

WASHINGTON STATE
Department of Social & Health Services
Office of the Deaf and Hard of Hearing

ODHH SYMPOSIUM:
PAST, PRESENT, FUTURE

1979-2009

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Olympia, Washington

BREAKOUT SESSION: 1:30-3:00 p.m. Room: SL03

TAKEN BY Darlene Pickard, Certified CART Provider, RDR

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Communication Access Realtime Translation (CART) is provided in order to facilitate
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Welcome.

The CART will be displayed on this screen.

>> ALISON ROBBINS: Stand right in between the screens. First slide.
Okay.

Good afternoon. My name is Alison Robins, and I work in the Office of Quality and Care Management with the Health and Recovery Services Administration. What we do in our office is we write and manage the managed care contracts that serve Medicaid clients and other clients.

What we would like to do this afternoon in this presentation is to talk about a little bit about the mission statement of DSHS and Health and Recovery Services Administration, and the Mental Health Division, which is now part of a new division called Division of Behavioral Health and Recovery.

We also want to talk a little bit about the Washington's public mental health system, legislation that was passed in the last couple of years regarding mental health issues, some of the things that are expected by the regional support networks through their contracts, and then we're going to talk a little bit about barriers to services. Vazaskia will be talking about disparities in mental health care.

After that we hope to open up the floor to discussion of these issues.

The mission statement I'm going to let you read all those yourself. But, basically, the mission of DSHS and Health and Recovery Services Administration is to serve the most fragile and vulnerable residents of the state of Washington.

>> They're asking do you have a microphone you could use to work with this?

>> ALISON ROBBINS: I don't know.

>> HANK BALDERRAMA: Right there.

>> ALISON ROBBINS: All right.

>> That's better. That's better.

>> ALISON ROBBINS: Is that helpful.

>> Colleen: What number microphone is that? It's on. Is that loud enough for people? Can you hear me better now? Little more.

>> Hold the microphone up a little bit.

>> ALISON ROBBINS: I'll just hold it. That's okay. The basic mission of the Health and Recovery Services Administration in general and the mental health portion of the program, specifically, is to provide services to vulnerable members of Washington's population. Mental health division folks have changed their mission to focus more on recovery and resiliency than just medication and treatment the way it was in the past.

What we want to focus on right now is some of the services that are provided in the outpatient community mental health system. We have 13 regional support networks in the state of Washington. Those are what we call quasi-governmental entities. And they are supported through counties and groups of counties. They contract with about 145 community mental health

centers and treatment facilities and serve almost 250,000 of our clients. And that provides outpatient treatment services.

>> Can we hold on for a second, please.

>> From where you're standing, people on this side can't see the captioning. How's this? Okay.

>> ALISON ROBBINS: In addition to the outpatient services that are provided through these regional support networks; we have two adult state-run hospitals that provide in-patient treatment for clients. One is in Medical Lake in Eastern Washington and the other is up in Lakewood. They serve about 2,000 clients in an in-patient manner.

Also, located on the campus of Western State Hospital is a children's facility called the Child Study and Treatment Center, and that center serves children with long-term mental illness.

To run these 13 RSNs and three state hospitals, we have about 4,000 staff. Most of those folks work in the three in-patient hospitals. The rest of us, about 50 people, work in over in Cherry Street Plaza, not too far from here. We have responsibility for the oversight and management of the state Medicaid waiver and the federal block grant, which are the two documents that give us the authority to provide the services that we provide in the mental health system.

We also have responsibility for the contracts with the regional support networks. We work very hard on a daily basis to ensure that those regional support networks comply with contract requirements and the rules that are outlined in our federal waiver and block grant. We also have staff who manage special projects and program initiatives and pilot projects that we get special funding for not only through the legislative process but sometimes through private grant funds.

In addition to all that, we do process quite a few payments for services that are provided through our fee for service system. We have two staff people whose sole function is to go around the state and audit and check for compliance with the 13 regional support networks. They also certify those networks and providers that work with them.

Additionally, we, in the Health and Recovery Services Administration, are working very, very hard to integrate all our services a little bit more than they are now. What we have had in the past is a mental health system, a medical system, and a drug and alcohol treatment system.

We are working little by little to integrate those three systems into one system so that people can get all of their needed services without having to figure out who and where they should talk to in each separate system.

We also work with tribal governments in a government-to-government relationship to ensure that American Indian and Alaska native clients get the same services as other folks.

We do a lot of studies and reports for the legislature. And then we do planning, discharge planning, care coordination services for patients in the treatment facilities so they can transfer back into the community. Now I'll turn it over to Hank Balderrama.

>> HANK BALDERRAMA: Thank you. And thank you, Alison. I'm Hank Balderrama. I work for what is the mental health section of newly created Division of Behavioral Health and Recovery in the Health and Recovery Services Administration.

Alison mentioned to you that we just recently combined mental health and substance abuse operations into one division.

And within that transition we're also working with healthcare services division to implement an integrated healthcare --

(BRIEF INTERRUPTION IN TRANSCRIPT)

>> HANK BALDERRAMA: I think we're ready to go again.

I was starting to tell you a little bit about the Division of Behavioral Health and Recovery Services and the transitions that we're going through. I want to tell you a little bit about what I will cover this afternoon. First I'll talk to you a little bit about the types of personnel who work specifically on the mental health side of the service system. I'll describe to you as well something about how the service system is set up, our current structure.

We do know about some barriers. We worked on that but we anticipate that you'll probably know a whole lot more about barriers that we can learn from. At the end of the presentation, after all three of us has presented, we hope that we'll be able to engage with you in a discussion about your concerns. Hopefully, as well, your solutions, not just your concerns, in a workable manner will help us make things better.

Next slide.

I think many of you know what a Washington Administrative Code is, a WAC. It's a state regulation. The basic set of state regulations that define mental health services are 388-865. You have before you a slide which has the formal definition of mental health professionals. Essentially, mental health professionals are people with upper level degrees who have engaged in specializing and serving people in the mental health field. Just because you've gone through school, that's part of the qualifications. We also want you to have some direct service experience before you're considered a full professional.

Now, mental health professionals generally are folks who oversee services. A lot of the folks who provide services directly in the public mental health system may not be full-fledged mental health professionals, but they certainly have supervision and access to consultation from mental health professionals in serving people.

We also have a very special category of mental health professionals called mental health specialists. There actually are four types of mental health specialists. There's children's mental health specialists, older adults or geriatric mental health specialists; racial, ethnic gender minority specialist; and disability mental health specialists. Disability is used in the generic term.

Kids and older adult professionals are relatively self-explanatory.

Racial ethnic minority specialists -- those are folks who specialize in working with one or more specific populations. The general criteria for being a specialist is that you first need to be a mental health professional, then you

have to have at least one year's specializing in working with a particular population, and you have to have some specialized training, 100 hours in doing that.

In the case of racial, gender, ethnic minorities, we also want people to be culturally competent.

Now keep in mind that these criteria are currently defined in WAC. Some of us recognize that the WAC needs to be revised and recognize that culture is a pretty broad, encompassing term. Irrespective of who you are, we all have a culture or more than one culture to which we're most familiar.

We have requirements in WAC that talk about what RSNs must do to ensure that there's sufficient capacity to provide services to people who are residents of a particular service area.

Some of you may not be totally well familiar with what an RSN may be. It's either one county or multiple counties that band together to provide a range of services within a geographic service area.

Prior to 1989 individual counties provided services. Since 1989, with the creation of the Community Mental Health Reform Act, individual or groups of counties called RSNs provide a range of services. They do so by contracting with licensed community mental health agencies or community mental health centers.

There are three types of contracts that we have with regional support networks.

One of them is for state-only services. The state legislature mandates that certain services be provided to all residents of the state. Primarily, those are crisis services and short-term interventions.

Now our major funding source, other than the state legislature, is the centers for Medicare and Medicaid services, CMS. Don't ask me what happened to the second M, because there's supposed to be two. Those are the folks that administer Title 19 or Medicaid funds.

In addition to our state-only contract, we have a contract specifically for Medicaid services. Most of the people who get ongoing services in Washington State, ongoing mental health services, are Medicaid recipients. In order to receive services, a person needs to have medical necessity for service and a covered diagnosis much like people do in your insurance company for physical health, with the added emphasis that your condition needs to be severe enough to need treatment. You may have a mental illness. You may have a long-term mental illness. If you're relatively stable, your need for service may be minimal.

The third source of funding that we have is mental health block grant funding. Mental health block grant funding comes from the Center for Mental Health Services. It's a federal organization that's part of the substance abuse mental health services administration.

Mental health block grant funding is a flexible source of funding. It can be used for many things to help people who have either minor or major forms of mental illness to receive services. The major criteria for the block grant is it must be used for services that are not covered by Medicaid. If you're a

Medicaid recipient, we can provide services to you that are not sponsored by Medicaid. If you're a person who is not a Medicaid recipient, we can provide services to you that are covered by Medicaid until such time as you become covered or we can provide other things. This is our most flexible form of funding. It enables us to do some of the most creative things possible around the state, even things like assistance with housing, creative programming, new programming. One of the projects that Vazaskia will tell you about later is a use of a specialist for something we're funding with a block grant.

>> AUDIENCE: I have a question.

>> HANK BALDERRAMA: Okay. I'll take a brief question. We would like for you mostly to hold your questions until the end. If it's a brief question, that's fine.

>> RYAN BONDROFF: My name is Ryan. Can I ask a question In regards to the medical coupons? did you want me to hold off until you're done with your presentation?

>> HANK BALDERRAMA: I'm sorry. I don't understand the question yet.

>> AUDIENCE: I have a question with regard to medical coupons. Do you want me to wait or ask now?

>> HANK BALDERRAMA: Let me get into the detailed questions a little bit later, if that's okay. He's already asking me.

>> RYAN BONDROFF: It's a really quick question. I hope we don't get too far into it. For people who are on medical coupons, how many visits or how many visits will DSHS provide for counseling per year?

>> HANK BALDERRAMA: People who are on Medicaid who have medical coupons, their services are dependent on their diagnosis and their level of care needs. Irrespective of that, there isn't a limit on services. If you have a severe mental illness and you have ongoing need for services, then we're supposed to treat you until your need for services is less. If you just have mild mental illness, we might not provide services at all if your level of care doesn't merit ongoing services. We'll talk more about this later, and thank you for your patience.

>> RYAN BONDROFF: All right, thank you.

>> HANK BALDERRAMA: We do require RSNs to provide certain things that I think may be of interest to you. One is that people are supposed to provide for interpreting services consistent with DSHS administrative policy and at no charge to the recipient of services.

Mental health services are supposed to be provided to people in accordance with their need. RSNs are supposed to have sufficient levels of personnel available to meet the need. The reality is that we don't always meet or exceed the requirements. Sometimes we fall a little bit short through no ill will on the part of anyone.

We have 13 RSNs around the state. And each has a provider network. In other words, the RSNs do not provide direct services. They subcontract with licensed mental health agencies. If you or someone you know may need mental health treatment, we would refer you first to the RSN who then may refer you to the local mental health center or we may just refer you to the mental

health center depending on where you're located.

Going to non-Medicaid services --

>> JULIA PETERSEN: I have a question.

>> HANK BALDERRAMA: Okay.

>> JULIA PETERSEN: I'm looking at the clock, and we have had the chance to hear you talk for the past 45 minutes. Therefore, we now have only 45 minutes left in this symposium. I have noticed there are some side conversations going on related to your presentation, and we may be able to make a good use of the next 45 minutes for you to hear the deaf and hard of hearing individuals' comments, concerns or questions. I suppose you would be interested in hearing their common concerns. I just noticed that several people in the audience signing "yes" at the moment referring to their interest in having the discussion at this time.

>> HANK BALDERRAMA: we're happy to accommodate you. We will abbreviate our remarks, and we do want to make sure that Vazaskia has a moment as well out respect for her preparation. yes, we would like to engage in discussion with you.

Let me finish up by telling you that we have identified some barriers to services ourselves.

One is a shortage of mental health specialists. People who are qualified to guide others who are not specialists to meet specialized needs. We don't have a way to provide certification and credentialing for specialists, which means that there is a variation in the level of care and competence that a specialist may be able to offer either by providing services directly or through consultation. There are some things that we know about that we hope you will help us think through and figure out some strategies for improvement.

Again, out of respect for Vazaskia, we'll ask her to speak briefly, and, yes, we'll spend the rest of the session engaging with you and having some dialogue. Thank you.

>> VAZASKIA CALDWELL: Hello. And you will be happy to hear that I can make mine in less than five minutes. I might even do it in three. Okay.

What I've been tasked with doing is talking to you a little bit about the national policy summit that we were invited to apply to participate in. We were one of six states that were able to participate. We had a successful application process. The policy summit was around eliminating disparities in mental health care. We met in June, and we took a delegation with us of about seven people. And what we were looking at were issues and concerns we had around our state and something that we could take on in terms of a policy initiative. What we came up with is kind of alludes to what Hank just mentioned moments ago was barriers and challenges to mental health specialists. We know there are barriers. We know there are challenges. We have the WAC to guide us. What we also know is that access and outcomes are poor in several communities. When we went to the policy summit -- I'm just going to go over really briefly and I'm going to look at my notes so that I can kind of wrap this up for you, because it's a work in process. Let's see. The first thing that I want to share with you -- and it's on my last slide. It's the second

slide, was that what our delegation did first was work on developing a vision statement. The vision was that all will have access to and benefit from culturally and linguistically competent mental health care services and supports in their chosen communities.

The way we intend to do this is our action plan is to establish some baseline data and service delivery capacity by race, ethnicity, age, and culture. When we put culture in there, we will get it on a broad spectrum covering all the diverse groups.

Then we looked at establishing a policy home for this initiative, and one of our partners at the summit was the Governor's Interagency Council on Health Disparities.

The third thing was ensuring workforce capacity and competencies. That's why we're here today. We can hear back from you what would a mental health specialist need to do to be competent in meeting the needs of the deaf and hard of hearing, and then to set some systemic accountable measures.

Now, we have a representative, Tina Orwall, who has been an incredible advocate for us. She's been meeting with other legislators to get behind this initiative. What it does it takes the WACs that Hank went over with you and will make them actionable. We can develop some standards. We can develop some trainings. We can develop ways to recruit more mental health professionals and mental health specialists to meet the needs of the populations in Washington State.

With that said, I don't think I took up five minutes. But I do want to open it up to what your needs and your concerns are today.

Before I go, I want to say thank you for allowing us to be part of this symposium. It has been eye opening. It's been a wonderful partnership with Eric and Claudia. Please be gentle. I have some wonderful markers. So any recommendations or suggestions you have, I will be writing them on the board.

(APPLAUSE)

Thank you. Okay. Who wants to ask questions first?

>> CHAR PARSLEY: Hi, this is Char. I have a concern, not an actual question. My concern is that, when you talk about mental health specialists, often times it's not the actual person who's in that actual group. Maybe it's a white person who is trying to work with or maybe teach other people about the African-American community or about the Deaf community. That really just doesn't fit. That specialist should be of that group or that category and not just somebody who is an outsider coming in to teach about the group. It just doesn't work that way. It's not effective.

>> VAZASKIA CALDWELL: You just said what exactly one of the largest challenges I have heard from other mental health specialists. People do want to hear back from people within their own communities. Often times an African-American will want an African-American provider. Now, when we look at the requirements for a mental health professional or specialist, we're already asking them that they have to be a psychiatrist or a psychologist or a social worker first. To be a specialist, they have to be specialized in that specific population. A mental health specialist working with an

African-American would have to have the education requirements and also have worked within that community for over a year. They're working in the community. Would I prefer to have an African-American person work for me or someone that has the education, has worked within my community, has developed the trust and be able to provide me the quality service so that I can achieve the same types of outcomes of a majority population? For the most part, yes, I would love to have a black provider, an African-American provider. More importantly, I want someone that is skilled, that can navigate me through the system so that I can have the best possible outcome. It's really important to hear back from you because there is a difference in working with your population, the deaf and hard of hearing or the deaf and blind or the diversity within your population. The only way we'll know how to make it specific and that that additional year to be a specialist will meet your needs is if we hear back from you.

>> JAIME WILSON: My name is Jamie Wilson. And, you know, I was just thinking about your recent comments. But, first of all, let me just say thank you so much for taking the time to come here to educate us about your services and try to learn about increasing accessibility to services to the deaf and hard of hearing population. I really appreciate your efforts.

I think one thing that's important to be aware of the deaf and hard of hearing population that's kind of complex when you're serving them is that, if you have a "specialist" who is hearing and they don't know sign and they work through a sign language interpreter, sometimes the full benefits of treatment are missing. This would be different than going through treatment with someone who is of same race or ethnic only. For example, you would match an African American provider with another African-American patient. That would be direct. But with the deaf and hard of hearing, it becomes more complex because you have a sign language interpreter that kind of goes in the middle and is not just matched based on ethnicity. There's a lot of communication breakdowns that could happen. That's why having a provider who can communicate in a person directly in their first language is a great benefit.

>> VAZASKIA CALDWELL: I completely agree with you and I thank you so much for that. It's a learning process for me. It's something that we'll be able to share as we start initiating this new policy initiative that we will be able to invite you to be part of that. We need partners that will be at the table to address these concerns. I've done a lot of research, and Claudia over here gave me a lot of information about the vast diversity, the miscommunication, the misdiagnosis of getting the type of counseling for the deaf and hard of hearing. I understand exactly what you say, and I thank you for sharing that and that definitely will go on the board when I can make it over there to write it down.

>> ALISON ROBBINS: I can write.

>> AUDIENCE: Another issue would be that I'm hearing often is that they say that King County has all the resources.

Why aren't deaf and hard of hearing going there? They have enough there. But many people don't have cars, they don't drive or they prefer to just stay close to their local community, maybe with their family. They don't have

that option.

They just have their one place. That's it so we're stuck. The deaf are already feeling oppressed. It's not going to be benefiting us. That's one thing that I've just noticed.

>> VAZASKIA CALDWELL: I just have to acknowledge what you just said because it is a challenge even getting providers. It's a challenge getting people to want to go and get that professional degree, get the specialized training. We have a shortage of providers, which is a challenge, and then getting them out into the other communities is a challenge. That's something that we have to look at in moving this policy initiative forward. Maybe that's where the investment has to come from -- investing in scholarships to get more people going in to the counseling profession. Are there resources there in all the communities? No. It's something that we will put on the forefront to share with the senior leadership, say, in moving this initiative forward. Thank you very much.

>> JULIA PETERSEN: Related to the communication noted during the current symposium, I have noticed that the interpreter, who is standing next to you, has made the decisions concerning who in the audience here gets a to share his or her thoughts. I would suggest that you, as the presenters, take some control rather than giving all of the power to the interpreter. You can go ahead and point to whoever has the turn to talk. I want to point out this situation which often happens in community settings where the interpreter can take over, either intentionally or not. It is imperative for us to empower DHH people to take some responsibility in communication situation, especially in mental health settings. This dynamic is often overlooked if a talker who is unable to communicate with a deaf individual is involved in the situation. I just want to let you know as it seems to be one of the best ways to work around the communication dynamics. Thanks.

>> AUDIENCE: Do you understand what she said? I think she's saying you shouldn't pick the interpreter. You should pick the next speaker yourself.

>> VAZASKIA CALDWELL: I said interpreter. That's understandable.
(BRIEF INTERRUPTION IN THE TRANSCRIPT)

I'll do that.

The next lady, please. You can. Okay, you can.

>> DAVID GAYLEAN: Hello. My name is David. I just got a job under HRSA. What I was doing for my Stephanie Lane. She said she wanted to develop a deaf and hard of hearing, Deaf-Blind services toolkit in mental health setting. I gave her a list for her to set up a cheat sheet. I would recommend contacting my supervisor, Stephanie, and helping get that moving.

>> VAZASKIA CALDWELL: Thank you. I did receive Stephanie Lane's name today from another person, so we'll definitely contact Stephanie. Lady in the back.

>> MICHAEL BOWER: My name is Michael Bower, and I'm here representing the Hearing Loss Association.

We keep using in this format the term "deaf" and "hard of hearing." And I really want to emphasize those are two separate groups. They have very

little in common. Culturally deaf people rely on sign language. It is their language. Hard of hearing people rely on technology and electronics, and they prefer to stay in the hearing world. If you're sending out mental health people who are lumping those all into one group, they're in for a rude surprise because they're two entirely different people: Different psychological issues, growing up with hearing loss versus losing your hearing at an adult stage, all kinds of things. I just wanted to point that out, when you're doing training, to please separate in your mind those two groups.

>> VAZASKIA CALDWELL: Thank you. That's why I did earlier today in the bigger forum using deaf, blind, the diversity of that category, specialized groups. I will definitely make a note to use the appropriate language. Thank you. This lady. I haven't gone on this side of the room enough. I'm going to go over here.

>> AUDIENCE: I'm coming from a different perspective. I'm a sign language interpreter and I go to mental health. Okay?

>> VAZASKIA CALDWELL: You go where?

>> AUDIENCE: I go and interpret mental health. What I see is not so much communication, I see the trust and then the case is transferred to another person and transferred to another person. I have seen one client that had five case managers and you can't set up trust. It's impossible. I mean, I just believe that if we had consistency, it would be a real successful world. I mean, just for your information, because I've seen it and it's not good. The Deaf community have a hard time establishing the trust. Once it's set up, it's good.

Then you transfer it. They're not sure that they can trust this person any more because the last one I trusted and lost that. Here we go again and again. I've seen it happen year after year after year. If something could be said about keeping your case load for maybe up to two years, five years or something, I mean, I'd like to see that, because I've seen it firsthand. It's awful. Just FYI.

>> VAZASKIA CALDWELL: That's good information. Thank you. That would be horrible. I'm sorry.

>> ANNE BALDWIN: Hi. I'll try signing and talking at the same time. My name is Anne Baldwin. I work for Sound Mental Health. We have a big deaf program there. You mentioned people coming from other counties. Medicaid just works within the RSN. Even if people want to come to our agency from King County or from Snohomish County or Pierce County, they can't. RSN doesn't work that way. It's a big problem for kids at WSD. Maybe students go to Vancouver for school and come home on the weekends. Which crisis team covers them? That's a really big issue that needs to be sorted. What I think is a bigger issue is interpreting money within the case rate. If I remember correctly, before the '90s was interpreting money for Medicaid separate and not included in the case rate payment. Hank, is that true? Did it used to be separate?

>> HANK BALDERRAMA: I think so.

>> ANNE BALDWIN: I know at SMH, where we have five signing staff,

most are deaf, we spend a little over 100,000 a year on interpreting, about the same we spend on staff salaries. You get a few dollars more to work with them. It's called a differential payment for a deaf person. It doesn't even come close to covering the cost of interpreters. I've seen in the other counties, where they don't have signing staff, there's no funding for that. They do write back and forth with deaf people. If you're not culturally sensitive, there's no motivation to pay for the interpreter. People just don't do it. I think people in other counties aren't getting good quality care because there's no funding for the interpreters.

>> VAZASKIA CALDWELL: You make a good point. A part of the Washington Administrative Codes are requirements that you provide these services. The RSNs are required, and we handed out what the WAC says. Do we need to look at that? Absolutely. Are there issues? Absolutely. Can we shift funds to make sure that there are resources available to provide the care? We have to look at that.

>> AUDIENCE: Why did they choose to include it within the case rate? Medicaid pays for interpreting for doctor appointments and different things but is not included in the mental health case rate tiered mental health language.

>> VAZASKIA CALDWELL: Some are provided to provide interpreter services itself.

>> AUDIENCE: That's not my question. I'll ask Hank. Do you know why it was separated?

>> HANK BALDERRAMA: When the mental health division moved to a managed care capitated payment system, the cost of interpreters was wrapped up into that one rate. Irrespective of what language it may be, verbal or manual, it's all wrapped up in one rate. The RSNs and their providers are responsible to provide those services. That's a different arrangement than we have in physical healthcare, which has a separate payment mechanism.

>> ANNE BALDWIN: Which is my question. Why can't mental health also have a separate payment mechanism? I know you're legally required to pay for the interpreter. A lot of people that we see aren't getting it because interpreters are 100 bucks an hour.

>> HANK BALDERRAMA: This is something I'm not totally familiar with. I think it's rooted in the waiver that we have from centers for Medicare and Medicaid services. They're the ones who made the determination in agreement with previous mental health division administrations for that arrangement, just like centers for Medicare and Medicaid services have authorized a different arrangement for physical healthcare. I can't tell you why, and I don't have the authority to do that. I can say that I can try to learn a little bit more and try to get back to you on that, if you want to give me contact information.

>> ALISON ROBBINS: Another thing that would be helpful is for you to send us examples of when that happens when someone needs an interpreter and it's just not provided because it's too expensive or for whatever reason. If we have a specific case where someone needed an interpreter and it wasn't provided, we can do some investigating and find out the specifics of the case and then maybe do some enforcement, some technical assistance or something

like that. It always helps us to have examples.

There's a lot of cases where, because interpreters are expensive, the RSN doesn't get an interpreter. If we say Joe Smith needed an interpreter for a doctor's appointment or a mental health appointment and was not provided with one, then we can go do something with that.

>> CHAR PARSLEY: Related with that, if a deaf person lives way out in a rural area and the mental health services -- there's nobody out there to provide it and no interpreters in that rural area, for example, how could a deaf person get services from a mental health therapist who is qualified plus not have the interpreter? You'd have to look at that part of it as well as far as related to the rural services. They should have statewide personnel who could go and help in those areas around the state. I don't know. I'm just throwing out an idea.

>> VAZASKIA CALDWELL: The idea that you had was written up in "The Social Worker," a publication that they just produced in terms of meeting the needs of the geographical areas that don't have access to those type of services that we need to find a way to make sure that resources or people or services are brought into those communities. That's a huge barrier -- geographical location and the lack of providers to meet the needs of those communities. That is something that we're looking at.

Back in the far back.

>> RYAN BONDROFF: Hello. I'm Ryan Bondroff. I'm happy that we're having this discussion about mental health issues. In the past, I lived in Minnesota, Maryland and Massachusetts, I've seen what they have mental health programs for deaf, hard of hearing and deaf-blind people that include specialists who are qualified to work in those areas. Washington State has nothing. I think we had a residential program with Sound Mental Health, but it closed down. But we don't have anything else related for the programs for deaf and hard of hearing. So I'm just wondering why. That would just be my goal to establish something here in Washington State because we really need one here mental health services -- people are suffering and we have no support from the providers that would be required to have services to provide to them, like services for 24 hour support communication access and help to reinforce the different things that are important and to be able to continue those services.

>> JULIA PETERSON: Ryan, for your information, I noticed that there are some signs that the interpreter has missed in your comments. Are you talking about a residential program? (RYAN BONDROFF: "YES"). Interpreter said "health" instead of "residential program".

>> INTERPRETER: Oh, excuse me. Residential program.

>> RYAN BONDROFF: There are some kind of residential programs for hearing and deaf to be able to mix together. But they're not communication accessible for the deaf, Deaf-Blind individuals. So how could we make that happen? Couldn't we somehow establish a residential program with other options for people to be able to continue receiving support from the services?

>> VAZASKIA CALDWELL: That was a lot that I don't know. Let me just speak real quick. In terms of having residential or programs in our state to meet the needs of this specific population, you're saying we don't have this.

I'm not clear on what you're saying.

I can tell you this: Through what we're doing over at the Health and Recovery Services Administration, we're going through a behavioral health and primary care integration. We're looking at restructuring to make sure that all the programs and services that we provide will be provided in a patient-centered structure. I use "structure," but it's a little more flexible than I mean structure. I will take back what I captured or what Alison captured in terms of kind of like a --

(BRIEF INTERRUPTION IN TRANSCRIPT.)

>> AUDIENCE: I would like to see there's one -- let's place more there. They feel it's an undue burden. They already pay interpreter for one person. They don't want to add more because they're already paying for one. You could have a deaf population together. Same thing with SH standards, supportive housing, SL, supportive living. There's different levels of housing under the mental health system. there tends to be all these one people. Because of interpreting, we're back to the interpreting cost. Somehow that money needs to be separated so it doesn't get messed up in the finding the best resources for somebody.

>> VAZASKIA CALDWELL: And then also the best quality of care to meet the needs of the population. If you only have one person with a staff of 100, you're not going to give them the quality of care that they need. We need to do more investment in either providing a residential home that meets the needs of that population, or we need to invest in hiring or putting more money into supporting mental health specialists or mental health professionals. Or we can go outside of mental health care. We can do primary care.

>> AUDIENCE: Copy the DDD system. DDD has PSRS. They have great options for deaf people under DDD. Mental health does not.

>> VAZASKIA CALDWELL: That's a really good point for us to take back to look at as a model of what we can be doing with our policy initiatives. So thank you very much.

Actually, Hank is the mental health expert. So how am I doing, Hank?

>> HANK BALDERRAMA: You're doing great.

>> VAZASKIA CALDWELL: Okay. Let's see. Let's go all the way back here. Someone who hasn't spoken yet.

>> JAMES CHRISTIANSON: Hi, I'm James. I'm from Bellingham. Really close up there to Canada. I work at a deaf center. One customer I have was court ordered to go into mental health services, and he wanted me to come with. I thought okay, this will be a great experience for me. I sat there and watched as an advocate with an interpreter present as well. And then we have the mental health counselor. It was about anger management.

Anyway, they were discussing things and going forth. I thought hmm, okay.

Then the interpreter was interpreting and then somehow the deaf individual said no. And the interpreter is trying to describe something, explain something. And I was thinking a lot of the comments were actually coming from the interpreter. So the mental health professional would say something. And

the interpreter was expanding a lot on it. And, of course, they looked at me. And I said, "okay, that's fine." Kind of felt like a deaf interpreter at this point. So I started expanding on the ideas.

Hearing people typically use ideas abstract information to explain deaf individuals, not visual aids.

They'll say this was only an example. And, of course, the deaf person said I haven't done that. They use different examples, like this and like that. The deaf person is saying, no, I haven't done that, I haven't done any of that.

After a one-hour discussion, we left. The deaf person was commenting about the process, and it took me another hour to explain what actually happened within that service.

The next week we did the same thing all over again. We took an hour after the service to expand and explain to the deaf individual. And so that's an issue right there is that deaf people are very visual. When it comes to abstract ideas, there's a disparity there. It would be really nice if we had deaf individuals who were doing deaf treatment.

>> VAZASKIA CALDWELL: I agree.

(APPLAUSE)

Me too. Now whose hand's up. We're going to go to someone who hasn't spoken yet.

>> MELISSA KOSA: Hi, my name is Melissa Kosa. I'm a Deaf-Blind person. I just wanted to add that comment. If we have different interpreters for the situation, it creates a lot of confusion because any interpreters are not familiar to the information. If you have two or three same interpreters, these interpreters would be familiar to that any information as usual. For example, I take a treatment with my two interpreters who have knowledge of situations and have a good relationship with me and my specialist. In addition, two interpreters know my deaf-blind needs in a different way of communication through American Sign Language. What if any deaf specialist is not available, they have choice to meet with any hearing specialists. That way, we need the same interpreters. That would work smoothly. It ensures deaf, deaf-blind and hard of hearing to be satisfied.

>> VAZASKIA CALDWELL: Okay. Thank you. I know that -- yes, right here.

>> LAUREN RAFF: I have two solutions. The two solutions that I had come up with were to see if we can come up with a similar program here that Ohio had. The grant was not specifically for deaf people only to specialize in mental health social work for deaf, hard of hearing, deaf-blind and late deafened. It was also for hearing people who want to work with this population too.

As for the second solution, the message I was trying to relay was that in this work, traveling throughout rural Indiana, I connected with a variety of mental health agencies that serviced those rural areas. We set up a protocol in which they would be trained in providing better services for their deaf clients, recognize when an emergency was an emergency, how to get the appropriate interpreters out there and to contact me or my agency if they need us to come

out to work with these clients. We could think about doing something like that here, in Washington.

>> VAZASKIA CALDWELL: That's a good option. Ohio has been a leader in providing services and recruiting people to work in the deaf and hard of hearing community. I was read some research from as early as the 1950s when there were a lot of misdiagnosis of deaf and hard of hearing in terms of mental health issues. They have a wonderful model and what I'll do is I'll pull some of that information as well. Thanks for your input. I think Allison captured everything.

>> ALISON ROBBINS: I hope so.

>> VAZASKIA CALDWELL: Right up here. Jaime.

>> JAIME WILSON: I notice you're emphasizing the point that it is important to provide services to a person in their first language. That's really important. I think one of the barriers to that is that we have some qualified providers that can offer services in the deaf and hard of hearing person's first language. The problem seems to be that these culturally appropriate resources are s they're not very well known. Sometimes when you have a mental health professional who is not culturally competent to provide services to the deaf and hard of hearing working with this very population because they don't know of any other resources that are available. The competent cultural providers are not well known or accessible to the public.

>> VAZASKIA CALDWELL: Prior to coming here today, I was going to ask Hank to pull that information as to how many mental health professionals or providers do we have that are deaf or hard of hearing. That's something that we have to find out to see if we can meet the needs of every community in Washington State. We need to know that. We may have that information. We can check. Thank you Jaime.

Right here. I haven't heard from her yet.

>> ARIELE BELLO: One problem is that we have so many private mental health practices, you know, with private insurance. We need to do something more along the lines of medical for those who are on the medical coupons and that need the treatment but they can't get it and they can't afford private insurance as well. That's really where the demand is. When you're out in the rural areas, they're not allowing them to go out to other counties to get mental health services. That's a very big problem. In regards to the medical coupon, if they allowed them to go get services, like, for example, they could provide transportation, cabs, access and so forth, which would ensure that the person can go to another county where they do have services with a deaf mental health specialist that would accept medical coupons. A lot of those places only take private insurance.

>> VAZASKIA CALDWELL: Good point. Yeah, that does make sense. That if you don't have a provider in your RSN territory, if you're living within that community, then I agree. You should be able to go to another one. Vazaskia agrees. On the other hand, you shouldn't have to go outside your community to get treatment. You really shouldn't so we have that down. That's a very good -- I'm going right over here.

>> AUDIENCE: Hi. My name is Sunshine. I work at Southeast Washington Service Center for the Deaf and Hard of Hearing. We have two offices that serve about 17 counties.

And Yakima, I know that we do have one mental health professional who works full time, meaning that she's got odd hours. She's available at 7:00 in the morning, 4:00. She also works with interpreters. She's hearing, and she signs a little bit, but that's the only person that I know of that's available in the area. There's no other counselors that are available to work with those challenges.

Another challenge is we do not have enough interpreters in the area, so the community suffers. Maybe, for example, if there is a crisis, needing counseling right away, the whole situation is very sticky. There's a lot of burnout so we need people who can sign -- advocates, interpreters, so forth. The community is really hurting out there.

>> VAZASKIA CALDWELL: Okay. Thank you. Go right here and then back.

>> CHAR PARSLEY: I'm from Spokane. That's east. We have the same situation happening. We have a person who is hard of hearing, but works for Spokane mental health. They used to have a therapist, which was me, but then they decided they did not need specialized therapists and let other general therapists work with special populations. We're wondering where do deaf and hard of hearing people go for their services. There's absolutely nothing available in Eastern Washington. All of Eastern Washington is seriously in need.

Also, I wanted to share one experience I had with an interpreter. If you bring in an interpreter, you have to ensure that the interpreter has the experience or is qualified to do mental health interpreting because the interpreter I had actually really created some chaos in my therapy. We need to make sure that interpreters are qualified to do mental health work. Maybe that's where ODHH can come into the picture and can, you know, certify people to actually do mental health interpreting.

>> VAZASKIA CALDWELL: Great. That would be a great partnership, too, with the mental health or behavioral health and recovery division as we move forward to do a partnership like that to make sure that people are truly qualified to provide the interpretive services. That's something that I've heard frequently about the quality of interpretive services or even the translation of materials in the appropriate languages. Thank you. I know we captured that. Let's see. Right here. I know you have a question or a statement.

>> JULIA: I am a Mental Health Therapist at Seattle Children's Hospital, Department of Psychiatry, DHH Program. Cultural sensitivity and cultural competency are very critical when providing mental health services to the deaf and hard of hearing population. The linguistics aspect should be not the only consideration, but cultural-competency is needed as well in a therapist. For example, a client may be approved for 20 therapy sessions according to the tier level system. Often the number of sessions for the general population is ineffective for DHH clients because the hearing society often does not provide accessible mental health information (i.e. sign language or DHH-friendly media)

for the DHH population. Therefore, DHH clients often are exposed to the concept of therapy during their enrollment of tiered services which would easily use up the initial few or many sessions for psychoeducation. Often that is not equivalent to the needs of the DHH clients and by the time clients may be ready for therapy the number of approved sessions may have run out. Typically, RSN requires a special population consultation. Factually some therapists don't contract with out-of-county fluent signing therapists to provide direct therapy especially if clients request for this or to obtain consultation. RSN requires at least a one-hour special population consultation which does not mean a therapist in the field of deafness is automatically qualified in providing mental health services to the DHH population. That's very common, especially since mental health services are based on county-wide, rather than state-wide model. This is a scary scenario which gives the county the power to make those decisions, even though they might not be trained or qualified in providing direct mental health services in at least proficient communication skills (i.e. sign language). That is really where the danger comes in. When I started working in the field of mental health 19 years ago, services were based on a statewide model and coordination amongst agencies was more effective in comparison to the present system especially in the provision of services to DHH population. I'm interested in knowing if there's a person who is qualified to work with deaf and hard of hearing individuals in the Division of Behaviors and Recovery.

>> In the mental health department.

>> VAZASKIA CALDWELL: Which would be Hank. Is there someone qualified to work with the deaf and hard of hearing? Hank is saying no.

>> JULIA: Consider consulting with Ministry of Mental Health in British Columbia, Canada as they have been active in calling in deafness specialists for consulting and becoming creative in providing mental health services for DHH clients including those ones in rural areas.

>> VAZASKIA CALDWELL: This is what I have to say. It's two minutes until the end. I'm going to say this.

I will leave a piece of paper in the back of the room. In the process of doing the policy summit, we're going to be meeting with our senior leadership team next week to talk about mental health specialists and professionals and some of the things that came out of our summit. In addition, I'm going to make it a priority to address some of the issues that were brought up here today. I'm going to leave a piece of paper back there, because we are going to bring partners to the table to address issues that concern them.

All of you have been very concerned. If you are interested in being part of that discussion, part of that group to change what's going on in terms of mental health specialists, mental health professionals, resources and services, to rural communities, barrier issues in terms of geographical locations and providing services, leave me your name. I will make sure that, as we move forward, that you're included in the opportunities to make your voices heard for your population or the specific population that we're talking about today. That's the promise that I can make to you.

My field, just for the record, I am the manager for Health Disparities

Reduction Initiative, which covers a multitude of things. I am definitely vested and that's why I'm here today, because I want to hear what your needs are. I can guarantee you I will be an advocate for these issues for you, but you have to come to the table and give of yourself and of your time because you're going to be stronger, powerful, and know what to say. I know that there's certain things that I can speak on and there's certain things that I can't. I'm definitely going to make sure that there's room at the table for you to be there and for your voices to be heard. With that said, I want to thank you all for your time and all of your input. I'm sure Hank and Allison and I will go over these notes. If we can leave a piece of paper back there, I really want e-mail addresses, because I'm an e-mail fanatic. Thank you again. I'm going to turn it over to Claudia Foy to close out.

>> Hi.

>> VAZASKIA CALDWELL: She wasn't paying attention to me. You get to summarize.

>> ALISON ROBBINS: She wasn't going to use the microphone.

>> VAZASKIA CALDWELL: Sorry.

>> CLAUDIA FOY: I'm going to wrap this up and thank you for all your comments. Your comments are very important. We will work together in following through your comments. I'm hoping that we will continue to set up some kind of a roundtable discussion that we meet again and continue to discuss the issues and recommendations for long-term mental health plan for the deaf, hard of hearing, and Deaf-Blind people in Washington.

Vazaskia, Allison and Hank, I want to thank the three of you very much for coming here.

(APPLAUSE)

We've learned a lot from you, but we would like to learn a lot more from all of you. Again, thank you for coming and sharing your comments with us. Please stay in touch with us.

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