members of the Advisory Committee. Pat Nelson developed the procedures for the focus groups and interviews with key informants (See the Facilitator’s Guide and Examples of Interview Questions at the end of this Appendix). Linda Hill facilitated the community consultation process on Vancouver Island and Prince George. Pat Nelson facilitated the community consultation process in Vancouver and the Okanagan.

Table 2 gives an overview of who participated in the community consultation process. We interviewed a total of 76 Deaf and 85 Hearing stakeholders (161 people)

<table>
<thead>
<tr>
<th>Place</th>
<th>Well Being Program Staff, and Contracted Service Providers</th>
<th>Service providers from mainstream agencies who have some contact with deaf consumers</th>
<th>Service Providers who mainly serve deaf individuals and families (Government and Non Government)</th>
<th>Community Members (Deaf individuals and Hearing Family Members)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deaf</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>1</td>
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<td>6</td>
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<td>27</td>
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</tr>
<tr>
<td>Pr. George</td>
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<td>Hearing</td>
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<tr>
<td>Kelowna</td>
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<td>1</td>
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<td>26</td>
<td>15</td>
<td>34</td>
<td>86</td>
<td>161</td>
</tr>
</tbody>
</table>
TABLE 3 gives an overview of who participated in the focus groups. Several advisory committee members helped organize and co-facilitate focus groups. Other advisory committee members participated in focus groups or were interviewed as key informants. The following table describes the focus groups.

TABLE 3: OVERVIEW OF FOCUS GROUP PARTICIPANTS

<table>
<thead>
<tr>
<th>Date</th>
<th>Place</th>
<th>Deaf Participants</th>
<th>Family Members</th>
<th>Invited Observers</th>
<th>Facilitators and Note Takers</th>
<th>Interpreters</th>
<th>Total People in each Focus Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 01</td>
<td>Vancouver</td>
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<td>0</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>November 09</td>
<td>Nanaimo</td>
<td>6</td>
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A total of 53 Deaf individuals (including 45 community members and 8 service providers) and 3 parents of Deaf adults participated in the focus groups. In addition, we interviewed the following Deaf individuals and Hearing parents individually and in small groups:

- Hearing parents 24
- Deaf/Blind individuals (Vancouver) 03
- Deaf adolescents at Victory Hill Residence 06
- Deaf individuals who did not feel comfortable attending focus groups because of victim/offender issues (Vancouver, Vancouver Island, Prince George) 05

The age range of the people we interviewed was 16 to 73 years. The parents we interviewed have Deaf children who range in age from 3 years to 33 years. A variety of cultural and ethnic backgrounds were also represented, including the focus group in Duncan which was specifically for Deaf First Nations individuals who came from various parts of Vancouver Island. Several people with visible disabilities participated in focus groups in Prince George and Victoria. However, our impression (that was confirmed by local community organizers) is that the views of Deaf people with cognitive disabilities and chronic mental illness were somewhat under-represented in the community consultation process. (However several of the service providers who we interviewed work directly with Deaf individuals who have disabilities and/or mental illness).
We interviewed key informants individually and in small groups from the following organizations:

Well Being Program Staff, consultants, interpreters, therapists 26  
Jericho Individual Compensation Program 6  
Island Deaf and Hard of Hearing Centre 3  
Provincial School for the Deaf 5  
Western Institute for the Deaf and Hard of Hearing - Prince George 3  
Deaf and Hard of Hearing Education, Prince George School District 2  
BC Deaf Children's Society 2  
Community Living Services Ministry for Children and Families 3  
Vicory Hill Residence 3  
Child and Youth Services in Victoria, Ministry for Children and Families 2  
Greater Vancouver Mental Health Services Society 2  
Prince George Interpreters Association 2  
Vocational Rehabilitation Services 2  
Deaf Access Office 1  
Disability Benefits Office, Ministry of Social and Economic Development 1  
Mental Health Services, Capital Regional Health District 1  
Provincial Audiology Services, Ministry of Children and Families 1  
Provincial Resource Program, Sooke School District 1  
Public Health Office, Prince George 1  
READ 2000, Adult Deaf Education Program, Sooke School District 1  
Vancouver/Richmond Health Board 1  
Western Institute for the Deaf and Hard of Hearing - Vancouver 1

Data Analysis
Pat Nelson and Linda Hill presented preliminary observations at two Advisory Committee Meetings held November 26 and December 16, 1999. During the month of February, 2000 Linda Hill entered the community consultation data into a database and analyzed the records following the same qualitative procedures described above (see Literature and Document Review). She developed recommendations and submitted two drafts of the report to Wayne Fullerton and Clem Meunier who provided feedback and guided two stages of revisions. A final draft report was submitted to the Advisory Committee members and the Inter-ministerial Jericho Coordinating Committee on February 25, 2000. On March 29, 2000, Linda Hill and Anita Harding presented the report to the Interministry Advisory Committee. Final revisions were done March 30-April 13, and the completed report was submitted to the BC Government on April 14, 2000.

Limitations Related to the Time Line
Although we gathered a great deal of information in a very short period of time, we have not by any means gathered information from all possible sources. In particular there is a need to collect more information about models of service delivery from other provinces and countries.

Unfortunately, Pat Nelson became ill in December and eventually had to make the difficult decision that she was not well enough to analyze the data and draft the report. The final report was submitted 10 weeks later than originally scheduled.
Limitations of Community representation:
We did not fully represent the diverse make-up of the Deaf population during the community consultation process. We did include Deaf people from various ethnic backgrounds on the advisory committee and in the focus groups. We also facilitated one focus group for First Nations individuals. In addition, we met individually with several former Jericho students who are "in hiding" from the Deaf community related to abuse issues. In addition to meeting with active, central members of the mainstream Deaf community, we had discussions with Deaf teenagers, Deaf seniors, parents of Deaf children, Deaf-Blind individuals, and Deaf individuals who have other disabilities. We interviewed service providers who work with Deaf consumers who are mentally ill and/or developmentally disabled. However, we did not meet with everyone, and so, as in all research, the comments collected represent only a sample of the range of opinions and ideas about the topic being studied. One of the main limitations is that almost all of our community consultation was oriented toward the signing Deaf community and the needs of oral Deaf individuals were not addressed thoroughly.

Limitations of the Scope of the Target Population
It is also most important to note that the needs of the much larger hard-of-hearing population have not been addressed in this review. Several service providers have pointed out that a significant number of hard of hearing and late Deafened individuals do face significant mental health problems related to hearing impairment issues such as adjustment to hearing loss and communication anxiety. Communication accommodations and hard of hearing issues are not well understood by mainstream counsellors and so these individuals also face barriers accessing appropriate counselling about their issues. More research is needed to clarify the mental health needs of hard of hearing, and late Deafened individuals and their families.

Delays in Payments and Reimbursements
Honorariums and reimbursements to participants as well as the payment for other expenses incurred were not handled in a timely fashion due to the short time frame, the inability to sufficiently fund expenses in advance, and Pat Nelson’s unexpected illness that further delayed submissions of invoices. As a result, some individuals have voiced their concern about the payment delay. It is hoped that the generally positive reception of the review within the Deaf community has not been compromised by this delay.
FACILITATOR'S GUIDE FOR DEAF CONSUMER FOCUS GROUPS

INTRODUCTION

Materials Required:

Flip chart/felt pens
Parking Lot Page taped on the wall
Survey Sheets
Pens/pencils for 10 participants
Name tags (first name only)
Agendas

Setting the stage:

- Introduce self, community organizer, and recorder, or have the community organizer introduce you. Provide a brief explanation of your own background relevant to the review. Mention the following points:

  * take a neutral stance in the outcome of the review, major task is to listen well and to record all participants view points
  * committed to Deaf community participation in the review, let us know whether there are any Deaf interests not present, if so, we could talk after the group re: the possibility of including them in some way

- Ask participants to introduce selves, if they are comfortable they might wish to say what their particular interest is in today's group

- Provide a brief explanation of the process to date. Include the following points:

  * contracted by MCF and the Interministerial Jericho Coordinating Committee
  * 6 focus groups (made up of individuals who have used mental health services, family members who have used mental health services, individuals with knowledge about mental health services for Deaf people), locations of groups
  * 75 key informant interviews (group discussions, telephone/TTY, face-to-face interviews with Deaf and hearing individuals who have knowledge of mental health services, deliver mental health services, expertise in delivery of mental health services for Deaf people, interpreters, regional government staff involved in service planning)
  * local Deaf community members roles in organizing the focus groups, and the Deaf Advisory Committee with regional representation that is helping to guide the review process
  * report on findings to the IJCC steering committee by late December, the report will not name individuals, will preserve confidentiality, will have been reviewed by the Advisory Committee prior to final draft. Initially the report is for Treasury Board, but at some date the report will be made accessible to members of the Deaf community.
  * remind people that they have the option of filling out the survey, it is an individuals decision whether to respond to each question or not, and their contributions will be anonymous.
Today's Task

Refer people to the agenda and cover the two following tasks:

1) we want to find out about Deaf people's experiences using mental health services, what was helpful, what was missing, what improvements could be made, what difference it made in their lives

2) we want to talk about how services are delivered now, what are the barriers that stop people from using services, what mental health services should look like in the future

Process

• We want to record the range of responses to each of the questions, we are not here to reach agreement, or to build consensus, every response will be noted

• Talk about the guidelines for giving everyone an opportunity to speak

• Reference to washrooms, refreshments, break during the group

Parking Lot Page

• Explain how it works: problems, complaints, tensions, critical issues cannot be resolved today and rather than get stuck we will record each of the concerns on the parking lot page(s) and they will be included as an appendix to the report, and will be given to the MCF/MH liaisons to the IJCC (Wayne and Clem)

• People can feel free to add to the parking lot page during the break if they wish

Recorder's Tips

• Number each page and indicate the question that is being addressed

• If you have any doubt or have not heard comments, please ask participants to repeat or check that what you have written has captured the meaning accurately

Facilitator Summary Sheet

The facilitator summary sheet will be completed after we have finalized the questions for the focus group. The items on the sheet will reflect directly on the questions as well as a few items that are related to the dynamic of the group. If the recorder is willing, it might be useful to have them to fill out the summary sheet as well.

Honorariums

If we both use the same honorarium sheets to have participants and recorders fill out, it will probably make it easier for MCF to reimburse us. The same goes for the invoices filled out by the community organizers.
FOCUS GROUP QUESTIONS

A. Current Services

Today we want to find out about Deaf people's experiences in using mental health services. When we talk about someone who is experiencing poor mental health, we mean someone who may feel some of these ways:

depressed, not sleeping well, not eating well, feeling angry all the time, being aggressive, feeling isolated from everyone, feeling bad about themselves, not able to talk to anyone, feeling hopeless, feeling stressed out, not able to cope, feeling suicidal, feel bad due to physical or sexual abuse, or... (people could add to this list if they wish)

It could also be someone who has a mental illness like major depression or schizophrenia, or psychosis.

1. If you, or a family member have been experiencing feelings like this where do you go for help?
   * family, friends,
   * local community services (mental health centre, physician, and treatment programs)
   * Well-Being Program
   * local Deaf-serving agency (IDHH, WID, Deaf Club or Association)
   * other services (Family Services, private practice therapists, psychiatrists, disabilities agencies)

2. Tell us about the help/services that you received.
   * which organization/service is identified?
   * what kind of difference did the help make in your life?
   * what was most helpful to you?
   * was there any kind of help that was missing?
   * what would have improved the help that you received?

3. What difference did these services make in your life?
   * ability to function in daily life
   * relationships
   * family/community connections
   * Jericho compensation program
   * feeling better, higher self esteem, happier,
   * able to work
4. Tell us about anything that stopped you from getting the help you needed.

* issues related to self (e.g., don't know of any service, fearful, stigma associated with mental health problems, confidentiality issues, and lack of understanding re: Deaf culture)
* systemic issues (e.g., lack of interpreters, lack of appropriate professional service, discrimination, waiting lists, not eligible for service mandate, lack of understanding of Deaf communication issues)

5. What is needed to help overcome barriers to service?

* personal
* systemic
* specific service
* cultural and communication issues

B. Future Services

When people are talking about having good mental health they mean feeling some of these ways, for instance:

feeling happy, able to trust people, being self confident, feeling connected to family and friends, able to deal with stress, able to handle anger appropriately, accepting support from others, feeling physically well, taking care of one self, able to cope with daily life, having some stability in life....or (people could add other characteristics of good mental health here)

6. What kind of support do you need to have good mental health? to recover good mental health? (Explain that help may fit in different categories, for instance mental health, social health, economic health, or community health, and ask how they would categorize the support)

* mental health category
* social/economic/community health category

7. There are different models used to deliver mental health services. For instance, the way services are delivered now. (draw a picture of this and explain features of it)

Current model:

* central program (Well-Being Program) that is Deaf specific, but attached to mainstream mental health agency (GVMHSS)
* central program that is located in the Lower Mainland with outreach services to other parts of the province (staff travel to do workshops, intake from central office to contract for private therapy in different communities, provide referral and resource information around the province, liaise with mental health centres)
* central program funding support workers in other regional Deaf agencies (e.g., support workers at IDHH to serve Victoria, and the Island)
From your experience what are the strengths of the current model of mental health service delivery? what are the weaknesses?

* local, regional issues re: accessibility, confidentiality, availability of services
* Deaf community ownership of the service
* trust in the Well-Being Program and in the contracted Deaf agencies (e.g., IDHH)
* preference for local Deaf agency to deliver
* resources are all located in the Lower Mainland

8. What other model could you imagine for delivering mental health services to the Deaf community around the province?

* existing Deaf agencies in region or local communities providing the service with no central organization or limited central organization (name a regional/local agency that people would trust)
* hiring professionals into mainstream agencies (or mental health centres) who are sensitive to Deaf culture, sign, or can use interpreters
* expanding the outreach capacity of the existing system
* others

9. What do you think are the most important qualities to include in providing Deaf mental health services?

* accessibility - culturally, linguistically
* accessibility - geographically
* accessibility - financially
* accessibility - professional expertise
* empowering of the Deaf community
* defined and delivered by Deaf agencies
* others

10. Any questions?

THANK YOU
KEY INFORMANT QUESTIONS

The following is a list of the types of questions that we asked key informants during individual and small group interviews. Pat Nelson prepared interview protocols that selected specific questions and adapted them to the role of the individuals being interviewed.

- Tell us about the demand for Deaf mental health services

- What services exist in the community that you are able to refer Deaf clients to for additional or ongoing support? (mainstream, Deaf specific)

- What, if any, barriers stop people from accessing these services?

- From your perspective what, if any, gaps in mental health services exist? (age related, type, intensity)

- If we look at the issues/problems that you and others have identified that Deaf children face, what are the behaviours or indicators that determine the need specifically for mental health service?

- In considering the adult Deaf population, again how do we differentiate between the type or severity of problem that requires mental health services as opposed to those which could be dealt with in other kinds of services?

- What impact, if any, does working with a Deaf client have on length of service? treatment modality? therapeutic outcomes?

- What, if anything, differentiates hearing clients from Deaf clients? Deaf RHAP clients from other clients?

- From your involvement and observations how would you characterize the services offered through the WBP? (strengths and weaknesses, barriers to service, gaps in service

- What suggestions would you make to improve WBP services? (therapy, counselling, interpreting, support work, psychoeducation, case management/coordination, referrals)

- What role should the WBP play in supporting the network of services? Does this role differ in the Lower Mainland from other areas in the province? (Direct service delivery, coordinating services, Community Awareness, Advocacy, Brokerage services, Community Education, Other . . . Explain

- Does the W.B.P. role differ in the Lower Mainland from other areas in the province? Explain.
- What resources are necessary to adequately meet the mental health needs of Deaf persons in the next fiscal year? (numbers, types of problems)

- Knowing that resources are limited, how would you suggest managing the need for counselling/therapy with Deaf clients and their families? (priorities, limitations, alternatives to therapy)

- The document review suggested providing groups as one way to deal with limited resources. What is your reaction to that idea?

- Currently W.B.P. services are delivered primarily through a centralized model with some outreach to regions around the province. From your perspective what are the advantages and disadvantages to this model? What changes, if any, would you suggest?

- How should mental health services for the Deaf community be provided over the long-term? (Deaf signing, hearing signing, hearing plus interpreter therapy, Deaf community involvement in planning, delivery, and evaluation of services, type of model, variations on the present model, Deaf specific, or combination of existing plus Deaf staff/signing staff)

- What is needed to ensure adequate access to the mental health service delivery system for Deaf people regardless of model?

- In what ways could service providers, funders, and community organizations collaborate more effectively to provide Deaf mental health services?

- Many reports that have been reviewed stress the importance of Deaf community involvement in the planning, delivery, and evaluation of mental health services. What are the ways in which you think this could happen? (local/regional, mainstream/Deaf org, mental health centre)

- The issue of community healing has come up through the review process, what are your ideas about how this issue could be approached? (get reaction to ideas suggested already)

- How can the long-term mental health needs of the Deaf community be ensured?

- Is there anything else that you would like to add? any critical issues that we have missed?

- Who else should be involved in this review process?
Appendix C:

Description of the Deaf Population in BC
Appendix D:

Review of Documents Relevant to Deaf Mental Health Issues
Appendix D: Document Review of Deaf Mental Health Issues

Mental Health Problems

The incidence of mental illness is about the same in the deaf and hard of hearing population as in the hearing population. However, difficulties adjusting to a world that was designed by and for the hearing majority are much higher. Deaf children, Deaf adults and their families have ongoing needs for individual, family, and community mental health supports and services. The ongoing themes are high rates of physical and sexual abuse, lack of communication, family disconnection, isolation, discrimination, and communication barriers.

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Effects of Physical and Sexual Abuse (229 comments in 20 documents)

Community Effects (134 comments in 15 documents)
See references 18a, 2, 15, 5, 16, 17, 18, 21, 22, 25, 29, 30, 33, 34, 40

There is increasing recognition of the 'ripple effect' of institutional child abuse on First Nations communities throughout Canada. First Nations cultural values and practices are considered to have been "ripped away by colonialism, residential schools, relocation, and prejudicial attitudes that still exist in our society" in what has been frequently described as cultural genocide (Prince George Native Friendship Centre). The residential school experience has adversely affected aboriginal communities that continue to struggle with high rates of family violence and sexual abuse.

The legacy of on-going abuse has had effects on the BC Deaf community that some community leaders also connect to images of cultural genocide. The ripple effect of institutional abuse has become an inter-generational cycle that is fragmenting and impoverishing the entire Deaf community. However, acknowledging residential school abuse has been very difficult for the BC Deaf community because residential schools for Deaf children are highly valued in Deaf culture as gateways into the Deaf community. Until recently, the Deaf community has not acknowledged how closely physical and sexual abuse have been associated with the process of learning American Sign Language, Deaf cultural values, and entering the Deaf community. Problems related to sexual abuse at Jericho have caused tensions within the social centres of Deaf communities. Gossip and publicity about sexual abuse at Jericho is considered to have damaged the Deaf community and taken away their sense of pride in their school. The Greater
Vancouver Association of the Deaf feels that their members have been forced to reexamine priorities and get re-involved in advocacy.

Some Deaf individuals have withdrawn from Deaf culture into isolation, avoiding the Deaf community, but unable to participate in the Hearing world. Many Deaf people have extremely restricted support networks, and those who have withdrawn from the Deaf community may have no one to communicate fluently with.

Abuse cycles impact greatly on marriage and parenting. Young Deaf adults are struggling to build their family without adequate preparation and when information about marriage, parenting, responsibilities, crisis management, rights and responsibilities. Victims have married offenders. Spousal violence, child abuse, and apprehension of children is a reality in the Deaf community.

Abuse and upset within Deaf-Hearing families is also a reality. Hearing spouses and other Hearing family members can control access to communication and information. They may prohibit contact with Deaf friends, and/or refuse to learn or use Sign Language. Hearing parents of adult Deaf children may experience guilt and anger about failing to protect their children by sending them back to the dormitory. A high number of adult Deaf children are estranged from their Hearing families of origin as a result of a tangled combination of these issues related to lack of communication, isolation, and abuse.

At the same time, therapists caution that it is too easy to focus all the blame on the Jericho tragedy. One therapist described Jericho as the lightening rod for a pre-existing tidal wave that was unleashed by the disclosures and investigations.

**Ongoing risks of abuse:** (48 comments in 7 documents)

See references 2, 16, 17, 18a, 22, 32a, 36

Berger described how dependency and isolation made it possible for a culture of sexual abuse to develop at Jericho Hill School for the Deaf over a period of many years. Without communication, the safety net is not there within the family, the school, or society. The Law Commission of Canada describes how people charged with care of children can fail and refuse to protect them and how child abuse is allowed to simply relocate. Within these documents, grave concern is expressed over the on-going dependency, isolation, and vulnerability to abuse facing Deaf children today whether they are in mainstream classrooms, resource rooms, provincial resource centres, or the Provincial School for the Deaf. Perpetrators of physical and sexual abuse of Deaf children are almost never charged. Instead, they are moved to another setting where they continue to work in positions of power over Deaf children and adults. Without accountability, this on-going cycle of abuse of Deaf children continues to the present day. Therapists continue to see Deaf children who show signs of abuse and they consider that the risk of another Jericho tragedy remains very high.
**Individual Effects (37 comments in 16 documents)**

See references 2, 3, 12, 32a, 5, 15, 16, 18a, 18, 21, 22, 25, 30, 34, 36, 37

The individual effects of institutional childhood abuse on survivors have been well documented. Effects include: difficulty learning and concentrating, poor school achievement, rage and reactivity, entering into and leaving violent abusive relationships, alcohol or other drug abuse, as well as disconnection from family and other social relationships. The rate of ongoing health problems, hospital visits, crises, physical trauma and self-mutilation is high. Survivors of ongoing abuse show symptoms of post trauma stress disorder such as flashbacks, anxiety, panic, sleep disorders, foreboding, emotional vulnerability, dissociation and splitting, catastrophising, fear of and incapacity to trust people in positions of authority. Clients talk often of abandonment, betrayal and feelings of worthlessness. Issues of sexual identity confusion are common. There is a high rate of abuse survivors working in the sex trade and living on the street. Unemployment is high and many survivors are unable to work or are so reactive to daily life stresses that they have difficulty keeping employment or coping with life in a society where survival requires ego strength, a sense of worthiness, and boundaries.

Different individuals suffer in various degrees, and, of course, many of these problems are seen in mental health clients who do not self-identify as abuse victims. However, RHAP therapists emphasize that the acuity and level of intensity of problems is magnified in survivors of ongoing abuse in institutions. Being placed in abusive environments also exacerbates pre-existing problems of abandonment, attachment, and lack of trust that resulted from earlier betrayal in family of origin and institutionalization. As adults, this population has generally had lots of experience with various systems and services (e.g. legal system, rehabilitation, treatment programs, detoxification, drug and alcohol counselling) yet still a high degree of need.

Therapists who see clients referred from the Well Being Program mention post traumatic stress disorder, low self esteem, sexual abuse issues, alcohol abuse, violence, depression, relationship problems, community living difficulties, isolation, suicide attempts, on-going emotional suffering, frustration, high unemployment, poverty, and low literacy. Berger found some of the case histories to be shocking. There are comments that Deaf victims of violence experience double the shame, fear, isolation, tolerance, silence, powerlessness compared to Hearing victims. Isolation and abandonment by their own parents, caregivers, teachers, and others in authority leads to a deep-set distrust of the Hearing world.

**Abuse of Deaf Individuals Who Have Disabilities (10 comments in 3 documents)**

See references 2, 36, 18a

Deaf individuals who have disabilities experience lack of acceptance, devaluing and active rejection from members of both the Hearing and the Deaf communities caregivers feel overly taxed. The children at Jericho who were the most vulnerable to abuse had multiple handicaps or had difficulty signing. Psychiatric disturbance within the population of Deaf individuals who have disabilities appears to be very high.
Effects of growing up Deaf in a Hearing world (76 comments in 15 documents)

Being Deaf or having a Deaf family member, or providing service to Deaf consumers means dealing daily with deep, emotionally loaded issues associated with cultural identity and rights to information, communication, and language. The main sub-themes related to the impact of growing up Deaf in a Hearing world are summarized below.

Lack of Communication (27 comments in 6 documents)
See references 2, 15, 16, 18a, 22, 29
When Berger researched the context of sexual abuse at Jericho Hill School for the Deaf, he found it to be "intolerable for a society to countenance a situation where children can't communicate with parents". Deaf children born to Hearing parents tend to experience a poor communication situation at home where parents are not familiar with American Sign Language and find it difficult to communicate with their children about any complicated subject. When communication is lacking, Deaf children learn little of symbolic significance from their family and do not have values instilled in them in the same way that Hearing children do. Lack of communication at home and school is not a historical issue, but is a current problem facing many Deaf children and their families.

From the point of view of the Deaf community, lack of communication at home and school is abusive. Deaf advocates object to the deficit model of Deafness held by most Hearing professionals. They feel that homage to speech wrongly influences decisions about education, denies Deaf children access to American Sign Language (ASL), and results in years of lost education.

Family Disconnection (22 comments in 6 documents)
See references 2, 18a, 20, 22, 33, 36
This document review suggests that Deaf clients' emotional problems are often rooted in responses of their families to them as children. Deaf children often feel a lack of full acceptance by their parents who are usually going through a period of grieving characterized by sorrow, resentment, and a determination to overcome their child's deafness. Parents may have unrealistic expectations for oral success in mainstream situations, and they may fear losing their child to the Deaf community. Deaf children aged 8-10 are being referred to the Well Being Program with labels of aggression, out of control, and conduct disorder, when the root of the problem is anger and frustration related to communication issues. Students who attend residential schools - even children who go home every weekend - may feel alienated from their families, and their families may never really know them because of communication barriers, distance, and lack of time spent together.
Isolation (15 comments in 11 documents)
See references 2, 3, 17, 18, 18a, 20, 21, 22, 29, 30, 36
The theme of isolation is found throughout this review. Berger commented that "It is difficult to overemphasize how isolated the Deaf can be." Deaf loneliness is seen as different than Hearing loneliness. To illustrate: One ASL sign for isolation communicates the concept of sitting in a corner. Another sign for isolation/inferiority communicates the concept of being alone in a basement. Therapists commented that extreme isolation often leads to "fantastical realities with idiosyncratic meanings" that are fueled by watching television and trying to figure out the meanings behind the actions and the unseen words.

Discrimination (12 comments in 4 documents) See references 18a, 22, 24, 21
As a group, Deaf children and adults experience a high rate of school failure and low literacy. Many members of the Deaf community feel deprived of an education and communication. Deaf children and youth are seen to lack opportunities to learn social, emotional, and educational skills and acquire knowledge. Rates of unemployment and underemployment are high. As one therapist put it: "We are working with a population that is so constantly being discriminated against that a Hearing person refused to sell my client a puppy because of the attitude that a Deaf person can't look after a dog." The experience of discrimination is seen to generate trauma after trauma.
Document Review of Access Barriers

Access Barriers

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Inadequate access and service (53 comments in 9 documents)
See references 16, 21, 24, 27, 32, 33, 34, 35, 36
Deaf individuals have a daily experience of intense frustration because public services are so inaccessible. There is a pervasive feeling of isolation within Hearing services. There are systemic barriers throughout the system, even in government programs that are specifically set up to serve Deaf people. Deaf community members are well used to not being able to access services that Hearing community members take for granted. Deaf people who live in rural areas have even less access and choice.

Prior to the establishment of the Well Being Program, it was clear that mental health services for Deaf and Hard of Hearing consumers had not kept pace with trends for Hearing consumers. The small number of practitioners and specialized agencies serving Deaf and Hard of Hearing consumers were over extended and understaffed. Within these agencies there was a lack of trained mental health professionals. Within mainstream mental health agencies there was a lack of service providers who were trained in Deaf issues. There was also almost no recognition of sexual abuse issues in the Deaf population. These combined lacks meant that there was a very little counselling or follow up and support for Deaf children and adults who had mental health problems. All mental health resources were inadequate including: counselling, psychiatric consultation, emergency supports, early intervention, and support services of all kinds. There was also a lack of trained mental health interpreters, and few service providers knew how to deal with both Deaf issues and violence issues. There was a lack of mental health services for Deaf children and adults who had disabilities such as group homes, supported housing, life skills training, interpreter services, respite care, and rehabilitation.

Prior to the establishment of the Well Being Program, almost all the resources accessible to Deaf consumers were located in Vancouver, with the exception of a small, understaffed office for Deaf and Hard of Hearing people in Victoria. People were to traveling to or moving to Vancouver for all services, including psychiatric treatment, and other services, leaving their families and communities.
**Communication barriers** (24 comments in 10 documents)
See references 16, 17, 18, 18a, 21, 22, 24, 27, 34, 36
Communication barriers are a major problem facing almost all Deaf and many Hard of Hearing individuals who are trying to access mainstream mental health services. Staff at mainstream service agencies are unable to communicate in Sign Language, leading to ineffective communication. Writing notes and relying on informal support networks to support communication is completely inadequate. It is difficult to access interpreters. There are shortages and waiting lists. Interpreters working with the same client for many different purposes leads to discomfort over boundaries being crossed.

Technological solutions don't totally solve access barriers. The TTY and MRC are slow, and - because of language and literacy barriers - misunderstandings are frequent. Literacy-based technology is fairly inaccessible to Deaf immigrants or to Deaf consumers who have very low reading and writing abilities.

**Inappropriate Treatment** (31 comments in 5 documents)
See references 21, 24, 27, 34, 36
This document review points out that Deaf and Hard of Hearing individuals and families often receive inappropriate treatment from mainstream service providers. When the only access to mainstream mental health services is for clients who are diagnosed with DSM III illness, many service providers see Deaf clients as being outside of their agency mandate. Deaf individuals in need may fall between the cracks of available services. As a result, Deaf and Hard of Hearing clients are under-served or served in ways that are culturally insensitive. Clients often feel that they are not understood. Mainstream services are often avoided because Deaf and Hard of Hearing individuals predict that professionals will have limited knowledge about Deaf and Hard of Hearing issues. They may fear being re-victimized and Deaf parents have a very strong fear of losing their children if they seek help for domestic problems.

Inexperienced workers may be overwhelmed by deafness. Lack of knowledge and understanding impedes therapy. Clients may be incorrectly diagnosed and/or inappropriately referred by professionals who have no knowledge of appropriate resources for Deaf people. Professionals may minimize the difficulties of clients, or focus on deafness as the pathology to be addressed instead of focusing on client's concerns. Deaf individuals with disabilities are often under-served, misdiagnosed, and may be placed in group homes and institutions with no communication for years on end.

**Poor coordination of existing services** (10 comments in 3 documents)
See references 27, 34, 36
Several documents point out that to date the approach to mental health service delivery has been reactionary, disjointed and haphazard, resulting in fragmented and uncoordinated service delivery.
**Funding shortages** (6 comments in 4 documents)
See references 2, 6, 27, 36
The funding base is not solid and the main concern of the government is the emotional and financial burden of litigation. Prior to the Well Being program being set up, and recent provision of medical interpreting, there was a lack of funding for interpreters. Shortage of funding is still an issue.

**Concerns about confidentiality** (4 comments in 4 documents)
See references 18a, 19, 21, 36
Some clients express concerns about going to existing Deaf service agencies for help with mental health issues. There is fear of gossip, as well as concern that asking for help with a mental health problem will interfere with vocational opportunities. Confidentiality is highly sensitive in a small community where consumers may have multiple levels of interaction with service providers.
**Document Review of Recommendations for Deaf Mental Health Services**

**Recommendations For What Is Needed**

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**Service providers who understand Deaf culture, American Sign Language, and mental health issues** (132 comments in 22 documents)

A great deal of specialized knowledge, understanding, skill, and awareness is needed to work effectively in the Deaf community including fluency in ASL, awareness of and sensitivity to Deaf culture, the diversity of the Deaf community, and Hearing/Deaf family issues.

**Educate Service Providers** (83 comments in 15 documents)

See references 2, 14, 15, 18a, 21, 22, 25, 27, 28, 31, 32, 34, 35, 36, 39

All service providers need on-going education, training, supervision, and support. There is a need for accessible, culturally sensitive, comprehensive mental health training for mental health service providers who are Deaf. There is also a need for Hearing therapists to provide mentoring, co-therapy and coaching in partnership with para-professionals and new professionals who are Deaf. Another suggestion is for workers in non-profit agencies that serve Deaf clients to educate workers in mental health agencies about Deaf issues. Another recommendation is that that yearly conferences be funded. Therapists are seen to need opportunities to discuss, provide peer support and prevent burn out. Service providers need on-going training with respect to child abuse and neglect issues. Research needs to be shared in
order to improve and add to the limited field of knowledge and research in the area of mental health and Deaf and Hard of Hearing issues. Signing therapists and interpreters need continuous ASL upgrading to ensure clear client/therapist communication and understanding. Regularly updated resource guides assist information, referral and networking.

**Hire skilled service providers** (49 comments in 17 documents)
See references 6, 8, 14, 16, 18a, 19, 21, 24, 27, 31, 32, 33, 34, 35, 36, 37, 40
Clients want to access service providers who are already sensitized, well trained, aware and able to adapt the process and content of mental health services to Deaf culture and to diversity of clients. Choice of communication method is very important. Communication needs to be flexible to meet the variety in systems and strategies of communication used by Deaf and Hard of Hearing consumers as well as Hearing family members.

Intervenors who can provide support to Deaf-Blind consumers and other individuals who are Deaf plus have disabilities are needed. More home support workers and other mental health workers who can communicate with Deaf and Hard of Hearing clients are needed.

The most common recommendation is that Deaf community members be trained and hired as service providers (similar to training and hiring efforts in aboriginal communities). Another recommendation is to hire Deaf and Hearing professionals who are proficient in ASL and aware of Deaf cultural issues as consultants. A third recommendation is to encourage Hearing mental health professionals to take ASL and Deaf culture training.

Qualified, professional, highly skilled mental health interpreters are essential for provision of mental health services in the Deaf community. Unless the consumer chooses otherwise, non-signing service providers almost always need to partner with interpreters. All service providers (Hearing-Can-Sign, Deaf, Non-signing) require interpreters to work effectively whenever signing Deaf and non-signing people come together (e.g. meetings, family work). Recruitment and training of interpreters continues to be necessary to reduce critical shortages throughout the province. It is important to recognize that interpreters are not machines. Just as clients need to develop an ongoing relationship with their therapist, clients need to be able to develop an ongoing relationship with their mental health interpreter.

**Group Counselling** (100 comments in 22 documents)

A combination of groups and individual counselling may be the most effective way to serve the community. Several documents note that clients who do not benefit from individual counselling (unwilling or unable to express) can express themselves in and learn from group situations. Groups are recommended for children as well as adults. Group counselling does not replace individual counselling. This is partly because confidentiality and concern about gossip is highly sensitive in a small community and partly because groups fill different needs than individual therapy.
Psychoeducational Groups (60 comments in 21 documents)
See references 1, 2, 3, 5, 8, 14, 15, 17, 19, 20, 21, 22, 24, 25, 27, 28, 31, 32, 35, 36, 40
There are many recommendations for participatory, skill building workshops (day long or on-going courses) that give information and teach skills in a non-confronting, comfortable context. Access to information is a critical need, and issues of confidentiality are less problematic in information/skill oriented groups than in therapy groups.

Types of groups and workshops suggested include informational workshops, retreats for family members and their children, independent living programs for Deaf people who have disabilities, parenting support groups, social and recreational support groups for survivors of abuse, psychosocial rehabilitation, school prevention programs, and leadership training workshops. Courses and workshops can be supplemented by videos and books.

Suggested topics include: stress management, life skills, social skills, interpersonal relations, conflict resolution, personal safety skills, boundaries, human rights and rights of children, healthy sexuality, effects of child abuse and family violence, self defense, peer counselling, assertiveness, grief and loss, life skills, communication skills, literacy, sexuality education, understanding sexual abuse, appropriate behaviour, anger management, assertiveness, self esteem, respect, life skills. Hearing service providers and other Hearing community members need inter-cultural training and ASL instruction.

Group Therapy (30 comments in 11 documents)
See references 3, 5, 15, 19, 20, 21, 22, 25, 32, 36, 39
Healing circles, survivor groups, reconciliation groups, alcohol and drug therapy and other therapy groups are recommended often, but concern has been expressed about safety and confidentiality. Some recommend Deaf-only groups and some recommend Deaf/Hearing groups with a cross-cultural communication and awareness component.

Self Help (10 comments in 6 documents) See references 14, 15, 27, 28, 32, 36
Self help, mutual aid, and other support groups are often recommended.

Individual Therapy and Counselling (89 comments in 24 documents)
See references 18a, 32a, 1, 2, 3, 5, 6, 14, 19, 20, 21, 22, 24, 25, 27, 28, 29, 30, 31, 32, 34, 35, 36, 39
Confidential counselling services provided by skilled therapists acceptable to survivors are strongly recommended throughout these documents. The main need is for long term counselling regarding abuse. Survivors of abuse are seen to need this support as they go through disclosure and redress processes and for a therapeutically realistic time following. For example, the Jericho Individual Compensation Program (JIC) interim report strongly recommends that all claimants continue to receive counselling after the JIC process for as long as needed. This translates into years of therapy. Counselling includes individual counselling for children, youth and adults; partner counselling, and family therapy. Research-based treatment that stops offenders from re-offending is a desperate need in this closely-knit community. Match between client and therapist
is considered to be extremely important, leading to the need for choice and the ability to sometimes shop around for the right professionals. Some clients would prefer to have signing therapists who know ASL and others would prefer to use an interpreter to access a non-signing Hearing therapist who is likely to be less involved in the community. Clients need therapists who understand trauma issues and who can provide drug and alcohol counselling. At the same time, several documents recognize that, for some survivors, their success in life has been built on repression of memories of childhood abuse. Some survivors of abuse may not attempt to access counselling until many years have passed. Other survivors will never request counselling.

Deaf individuals who have survived extensive abuse and/or have disabilities or mental illness will require the same type of assertive community treatment approach that works well with psychiatric consumers who have an on-going need for support. Assertive community treatment keeps track of children and adults who are at high, high risk and/or have chronic mental health issues. Mental health workers provide individual support, assertive case management, and psycho-social rehabilitation counselling based on building skills and enhancing support networks, and close supervision without over-protecting or over-monitoring.

In a community largely made up of survivors of abuse, crisis intervention and support is a critical need. In a community that faces immense communication barriers, accessible crisis services are very difficult to provide.

There is also a need for shorter term counselling regarding issues specific to adjustment to developmental hearing impairment, progressive hearing loss, and Deaf/Hearing identity issues.

**Services to Families** (57 comments in 17 documents)

**Communication** (21 comments in 9 documents)
See references 2, 15, 16, 19, 21, 32, 33, 35, 36
Communication is the key to supporting Hearing families who have a Deaf family member. Families of Deaf children have a critical need for Sign Language instruction as well as support and training to facilitate their child's early language development. The Office of the Ombudsman recommended that publicly funded ASL instruction be made available throughout the province for parents and families of Deaf children. This need for communication is life long. Parents of Deaf children from early childhood to adulthood continuously inform us that "Communication with our Deaf children is our biggest priority." Deaf adults are passionate in their recommendations that ASL be recognized as an official language.

**Family Counselling** (19 comments in 9 documents)
See references 1, 2, 15, 16, 22, 24, 27, 33, 36
The documents reviewed emphasize the need to support families of survivors. Family counseling is necessary, not only to deal with effects of abuse on survivors, but on partners, children, and extended families. A priority for young adults and their families is to take steps to heal and to raise healthy children now.
The need to provide mental health services to Deaf and Hard of Hearing children and families is also emphasized. From the time of diagnosis and at subsequent transition points, parents need help to learn to communicate with their children, to manage behaviour problems, to learn about deafness, and to prevent abuse. Support needs to include siblings and other family members.

**Prevention and Monitoring (17 comments in 13 documents)**
See references 1, 2, 15, 16, 22, 24, 27, 28, 29, 31, 33, 34, 36
Early intervention and parent education are keys to preventing abuse, eliminating crises, avoiding family breakdown, reducing isolation, building knowledge and preventing eventual mental health problems. This includes early screening of behavioral and emotional problems; support to families with Deaf children to aid adjustment; and intervention with children, adults, and families who show disturbance that if left untreated would get worse.

There are also recommendations for open, independent, and on-going monitoring of how Deaf children are faring in all educational settings. In Ontario, advocates are assigned to all schools for Deaf students as independent safe guards. Prevention and education to break the inter-generational cycle of sexual abuse is needed. Mental health services need to be made available to Deaf students in all educational settings. School staff need to be properly screened and have on-going training in abuse issues.

**Community development (47 comments in 13 documents)**
See references 14, 15, 16, 21, 22, 24, 25, 27, 28, 34, 35, 36, 40
Physical, emotional and economic safety for children, families, and communities is the bottom-line of breaking abusive cycles. Rebuilding healthy connections involves connecting reaching out to family members and friends, and becoming involved in on-going service in the wider community. The Ministry of Health supports consumer initiatives that have diverse purposes such as mutual aid, skills, training, and economic development. The Deaf Community wants government commitment and funding to support people to come together in ways that are healing for individual community members and for the community as a whole. There is a need for leadership recruitment and training, especially of youth leaders. Advocacy is an important aspect of community development. Community advocacy can ensure that government and service agencies continue to reduce barriers.

**Ways out of poverty and violence (42 comments in 17 documents)**
See references 1, 14, 15, 16, 19, 22, 24, 27, 28, 29, 30, 31, 32 34, 35, 36, 39
There is general agreement that there is an increased need for social and mental health services for individuals and communities affected by institutional abuse. The Law Commission of Canada states that a more comprehensive approach focused on survivors and sensitive to individual needs would demonstrate that as a society we are not afraid to face up to the legacy of institutional child abuse.

The Deaf community has shifted from a community that is largely under-employed to a community that is largely unemployed. Deaf survivors of institutional abuse and/or communication isolation require rehabilitation. Assistance is needed to get on disability
benefits, access medical care, find affordable safe housing, make transitions toward safety, and find opportunities for recreation, socialization, and work. Educational opportunities were listed as one of the top priorities of redress in the Law Commission Discussion Paper. Communities that are making progress in addressing violence issues tend to be communities where there is good access to educational programs including upgrading, vocational training, college and university programs.

Deaf survivors need support to reconnect with their families and the Deaf community. There are rifts to repair so that people who are trying to solve poverty and violence issues by living isolated lives can be restored to full participation in a safer community.

Technology is one of the keys to reconnecting. Deaf and Hard of Hearing individuals need access to technical aids such as TTY’s, teleconferencing, email, and fax machines. Service providers need to have TTY’s in their offices, and all educational videos should be captioned.

**Provide Equitable Access** (28 comments in 7 documents)
See references 1, 14, 15, 22, 31, 32, 36
Deaf people throughout BC require equitable access to mental health services, including emergency resources and all government services. If the priorities of the 1998 Mental Health plan are applied to the Deaf community then, community-based services should reach the Deaf and Hard of Hearing individuals who are in greatest need and the least served:
• children, youths, and adults who are Deaf or Hard of Hearing and mentally ill
• children, youths and adults who are Deaf or Hard of Hearing and have substance abuse issues
• children and adults who are Deaf or Hard of Hearing and in conflict with the law
• people with the greatest degree of functional impairment, including individuals who are Deaf or Hard of Hearing and have disabilities
• those who have been sexually and physically abused
• Deaf women
• Deaf and Hard of Hearing individuals who are trying to cope with stresses associated directly with Deaf and hard Hearing issues and other mental health issues who are unable to access mainstream mental health those services due to Deaf and Hard of Hearing issues

**Provide Funding** (15 comments in 3 documents) See references 14, 28, 36
One of the goals of this review of Deaf counselling services is to take a critical look at allocations of resources. The allocation of resources needs to be balanced so that Deaf and Hard of Hearing clients have access that is similar to the access enjoyed by Hearing community members. Since at least half of the Deaf population lives outside of the Lower Mainland, there is also a need for resources to be distributed fairly throughout the province.
Principles of effective service delivery

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**Community control** (91 comments in 21 documents)

See references 1, 3, 5, 13, 14, 15, 16, 19, 21, 22, 24, 25, 27, 28, 29, 31, 32, 34, 35, 36, 40

These documents emphasize that communities have the right to control their own services, including the process of healing from abuse. This means that control of whatever services are provided needs to be with the Deaf community and that planning, implementation and delivery of services must be a partnership effort between government officials, Deaf community members, Hearing families, mental health service providers, and service providers who work in the Deaf community. Ministry mental health policies recognize that mental health services and promotional activities are strengthened when those whom they are designed to benefit participate in their implementation and design.

To ensure quality, the services need to be directly accountable to the population being served. Evaluation needs to be funded. Several documents recommend developing and training a community advisory committee with a majority of Deaf consumers. If services have pre-set goals, performance measures, and time lines then they are more readily evaluated.
Communication is the Key

Coordination and partnership (37 comments in 16 documents)
See references 1, 3, 6, 8, 13, 16, 21, 27, 28, 31, 32, 34, 35, 36, 39, 40
Whatever services are provided need to be well coordinated. Some documents emphasized the desirability of providing all services under one umbrella while other documents emphasized the need for collaboration between agencies and cooperation between the various ministries so that services are not fragmented. There is also a need to build linkages between Deaf services and mainstream services such as drug and alcohol treatment services and AIDS clinics. Since members of the Deaf community are spread throughout the province there is a need for wide area communication and networking throughout the province.

Accessible, equitable, and just services (20 comments in 9 documents)
See references 1, 15, 19, 21, 22, 25, 27, 28, 32
Services need to be equally accessible and geographically relevant. They need to engage people in ways that encourage and facilitate empowerment. Survivors need to be treated with respect.

Acknowledge the Harm (20 comments in 5 documents) See references 1, 15, 16, 22, 34
The documents related to abuse issues emphasize that addressing tertiary problems without acknowledging the root causes do not work. Therefore, services need to be provided in a context of acknowledging and assisting survivors to explore abuse issues. Understanding the damage and preventing it from re-occurring may be one path to individual and collective healing. Documents emphasize the importance of sharing information so that community members know their history, their rights and have opportunities to learn about what is being done

Cultural Sensitivity (17 comments in 7 documents)
See references 1, 14, 27, 28, 34,35, 36
In our increasingly diverse world we need services and planning that respond to the cultural diversity of communities. Service providers need to be sensitive and informed about Deaf culture and about communication differences, nuances, complexities, and access issues.

Clear vision and careful planning (11 comments in 7 documents)
See references 14, 15, 20, 25, 28, 31, 35
Effective services are guided by a clear vision and a carefully articulated philosophy and principles that have been developed by the users of those services.

Opportunity to Heal (10 comments in 7 documents)
See references 15, 22, 25, 27, 28, 31, 35
Services need to offer a real opportunity for healing. Healing means a variety of things such as ability to express emotions, self esteem, dealing with life without drugs and alcohol, looking forward to living, family reconciliation, reconnecting to the community.
Centred on safety (10 comments in 5 documents) See references 15, 22, 29, 31, 34
Stopping the cycles of abuse is critical to the mental health of members of the Deaf community and their families. There is a need to rebuild a sense of confidence that the community has become a safe place for healing and disclosure. The safety and well-being of children is at the centre of any mental health service system. In close-knit communities, services need to focus on treatment for both survivors of abuse and offenders.

Choice of services (9 comments in 5 documents) See references 21, 22, 27, 28, 35
Individualized, flexible services need to provide options for consumers such as respect for choice of interpreters.

Political will and leadership (7 comments in 7 documents)
See references 1, 14, 16, 22, 25, 28, 31
Services require political will and credible leadership by government and by the Deaf community.

Based on strengths and capacities of consumers (5 comments in 5 documents)
See references 21, 24, 25, 31, 35
Services need to be based on belief in consumer's capacities, gifts, strength, abilities and potential. They need to be opportunity focused, not problem focused.
# Recommended Models of Service Delivery

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**Comprehensive plan for service delivery** (33 comments in 14 documents)
See references 1, 5, 6, 8, 14, 16, 22, 27, 28, 31, 32, 34, 35, 36
The Ministry of Health 1998 Mental Health Plan recommends that all service delivery models be guided by best practices and that priority be given to those who experience long term mental illness and disability as well as those who experience acute, episodic serious mental illness. Ministry of Children and Families recommends multi-disciplinary, community based children's centres that provide child protection, family support, services to children with mental disorders, child and youth mental health services, children's public health, infant and child development programs, adolescent alcohol and drug treatment services, youth forensic services, and school based services. The documents that have looked specifically at Deaf and Hard of Hearing issues, point to a need for a comprehensive plan for delivery of mental health services to Deaf and Hard of Hearing individuals and families that would include this same range of services provided to the Hearing population.

**Centralized Service Delivery** (32 comments in 7 documents)
See references 1, 27, 32, 33, 34, 36, 39
The most common recommendation for delivery of mental health services to the Deaf community is through a centralized model of service delivery with a plan in place for equitable service delivery throughout the province. In this model a culturally-based Deaf and Hard of Hearing mental health office is set up in Vancouver, either as part of a Deaf and Hard of Hearing service agency or a Deaf resource/community or attached to a mainstream mental health agency. The office provides the full range of mental health services including crisis services to Deaf and Hard of Hearing individuals and their families in the whole province. The Well Being Program was developed from this model.

**Specific Approaches to Service Delivery** (20 comments in 11 documents)
See references 1, 6, 15, 16, 20, 21, 27, 32, 34, 36 39
Within any service system, decisions are made about specific approaches to service delivery. For example, some models of service delivery hire professionals as consultants and trainers only, with para-professionals providing almost all direct service. Another approach is to fund a therapeutic budget for purchase of contracted therapy services such as the Well Being Program has done. There is also the possibility of providing funding directly to individuals to allow them to purchase their own services.
In addition, several examples of effective programs are mentioned in these documents:

- Giarretto Child Sexual Abuse Treatment model
- Connect model (Toronto)
- Bio-psycho-social intervention model
- Women-centred therapeutic services with a feminist consciousness raising approach
- Alcohol and Drug treatment centres and treatment programs
- Home-based service (family visiting model)
- The Virginia Statewide service model
- The Swedish model
- The South Dakota model
- Culturally relevant services for Deaf in Ohio
- Deaf services of Cleveland
- South Carolina Experience in Mental Health services to Deaf in rural areas
- Brandywine Deaf Program socialization/life skills model (residential model)

**Residential Treatment** (16 comments in 5 documents) See references 1, 14, 20, 36, 39
Several documents describe the need for residential treatment services and supported living designed with the communication supports needed by Deaf and Hard of Hearing individuals who are also mentally ill and/or have disabilities. Ideas include: an in-patient psychiatric unit, group homes, a residential treatment centre for Deaf children, and a residential life skills/independent living training centre.

**Regionalized Service Delivery** (9 comments in 3 documents) See references 14, 36, 39
There is also some discussion of regionalized service delivery. Story found that Victoria-based service providers considered that "status as a collective member of outlying areas to eventually be serviced by the outreach aim is completely inadequate". She discussed the possibility of beginning in Vancouver by establishing a centralized program with outreach services and then eventually establishing satellite teams in Prince George, Kamloops, and Victoria.
References


Appendix E:

Description of Well Being Program Clients
Appendix F:

Signing Therapy:
Issues and Recommendations
Appendix F: Signing Therapy: Issues and Recommendations

This is a discussion of the need for signing therapists. During this review, Deaf consumers have made it clear that they prefer to communicate directly with therapists and other mental health service providers. There is a need to develop a plan that will address this service gap.

1. We appreciate therapy services from the Well Being Program
Participants in this review of Deaf mental health services were very appreciative of the therapy services provided by the Well Being Program. In fact, 218/298 (73%) of the positive comments about the Well Being Program were general positive comments about the benefits of therapy: For example:

- Finally we have therapy and medical interpreting so this means we are moving toward equality
- Therapy is vital to us for improving our life.
- Therapy is the key to see things in the world and prevent suicide
- I can discuss my concerns in confidence with a therapist who is certified.
- My counsellor helps our family understand communication and deaf culture
- I feel lucky that I have grown up with good access to therapy whenever I have needed it. I have received a great deal of support and I have found therapy/counselling to be very helpful at several points (a 26 year old individual who has accessed therapy three different times since 1990).

2. The three-way arrangement of seeing therapists with interpreters is not our preference
Participants in this community consultation had concerns related to the three-way arrangement of seeing therapists with interpreters Of the 359 comments that described concerns about the Well Being Program, 86 of them (24%) were criticisms about the therapist/client/interpreter triangle. Some of these comments are listed below:

- The therapy/interpreter situation is a bandaid solution.
- It is not easy to be in therapy with interpreter, there is not enough trust, and there is not a feeling of cultural comfort.
- Three people in the room compromises comfort.
- The therapy itself is good as far as it goes, but it is hard to explain to my therapist about deaf culture. The therapist doesn't understand this cultural background.
- It was hard going through a 3rd party; waiting for the therapist speak and then be interpreted. It is better to have therapist who knew ASL.
- The Well Being Program has been helpful but 3-way communication requires a lot of patience.
- The biggest weakness is the focus on interpreters. We don't understand the emphasis on interpreters. Why are they spending so much money with this emphasis on interpreters instead of supporting therapists to learn how to sign?
3. There is a need to hire mental health service providers who can sign and understand deaf issues
Of the 1644 suggestions about the future of Deaf mental health services, there were 183 recommendations (11%) related to the need to hire therapists who can sign and understand Deaf issues. Some of the comments are given here:

- We need more seasoned signing therapists
- With direct communication in therapy more can happen
- There are many deaf issues and I am sure I couldn't help my child with everything, so we need a deaf counsellor or someone who was educated in deaf culture, and knows about counselling our kids,
- Involve more Deaf in providing services; this will be cheaper in the long run.
- Better to have a skilled signing therapist or deaf therapist.
- Make use of local resources. For example, the coordinator of our Nanaimo office now has her masters in counselling, and is a fluent signer.
- It is important that the counsellors should be signing counsellors.
- We should hire someone who has Deaf in their family to work with Deaf.
- We need experts who understand both deaf and mental health issues to bridge this gap.
- The main thing for mental health is the capacity to communicate
- We would prefer a deaf person who has counselling, psychology background. Our second choice is a hearing/signing professional with a mental health background. Our third choice is hearing mental health professional who can't sign coming here with an interpreter
- Mental Health professionals who understand Deaf issues need to help the Deaf community to grow, and become stronger.
- Need direct communication and ability to match ASL to the level of the user

4. What do signing service providers do that makes the difference?
Several signing service providers were asked to describe what it is like to work with their Deaf clients. Here are a few illustrative responses.

- One of the main differences is that therapy goes a lot slower with many deaf clients. This is not because the communication is slower. This is because Deaf clients have been hit from so many different directions that their issues are a lot more complicated and multi-faceted.
- You can't compare Hearing mental health needs and Deaf mental health because of the systemic issues.
- A lot of re-parenting support.
- Understanding boundary, incest, backstabbing, and gossip issues that are part of serving the Deaf community.
- When I work with families, we sometimes try sessions without an interpreter as a way of assessing the dynamics of communication within the family, or we may also have sessions without an interpreter to work specifically on communication between family...
members. When the purpose of the family meeting is to discuss issues rather than to work on the process of communication, then I bring in an interpreter. Otherwise I am focusing too much on supporting the communication process and I am split.

- As a signing therapist, I find that it takes very little time for a Deaf client to develop trust with me. Deaf people decide to trust by asking these questions: Can I communicate with you? Do you understand my Deaf world? Do you understand me as an individual? Will you tell me what I need to know?
- Signing therapy provides immediate contact, a strong relationship, trust, and genuineness.
- When communication is fluent there is little need to ask for repetition or to repair misunderstandings. When there is no struggle, the Deaf client can simply relax and focus on personal growth.
- The Deaf client has the power to communicate in whatever way is the most comfortable.
- Our Deaf clients don't have to educate us about Deaf issues and Deaf culture. We know that stuff.
- I don't make assumptions or generalizations based on surface stereotypes about 'the Deaf', even based on stereotypes about my last five Deaf clients. I am not amazed or humbled by Deafness, I just do my work with my clients.
- We never get surprised at or impatient with what the client doesn't know. We are aware that information access is a Deaf issue.

5. What are the barriers to recruiting signing therapists?
First, there is a real shortage of trained and experienced mental health service providers who sign; Deaf or Hearing. Second, some individuals who would like to be more involved in providing mental health services to Deaf individuals and their families have significant gaps in their signing fluency, educational background, mental health training and/or experience, or their experience with Deaf and Hard of Hearing issues, and Deaf culture. Third, related to this issue of gaps, there are concerns expressed by some Deaf individuals that there is systemic discrimination within the education and service systems that prevents skilled Deaf people from entering into and advancing in the mental health field. Fourth, there are concerns expressed by the signing therapists that:

"We are not given credibility for our expertise as therapists who sign and understand Deaf culture. The Well Being Program would rather get experts from out of town to consult and give workshops than any of us. This has been hurtful."

(Community Consultation, 1999)

The more difficult reason to examine openly is that some individuals who would like to get more involved in mental health work face barriers related to past and current in-fighting issues, historical connections with problems at Jericho Hill School, poor personal reputation, or low professional credibility in the eyes of members of the Deaf community and/or in the eyes of staff in the Well Being Program itself. What ever the barriers are, there is a need to sort through them in ways that meet the needs and desires of Deaf consumers and respects existing resources.
6. Solving the problem.
Here are some ideas for how the problems related to lack of signing mental health service providers could begin to be solved.

a. There are 5 Hearing-can-sign therapists who are currently under contract with the Well Being Program. These therapists may be (and at least three definitely are) interested in increasing the amount of time they spend providing individual therapy and psychoeducational group services to deaf and hard of hearing clients. They are also willing to travel to other communities to provide therapy, psychoeducational services, and training. These signing therapists could be asked to provide training and mentorship to deaf therapists, mental health workers, and intervenors.

b. There are 3 Deaf community support workers currently under contract with the Well Being program and 1 Deaf community support worker working in a position funded by the Well Being Program on Vancouver Island. These para-professionals could become involved in training more Deaf mental health workers, and intervenors. They could also be brought in to help therapists to up-grade their signing skills and sensitivity to deaf culture. At least two of these para-professionals are interested in upgrading their own mental health qualifications so that they can become signing therapists.

c. There are currently 28 non-signing therapists who are under contract with the Well Being Program. A number of these therapists have shown excellent sensitivity to Deaf culture, are learning about Deaf and Hard of hearing issues, and have good ability to work with interpreters to provide mental health services to deaf clients. Is it possible that some of these therapists may be willing to participate in intensive language and cultural training to develop their own signing skills and continue to deepen their understanding of deaf and hard of hearing issues so that they can work toward the goal of becoming signing therapists? Alternatively, would these therapists be willing to pass on their skills to the Deaf community by providing mentoring and training to signing therapists, mental health workers, and intervenors?

d. There are currently about 25 mental health interpreters who are under contract with the Well Being Program. At least two of these highly skilled and qualified interpreters already have MA level degrees in counselling or other areas related to mental health. They may already be ready, willing, and able to become signing therapists. Other mental health interpreters may be willing to take training to become signing therapists. At the least, they may be able to help with some aspects of training signing therapists, mental health workers, and intervenors.

e. There are about 20 other Deaf and Hearing individuals living in the province who can sign, understand Deaf and Hard of hearing issues, and have expertise in mental health, social work, psychology or a related field. Although most of these individuals are currently employed in various capacities, at least some of these individuals are actively
seeking ways of becoming more involved in providing therapy and psychoeducational services to deaf children, adults and their families. Perhaps signing service providers could have their skills assessed and, if they meet certain standards, be provided with guidance to provide therapy on a part time basis. Several of these individuals could be asked to help train personnel.

f. There is a larger pool of Deaf and Hearing individuals throughout the province working as child and youth care workers and as individual intervenors for deaf individuals who are deaf-blind or who are deaf and have disabilities. Some of these individuals may have the potential to develop the set of skills needed to become community support workers in the Deaf community.

g. Deaf and Hearing students who have good potential need to be identified, encouraged, and supported (through practicum placements, internships, and special projects) to get involved in the field of Deaf mental health services.
Appendix G:

Deaf First Nations Focus Group
Appendix G: First Nations Focus Group

The First Nations Focus Group was the first time Aboriginal Deaf individuals on Vancouver Island have been invited to gather together to look specifically at their issues. This group was possible because of the community development work that began with outreach efforts of the Jericho Individual Compensation Program, and has been followed up by service providers from the Well Being Program and Island Deaf and Hard of Hearing Centre. Four of the six people who participated in this group had been living lives of extreme isolation until they were contacted as part of the JIC outreach process in 1998. They were existing in circumstances of deprivation and poverty, out of contact with the Deaf community and almost invisible to their own relations in their own communities. In the past two years, these four individuals have been helped to link up with service providers from Deaf agencies, First Nations Health Centres, and Native Friendship Centres, and become much more actively involved in their Aboriginal communities and/or in the Deaf community.

Venue and Host Agency:
Hiiye’yu Lelum (House of Friendship), Duncan

Host Agency Representative:
Brenda Bartleman, Family Support Worker, House of Friendship

Facilitators:
Leanne Rumley and Linda Hill

Communication Support:
Lois Wood, Island Deaf and Hard of Hearing Centre
Barb Ziegler, Island Deaf and Hard of Hearing Centre

Note Taker:
Sharon Rumley

Observer:
Bobbi Williams, Audiologist, Ministry for Children and Families

Summary of the Discussion
1. If you, or a family member have been experiencing feelings like this where do you go for help?

   • Native health clinics and centres
     - a family support worker
     - a nurse at Cowichan Tribes has been helping me
     - there is a nurse in a native health centre in Victoria who knows a little bit of Finger Spelling
   • Therapy (3)
• A counsellor for brief counselling, a therapist for longer term. Some people need continuous therapy.
• Getting grabbed and placed in the Big House, this is a spiritual place with a fire and dancing, the results can be a feeling of refreshment and empowerment.
• Deaf people have helped me, especially one Deaf man in Victoria.
• Deaf friends help me, unlike Hearing friends where there is ongoing confrontation. Hearing people tend not to understand as well as a Deaf person can, I prefer support from Deaf people.
• Steve (IDHHC vocational counsellor) and Lois (IDHHC/WBP community support worker) have helped me.
• The Aboriginal Disability Association conference was an inspiration. I was about the only Deaf person there and I had an interpreter there with me. I wish more people could have gone to the conference.

2. Tell us about the help/services that you received.

• Deaf interpreters and support workers help make the communication clear.
• Lois has been giving me a lot of support and I'm learning a lot through talking with Lois.
• I've learned a lot from Lois, she helps to make things clear to me.
• The native nurse helped me. I see her with an interpreter.
• One native nurse has been very supportive, she fingerspells and little and takes the time to write back and forth with me. Knowing some fingerspelling has been helpful, feels supportive.
• The Well Being Program is a good program for helping, it is very important.
• Therapy has helped me.
• Therapy has been OK.
• I go to therapy but it is not enough to go for an hour a month. I need someone who is willing to sit and listen to me for two hours more often (weekly or every 2 weeks).
• Family support is important.

3. What differences have these supports made in your life?

• I am having a better life. I am not depressed, I am feeling more uplifted, calmer, more peaceful. Before I was overly emotional and not at all calm.
• I had a real struggle growing up, a confusing life of holding things in. Now I am calmer, and I feel that things are being cleaned up; not solved yet, but I have had some help confronting my problems with my family.
• I am socializing now. I am meeting Deaf people and socializing.
• I am now seeing a few familiar faces to say hi to on the street. Before, I was much more lonely.
• I went for therapy for a short time and then quit. I know that I need to get more therapy. I am still feeling awkward and confused, and not sure if I am totally "better".
• I need more time, and more therapy, I have lived a life of isolation in a small town.
4. Tell us about anything that stopped you from getting the help you needed.

**Abuse Issues**
- Some of us have escaped from abusive environments and we are lost. Some of us are dealing with worry, death, grief and loss within our families.
- As First Nations people, some of our backgrounds have been tough, now we find it hard to trust.
- Some of us feel separated from our families
- I have experienced so many problems with drinking, death, alcoholism, I have had no help and no support to deal with the grief process, I feel lost and left out.
- Grief issues related to deaths
- I need help now from a social worker to contact the police and make a proper report. I tried previously to write down what had happened but the police didn't believe me and I was upset. I didn't know how to fix that up without an interpreter, and I felt oppressed.
- There is a lot of injustice in my life. So much to fix up and try to solve, but I don't know where to go to get the help I need with resolving my family problems without access to interpreters
- Not being believed was one of the most difficult experiences in my life. I feel as though I learned a lesson about how not to solve things and how not to sort things out.
- Now it is hard to focus on school because I feel as if I have lost my help. I am feeling isolated and upset and isolated.
- Growing up, I experienced abuse and domestic violence from which I had to escape. Finally my parents divorced. Whenever I was home from school visiting my family there was no communication. There was so much fighting and trouble: I would witness the hitting without being able to understand the reasons behind it. I just knew that there was trouble.
- I had a very tough life with a lot of hurt. All my life there was so much pain, no one loved me. There was suffering, and pain, and no love from my parents. I stayed in hospital for 5 years because I had tuberculosis. Then I was sent to JHS at age 10 for 8 years where I was abused by three people there. But I was also raped at home by relatives and in a hotel by a man. My mother abandoned me there. I have no idea where she was. All I have ever wanted is a good life, with love, but I was beat me up and hurt by my mother. There was so much drinking and hurt at home. The abuse at Jericho Hill School was even worse. I ran away from the school so many times. Finally, 2 weeks before Christmas at the age of 18, I made an excuse that I wanted to go home. I couldn't tell anyone what had been done to me. I never did go home to my Mom and Dad. I stayed at my aunts and uncles in (another community) since 1966, never gone home again. I finally saw my mom and dad one-year before died. We reconciled and had a few visits and time together before she passed away. I told her, "You don't have to hurt me because I'm stupid or dumb or Deaf." I was still hurting until I met (JIC reps). I contemplated suicide but I couldn't do it because I have a family now who need their mother. My mind is in isolation. When I was a child I had no clue who I am, or where I come from, I went to Indian residential school twice, but I don't remember. All I
remember they brought me there in isolation, I didn't know where I was. They took me to the school, then they took me to another place, and to foster homes, and then to Jericho. All the time there was isolation, too much moving, my mind is gone.

- I had family problems, my mother rejected me because of Deafness, and now I feel lost and without any parents. They are in Nanaimo but I haven't seen my mother for several years. We are separated from each other.

**Interpreter/Therapy Issues**

- There are not enough interpreters
- It is not easy to be in therapy with interpreter, there is not enough trust, and there is not a feeling of cultural comfort. I don't like having different interpreters in those private situations

**Isolation Issues**

- I used to sell ABC cards (equivalent in Deaf culture to panhandling) I stopped because I got worried that I would be picked up by the police.
- There are many cultural workshops and educational events in the Cowichan area, and my mother is always encouraging me to attend but I can't afford to pay for an interpreter and I don't want to go because I don't have the communication access.
- A lot of us are ignorant about native culture, I want to have communication and workshops to understand about native cultural issues. It seems that there is never any money to learn about myself as a First Nations person and about my heritage. I feel stuck. Native culture is important and I value it but I don't understand it.
- Growing up going to JHS, I had no opportunity to get traditional learning from the elders, I had no one there to teach me.

5. What is needed to help overcome barriers to service?

- I go to therapy now, but I'd rather have 2-hour appointments once a week or once every two weeks.
- People who can hear need to support us; that is what we want
- I want to know what my therapists background is so that I can build trust
- I want my therapist to link me up to social support services so that I can get the support I need to solve my family and social problems as well as my individual problems. I want to be able to get justice. Individual therapy isn't enough to solve social and legal problems
6. What kind of support do you need to have good mental health? to recover good mental health?

**More Therapy**
- *More time for therapy:* two hours of therapy twice a month so she could hear me and understand and help me with my life and help me do something and go on with my life.
- *Weekly therapy*

**ASL Instruction for families**
- *It is REALLY important for families to learn signing and communication:* We need more ASL instruction for families. My dream; my goal for the future is that the government and the college would partner to hire me to teach Hearing parents. I want to teach ASL to families. One of the reasons that Deaf First Nations people have so many problems and suffering is because of communication isolation.
- *My family needs to learn more sign language and they need to practice to help improve the communication.* We need someone to come to my home to help them learn ASL.
- *I want to keep improving signing in my family, so that the communication is not so limited, especially with my sister.* I find that I am always in a teacher role with my sister, she forgets each week, it would nice if there was some daily lessons so that the communication would be stronger, so that it would not be so frustrating.
- *Deaf people who have been isolated need opportunities to learn more signing communication.* I order to get out of isolation and be able to communicate with other Deaf people.
- *I would like to improve my signing skills*
- *I would like a Deaf person who could teach ASL to Deaf adults throughout BC, especially Deaf living in small isolated communicate:* An itinerant ASL teacher
- *I would like workshops about Deaf issues that my family could attend*

**Communication Access**
- *Interpreting support for attending funerals is important for native people,* because a lot of the relatives come so it is an opportunity to connect, and funerals are a very important part of native culture.
- *I need to be able to hire an interpreter if someone in my family dies.* I need access to interpreters for funerals so that I can understand the service.
- *Someone needs to become an interpreter for native Deaf people.*
- *I want interpreters for First Nations workshops and meetings,* so that there is less confusion, and I can join in. I don't want to feel bored. I want to book an interpreter, however, I can't afford to pay.

**Culturally based mental health services**
- *A native therapist.* Because of our cultural backgrounds we need a native therapist.
- *I want a native therapist who I feel connected to and can have a relationship with that is a relationship of trust and confidence*
- *I want to get help from people who can sign and understand Aboriginal culture*
• I want more support for my health. I think that women and men and children all need support provided in a culturally appropriate way.
• I want that kind of support. I want a supportive person who knows my culture.
• We need Deaf women and men to become community support workers in order to support Deaf native men, women and children.
• We need a Deaf native mentor in the community

Culturally Based Psychoeducation
• Deaf First Nations adults, teenagers and children need opportunities to understand their culture through ASL
• People need to know how and where to get an interpreter and how to access. We need to be educated about the resources that are available to Deaf people
• People need to know about IDHHC
• workshops
• Support groups, with Lois, so that we can learn,
• Life skills workshops on a regular basis
  Topics:
  • explaining and learning through lectures and discussions
  • managing my money, so I don't spend it wastefully and so that I understand how to pay my bills, and so that I can fairly share my expenses with my family.
  • I need to understand financial planning so that I can not have unpleasant surprises and not get confused
  • More understanding about contracts and legal documents
  • Emotions and controlling emotions, managing emotions
  • Anger management
  • Handling family problems and disputes
  • I want to learn how to identify my feelings, and my emotions
  • Mood management workshops
  • I don’t know how to work, and I don’t want to stay home all the time, I want to learn to care for myself and my home (pre-employment life skills)
  • Food: A native food and nutrition workshop
  • Form a support group to work together on these issues
  • Native people know nothing about their tribes names, bands, what are the names of them? We need more exposure to our history, family stories, elders. These need to be taught to Deaf children throughout BC
  • Deaf native people don’t understand about the status card
  • We don't know in depth about family trees, we need lessons in our culture and if someone can teach me about my culture, my heritage, name, the history of my family, that would be valuable.
  • We need to understand changes in our laws (e.g. related to changes in laws that have made it not possible to purchase cigarettes and resell them at a profit to white people)
• It is crucial for Deaf people to know about our traditional native medicines. Great to have a knowledgeable person present a workshop on traditional medicines. It would love to have someone take me through the forest and show me.... I want more information
• We have limited understanding about all aspects of our health: I want to learn more about healthy care of my teeth, my health, other issues in general.
• Understand the different rules for native people and whites re taxes.

Social support
• I need more support from my Deaf friends. Now that I am living in Victoria and conversing with a Deaf friend, I am improving my signing daily
• More time for us to get together in a group to enjoy mental health together
• I want to volunteer and help people and I love children. I want to care, share, help, and love and have understanding. I love to bake cookies, cake, pies and give to people. I want to get more involved with people.

7-8. From your experience what are the strengths of the current model of mental health service delivery? what are the weaknesses?

What other model could you imagine for delivering mental health services to the Deaf community around the province?

• I feel there is nothing in Port Hardy: there is only one person who can sign a bit and I’m not comfortable with her. There is a need for more interpreters in north island.
• There doesn’t seem to be enough support in the small communities in BC such as Nanaimo, PG, Kamloops, Williams Lake
• I am aware that there are many more Deaf people in Van than in Victoria and very few here in Duncan. However, it would be nice to have more workshops that we could sign up for. I want an increase in workshops in Duncan to understand about disability benefits and money and things like that.
• On the picture you have drawn, red shows where the development has already happened, Van seems strong but northern BC seems weak.
• Is it fair that Van and Van Island don’t have the same services?
• We need more services throughout BC
• I would like to have an agency in each community that would serve Deaf people. Not one office only, but offices throughout the province
• Native people have health services all over BC, but those health services do not have a lot of knowledge about native Deaf people. There is a need for itinerant teachers to go throughout BC to address the people who work in these offices so that Deaf native people can access their own communities.
• Deaf native people need more life skills wherever they live in BC.
9. What do you think are the most important qualities to include in providing Deaf mental health services?

- I want to be able to express myself to my family. We need funding from the government for family by family healing circles and family meetings with an interpreter to solve family problems and make the Deaf person part of the family and solve problems in the future.
- A priority is to spend money on sending support workers in to a family to get family problems solved. We need to have family meetings and learn to express ourselves and feel part of the discussions, and be part of getting feedback within my family.
- Deaf people and their families coming together with interpreters in healing circles, or going with an interpreter to a native healing circle
- I want therapy to continue and not be cut off. I want to keep on-going therapy
- I want more therapy 2 hrs per week on an ongoing schedule. This will help me to reach my goals.
- I want to socialize more. I want more friends.
- I want the confrontations with Hearing people to stop. I want more socialization with the Deaf community.
- I want more communication, socialization, getting out, so that I can clean up my life, reduce frustration, and feel hopeful.
- I want to live in a community where Hearing people understand what Deafness is about
- I feel it is important to have opportunities to socialize with Deaf and understand myself. Having the native community accept Deaf as part of the community.
- I want to continue to see Lois. I want more time with Lois.

10. The following social issues that came up during the session were parked here:

- I want out of poverty: I want to have enough money to have a nice, good life style to be able to have enough food, and medicine. I want education and proper nutrition.
- I want a job and a clean home
- I think it is important for Deaf and Hard of Hearing to have knowledge of the first nations organizations that are there through local bands or friendship centres. Native organizations need to seek out the different organizations that can bridge people who are Hearing impaired and people who are Hearing
- There needs to be improvement in Deaf education. The education at the provincial school for the Deaf is too simplistic (this individual attends the Provincial School now), more like at a grade 3 level in comparison to what my younger sisters are showing me from their grade 7 courses.
- People in the workplace need to be able to sign
- I want an interpreter when I go to a Dr. I want an interpreter for Drs. appt.
- This shows there is a need for more access and more knowledge about the availability of interpreter support
- I need to have access to literacy to improve my life.
- Our doctors offices may not be aware of interpreters and medical interpreting.
- I want to pay my electric bill myself at the bank instead of having it paid automatically because I don’t understand how it works.
Appendix H:

“The Parking Lot” of Social Issues
Appendix H: Parking Lot of Social Issues

The following important concerns and suggestions that are not directly related to mental health issues were identified during the community consultation process. They are summarized in this Appendix for consideration by providers of social, educational, and vocational services. These concerns fall into 6 main categories:

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<th>Deaf Access and Social Issues</th>
<th>Number of comments</th>
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Education Issues
(71/227 comments = 31.3% were about education issues)

Here are some illustrative comments about access to education.

There is lack of education, especially lack of access to post-secondary education
Education for Deaf blind is an issue
We need teachers who sign
I recently watched a television documentary about a prisoner who was rehabilitated while in prison. We need anger management and therapy and the same types of rehabilitation that are available to people who are sent to jail.
Educational qualifications for work are at least grade 12 and Deaf don't have that prerequisite.
Teachers in this school district don't tolerate people with differences well.
The worst is when school officials forget to book interpreters
Many teachers of the Deaf don't sign. How can they be qualified if they can't communicate? It is like being a qualified pilot who doesn't know how to fly a plane.
There are ASL/ Signed English, controversies in the school system
We need to have access to interpreting services for my child's school events
ASL should be in the schools as a language to be taught
Do away with assumption that English is better than ASL
Interpreters not respected in schools
The school system needs better qualifications for interpreters and more interpreters.
Right now it's more for interpreters and communication support. We need to get the education up, get the signing up. We don't want to fail our daughter.

Better literacy rates would result in fewer problems that are tied in with feeling good about ourselves.

The Provincial School for the Deaf does not keep in contact with the children's local community.

The Provincial School for the Deaf has so many Deaf with disabilities there, I am afraid to send my kids there who are healthy and normal.

There needs to be improvement in Deaf education. The education at the provincial school for the Deaf is too simplistic (this individual attends the Provincial School now), more like at a grade 3 level in comparison to what my younger sisters are showing me from their grade 7 courses.

We need more special support for Deaf-Blind kids

We need opportunities for Deaf adults who are First Nations to teach ASL to First Nations Deaf children and to adults as well and to Deaf First Nations adults who haven't had a lot of signing

I am for total communication, but it never really worked in the schools.

Vancouver Community College has cut funding for ESL/ASL for Deaf new Canadians

College of New Caledonia is awful access for Deaf, no counselling support, no understanding of stresses of Deaf needing a notetaker, or interpreter.

Education takes longer, we need to have tutors in school to help clearly understand spoken and written materials. Perhaps we can develop a peer tutor program.

My experience in adult education was feeling that the hearing people were all passing me and leaving me struggling to catch up behind. Much of my college experience felt like a waste of money but I finally passed.

Competencies of educational interpreters are a BIG issue. Many educational interpreters are not competent. A lot of the districts are hiring anyone who knows a few signs and can finger spell.

We are having a battle in the schools here (we need interpreters) educational interpreters only have Level 8. I only have Level 8 qualifications myself and not a day doesn't go by where I can't explain something.
Work
(49/227 comments = 21.6% were about employment issues and problems in the workplace)
Here are examples of what was discussed:

I have a difficult time even getting volunteer jobs because of communication access problems.
If the job requires learning or communication then the support is needed, not to do her work for them, but to support communication.
I run a business, I have difficulty, because of lack of communication.
My relationships with my coworkers "stunk". I spent 27 years putting up with on-going harassment, teasing, and being picked on. No one at work knew any signing beyond a couple of people who could barely fingerspell. That's why I retired. Now I just want to forget it.
There is limited friendships at work because of fear, communication barriers, misunderstandings, prejudice, stereotypes, generalizations and assumptions, "all Deaf should . . ."
There is also a need to have therapists available for dealing with on the job frustrations. Working in the hearing world is extremely frustrating. There is discrimination and marginalization and inequities of many kinds.
In Canada we have interpreters in school, but not in work. We really miss the presence of interpreters when we go to work
People who discriminate and control Deaf need to be fired, I need to feel in control, not controlled by hearing people.
Lunch hour sign language classes for my coworkers has made it possible for me to survive in my workplace and not quit and move away. Now I feel better because, I can communicate with people who are interested in communicating with me.
It feels like I am existing in the midst of garbage, I don't have the word power. I have to careful what I say. It is hard to lip-read. Communication breaks down, I don't know who is supporting me.
We will pay millions over life span of one Deaf person for disability benefits, etc. which is not what they want: they want work, to be productive, feel they are an integral part of something.
I don't know how to work, and I don't want to stay home all the time, I want to learn to care for myself and my home (pre-employment life skills)
I struggle with depression and I am trying to confront it. I know that what I really need is to get a job to improve my mental health, it is my human right to work: working would reduce my upset. I would feel better, and I would have less need for mental health services.

Deaf always get menial jobs and are oppressed. We can do but we are not given opportunities.

We had a horticulture program available to mental health clients in the summer but client didn’t have access.

Pre-employment problems impact greatly on mental health.

We would like a government brochure that could be attached to our resumes to explain about Deaf issues and Deaf culture to potential employers.

Victoria doesn't seem to have that job coaching and job support why is that? We are just told "No, no, no.", and we have no support. We get kicked out of school, "Bye-bye, look for a job yourself." We need more services here for Deaf, because unemployment is so high.

We need interpreting for hobbies. This may eventually lead to employment.

Equity and Justice Issues
(40/227 comments = 17.6% were about equity issues)
Here are some examples of the comments that were made about equity and justice:

A cross cultural mediator needed

It's always white males in power. Where are Deaf located in the hierarchy? We need to follow the laws for equity and recognize ASL. In USA they have the Americans with Disabilities Act. We need something similar to ADA in US, to prevent discrimination.

Office of Disability Issues is a problem because Deaf representation is not good.

The people who abused our children (several former staff of Jericho Hill School for the Deaf dormitory were individually named) should get up and try to justify what they did and why they are still in Government jobs. They wrecked our kids and are walking free. Justice should be brought to them.

The danger is putting too much onto Mental Health services and failing to recognize the responsibilities of other service providers to come up with integrated supports and services.

Discrimination and harassment of Deaf employees are daily issues.

Bill 142 gives Deaf children more rights. Most hearing parents make the decisions about their children’s education, Children feel as if not choice, bill 142 gives Deaf children rights to reach best potential who decides about the education of Deaf children.
Remember when they were trying to lobby against McGeer closing down Jericho Hill School for the Deaf in the 1970's? This reminds me of that time.

We need a Deaf awareness year just like the 'Year of the Child'

I am always having to explain, many people assume that because of my good speech I can lip-read. Being an oral Deaf adult is stressful.

Medical interpreting is wonderful, we also need it for dentists to understand the explanation, would like

I know we should lobby, and I know that Deaf people have tried to lobby, for things such as lower prices in cable etc.: we've participated in so many rallies: it is so draining.

Poverty
(31/227 comments = 13.7% related to poverty issues)
Here are some examples of what respondents said about poverty in the Deaf community.

Poverty for Deaf who move to Vancouver; abject poverty. The Deaf don't even know about Salvation Army, food bank etc.

There is a lot of suffering related to poverty and work inequity

Owning our own home is impossible, no matter how hard we try

Disability benefits are so limited; we have so many expensive needs and disability benefits not enough.

Negotiating for funding to meet our basic needs takes so long

Island Deaf and Hard of Hearing Centre doesn't have this ability to advocate for our financial needs. They are dependent on service clubs to try to get help for everything

Poverty is a huge issue. We need financial counselling and money management support. We need opportunities to learn accounting, life skills, and money management.

Many Deaf are unemployed and I feel sad for them all on welfare. They are really stuck. Is the reason that the employer can’t afford to pay for an interpreter is that it? Are Deaf people too expensive to hire?

A huge issue has been housing! If housing could be included in the services offered. I can provide health and safety based supports, but it is so it is hard to get the stability this client needs. A stable living situation would minimize the number of moves. Wait lists are so long and poverty is such a big part. Deaf sometimes get evicted from their homes because they don't have the life skills needed to take responsibility for all aspects of housing; they then need help looking for housing

We need mental health housing for Deaf

We need a safe house for Deaf
Technology,
(20/227 comments = 8.8% were about access to technology)
Here are the types of comments that were made:

Social workers and landlords need to respect that Deaf need technology for access
(flashing doorbell)

We need TTY technology and other emergency technology

When I need to use the phone or access a service I go to write and people ignore me, I
also feel uncomfortable asking a waiter or other worker to make phone calls for me. I
realize the government has a shortage of money but TTY's are still important in public
places.

We also need some kind of TTY cell phone

Recently the new Nanaimo library asked the Deaf community to give feedback about
what is needed: we recommended a TTY be installed and some other visual-based
technology. We fully expected that because we had given input, this technology would
be installed. Then we went to the ribbon cutting ceremony and walked in to find that
nothing we had recommended had been put in place. We were extremely disappointed
that we hadn't really been listened to and our recommendations hadn't been addressed.
When we asked we were told that the Nanaimo Deaf community is so small, it didn't
seem worth it to put a TTY in.

I want to know what is going on in the world, I want someone signing the news, or
someone to change close captioning into easier English so that I can understand more
fully.

All work places must have a TTY, so that we don't have to just go through mrc all the
time

The kids help line doesn't have a TTY

Emergency
(16/227 comments = 7.0% were about emergency access)
Here are some examples of comments made:

Deaf access to emergency services is very difficult because emergency personnel may
not know I am Deaf. I am planning to get an alert bracelet to alert that I am Deaf.

Emergency situations are the hardest time to contact interpreters

I also don't trust that 911 works properly for Deaf people. What will happen if I need to
have someone come quickly?
Also when hearing emergency responders (police, ambulance) respond to emergencies
and they don't know that the person they are to be responding to is Deaf, this can lead to
misunderstandings. These misunderstandings can escalate to violence (e.g. Deaf person
reaches down for a pen and paper, and the police think he/she is reaching for a gun, and
suddenly their guns are drawn on the Deaf person)

There is a need to set up police training workshops to teach about Deaf culture,
language etc. difficult in emergency situations with police, writing notes not adequate

There needs to be, training so that emergency personnel know basic sign language

He was in jail with no interpreter.
Appendix I:
Psychoeducation Topics
Appendix I: Psychoeducation Topics

Participants made many suggestions for topics that could be addressed through psychoeducation. This list will be helpful in program planning:

**Deaf and Hard of Hearing Issues**
- Deaf pride 2
- Hard of hearing issues (identity, aural rehabilitation, working with deaf) 3
- Understanding hearing culture 1

**Interpersonal Skills**
- anger management 9
- communication (asking questions, staying on topic) 6
- assertiveness 2
- teamwork and problem solving skills 2
- boundaries 1
- conflict management 1
- group process, group dynamics and interpersonal relations 1
- harassment in the workplace 1
- understanding behaviour 1

**Life Style**
- life skills 4
- alcohol and drug issues 3
- friendship 1
- well being 1

**Mood**
- managing emotions and moods 4
- depression 2
- self esteem 1
- stress management 1
### Information

- Mental health awareness: 6
- AIDS and HIV: 3
- CPR and first aid: 3
- Financial planning and money management: 3
- Contracts and legal documents: 1
- Emergency preparedness: 1
- Government systems; how do they work: 1
- Literacy: 1
- Menopause: 1
- Self defense: 1
- Sexuality: 1
- Suicide prevention: 1

### Children and Families

- Attention deficit disorder: 2
- Family problems: 1
- Children's rights: 1

### Community Development

- Positive ways to deal with backstabbing and gossip: 2
- Ground rules for setting an agenda: 1
- Community development: 1
- Support for recent immigrants: 1
- Cultural diversity: 1
- Empowerment: 1
- Leadership: 1
- Reconciliation and forgiveness: 1

### Support Groups

- Attend mainstream groups with interpreting support: 2
- Men's group: 2
- Adventure programming/activity based groups: 2
- Gay/lesbian support group: 1
- Group for dealing with depression: 1
- Insight therapy group: 1
- Teen group: 1
- Community reconciliation groups: 1
- Family reconciliation groups: 1
- First Nations support group: 1
- Support group for the worried well: 1
- Deaf and Hearing cross-cultural group: 1
- Late Deafened: 1