

Providing Substance Abuse Treatment to Deaf and Hard of Hearing Clients

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Deaf Culture and Substance Abuse

Suppose you had to use flashing lights or stomp on the floor to get another person's attention. Consider a language that incorporates the use of non-verbal communication which includes an emphasis on facial expressions, is highly visual and has a grammatical structure distinct from the English language.

These are all aspects of a culture which has worked its way steadily to the forefront, especially in the past ten years. Several events fueled this emergence of Deaf Culture including the following: the enactment of the Americans with Disabilities Act; the awarding of an Academy Award to Marlee Maitlin, a deaf actress for her role in "Children of a Lesser God"; and the protest of students at Gallaudet University (the world's only liberal arts college for the deaf) resulting in the selection of a deaf University President over a previously appointed hearing individual. Like other cultural groups, deaf people share experiences, a history and language. In fact, at the heart of Deaf Culture is the pride in American Sign Language (ASL), which is a complete natural visual language, quite independent of English with its own set of grammatical rules and used daily by more than half a million Americans.

The recognition and understanding of substance abuse within the Deaf Community significantly lags behind the hearing community. There is a strong discomfort in discussing the topic and a negative stigma attached to those that may be identified as having a substance abuse problem. There is also denial of the abusive use of alcohol and other drugs within the Deaf Community. Little research has been done to accurately identify the level of substance abuse among deaf people. Research methods developed to gather this information in hearing communities are often ineffective among deaf people for a variety of reasons which include: distrust of predominantly hearing researchers; fear of ostracism and labeling; and the inaccessibility of assessment instruments due to language limitations.

Considering the few studies that have been done, it appears that substance abuse is a problem in the Deaf Community. Dr. William Mc Crone (1994), projects that there are approximately 5,105 deaf crack users, 3,505 deaf heroin users, 31,915 deaf cocaine users and 97,745 deaf marijuana users in the U.S. today. The National Council on Alcoholism suggests that at least 600,000 individuals experience both alcoholism and hearing loss (Kearns, 1989). Most professionals familiar with substance abuse and deafness identify a level of substance abuse that is at least equal to the traditional field estimate of eight to ten percent in the general population (Grant, et al, 1988). Deaf people present a challenge in terms of the provision of alcohol and other drug treatment services due to their unique cultural profile and numerous communication and accessibility issues. This may be evidenced by the low level of utilization of treatment services by deaf people. Robert Wood Johnson Foundation (1993) estimates more that 800,000 people in alcohol and drug abuse treatment at any given time. Based on one half of one percent of the population represented by deaf people, there should be 4,000 deaf and hard of hearing people in

treatment. No evidence of this level of treatment service for deaf people is seen at the present time.

Deafness as a Barrier to Treatment and Recovery

Imagine yourself in another country, unable to speak or read the language and in need of substance abuse treatment. Upon admission to a treatment program, all counseling would be provided in that foreign language and you would have no interpreter. What feelings would you experience? What barriers would you face? How likely would you be to have a successful treatment experience? This scenario is comparable to the situation that deaf and hard of hearing people face when trying to access substance abuse treatment services.

Communication barriers often exist in family systems with a deaf member since ninety percent of all parents of deaf children are hearing (Schein, 1974). Poor communication between parent and child is often a valid predictor of substance abuse (Babst et. al., 1976; Carter, 1983). Deaf people are unlike any other ethnic group because parents and children are likely to identify with two different cultures (Dolnick, 1993). Many parents of deaf children learn only minimal sign language which is inadequate communication for educating their children about alcohol and other drugs. The tendency of family members, friends and even professionals to take care of and protect deaf and hard of hearing individuals often exacerbates the chemical dependency issues. This may result in the deaf or hard of hearing person not being held accountable for his/her behaviors.

Comprehensive substance abuse prevention programs were implemented in many public schools for hearing students more than a decade ago. However, many deaf people have not had access to the increasing volume and quality of prevention programs provided to their hearing counterparts. School based prevention programs and public service announcements generally do not provide communication access to deaf persons. Many young deaf people are ill-prepared to deal with the pressures by peers and other individuals to use mood altering chemicals. As a result of the lack of information and education, deaf and hard of hearing individuals may not be well informed about the risks of using alcohol and other drugs, about addiction, or treatment and various recovery programs such as Alcoholics Anonymous, Alateen and Alanon.

Assessment of substance abuse problems when working with deaf and hard of hearing individuals also presents difficulties since there are no formalized assessment tools normed or specifically designed to use with this population. Additionally, most assessors are unfamiliar with how to work with deaf people and are even less likely to be fluent in American Sign Language. Those who have some awareness of the needs of deaf people, may attempt to utilize a sign language interpreter for the assessment process. Although this may be a satisfactory accommodation, problems of interpreter availability, interpreter qualifications and the complication of a third party in the assessment interview raise additional concerns about the validity of the assessment. Also, many deaf people may be unfamiliar with the terminology used by assessors and may be hesitant to ask for clarification resulting in an inaccurate depiction of the deaf individual's needs for chemical dependency services. For example, a typical question

may deal with the experience of a "black out" which is a significant diagnostic feature of chemical dependency. In assessing a deaf client, the interviewer may need to explain the phenomenon in addition to (or instead of) using the term "blackout". The interviewer who fails to explain concepts and/or vocabulary that may be unfamiliar, risks compromising the validity of the assessment (Guthmann & Sandberg, 1995). The use of self-report paper-and-pen or computerized tools, both heavily dependent on knowledge of English language, are also inappropriate for a population for whom English is not their first language. All of these factors lead to a high possibility for inaccurate assessment data.

A deaf individual who is placed in a treatment facility for hearing people is usually given sporadic opportunities for communication contingent on interpreter availability and funding. An interpreter may be provided on a limited basis for groups or other specific activities. The absence of an interpreter precludes deaf patients having equal access to staff and severely restricts interactions with other clients. The deaf person often misses out on much of the communication between peers that frequently occurs during unstructured times. Such interactions are a key part of the treatment process. The majority of treatment programs that are designed to work with hearing individuals have a heavy emphasis on tasks that focus on reading and writing skills. Since American Sign Language is a highly visual language, approaches in treatment need to use creative visual approaches to be successful with this population.

The optimal placement for deaf individuals should include specialized services such as: adapted therapeutic approaches, staff fluent in American Sign Language, recovering deaf role models, technology support such as TTY's (which allow deaf people to communicate on the telephone), assistive listening devices, flashing light signals, decoders and captioned video materials. Good communication is essential in the educational, therapeutic and peer interactions dimensions of a well-designed program.

Even for those deaf people who are able to find and complete treatment, barriers remain in their ongoing recovery. In most locations, few resources such as counseling, outpatient services or support groups are accessible to deaf persons. Even Alcoholics Anonymous and other Twelve Step groups, the mainstay of recovery for many hearing people, face challenges in being accessible to deaf people. Twelve Step sponsors who provide mentoring and support for those new to recovery are seldom able to effectively communicate with deaf recovering people. Within the group of recovering persons, few deaf role models are available to support those who are new to recovery. A common suggestion in recovery is to avoid old acquaintances and environments associated with chemical use. Most hearing people in recovery have choices and options of places to go and people to see. They can realistically develop new friendships in the recovering community. In contrast, many deaf people in recovery are isolated and have a limited circle of sober, deaf friends.

The challenges are numerous and difficult, but growing numbers of deaf and hard of hearing people are finding their way to treatment and practicing the principles of recovery. This is due in part to specialized programs like the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals, a program of Fairview Recovery Services.

A Model Program

The Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals (MCDPDHHI) is a specialized program designed to meet the communication and cultural needs of deaf and hard of hearing persons in chemical dependency treatment. The Program is comprised of a highly trained staff who provide a full range of treatment services. Staff are fluent in sign languages as well as knowledgeable about and sensitive to Deaf Culture. Program offerings include individual and group therapy, educational offerings, spirituality group, grief group, recreational therapy, men's/women's groups, participation in accessible Twelve Step groups, comprehensive assessment services and aftercare planning.

The Program operates on a Twelve Step philosophy using treatment approaches that are modified to respect the linguistic and cultural needs of the clients. As opposed to the traditional emphasis on reading and writing, clients are encouraged to use a variety of methods including the use of drawing, role play, and communication using a variety of sign language systems. Any written material used in the Program is modified and video materials are developed and presented using sign language, voice and captioning. TTY's, assistive listening devices, flashing light signals, decoders and other technology help to make the treatment setting accessible to deaf and hard of hearing clients.

Phase I: Evaluation/Assessment At the MCDPDHHI, treatment is provided in three phases. Phase I is the evaluation/assessment phase in which information about the client is gathered. The assessment includes data on the client's medical background, a social history, a chemical use history, a clinical assessment and a communication assessment. The communication assessment is an important tool which profiles a client's communication needs and facilitates the provision of treatment and support using the client's preferred method of communication. During Phase I, clients also complete a drug chart assignment providing information about the different drugs they have used, a description of their last use and examples of consequences of their use in major life areas such as physical health, legal, family, social, work/school and financial. With few exceptions, drug chart work and many other assignments are done through drawing. The use of drawing removes the barrier created for many deaf people by the English language. It also encourages clients to be in touch with their experiences and, as a result, to be more in touch with the feelings connected to those experiences. Each completed assignment is shared with peers and staff in a group setting, most often using American Sign Language.

Phase II: Primary Treatment During the primary treatment phase, clients receive education about the Twelve Steps and work toward completing assignments related to Steps One through Five. The goal of this phase is for clients to integrate the concepts of the Twelve Steps into their recovery and is more important than the number of Steps completed. The typical Step work assignments used by programs for hearing persons have been modified to meet the needs of the clients at the MCDPDHHI. Rationale developed by the treatment staff for various portions of step assignments help to identify the objectives of each assignment and determine if the client has met the objective.

Beginning in Phase I and continuing throughout treatment, clients are provided information about the programs of AA, NA and other Twelve Step groups as well as the opportunity to be involved in these meetings. A family week experience is provided for clients and their families as appropriate whenever possible. Such an experience is often the first time many families are able to explore issues related to alcohol and drug use and its impact on the family. If family members are unable to attend, materials, referral to other resources and phone contact with staff is available to all family members.

The MCDPDHHI uses a behavioral approach with clients which includes education and support designed to help individuals identify and correct self-defeating behaviors. Intervention efforts are matched to behaviors of concern. An initial intervention would typically be a one-to-one discussion with the counselor which often helps the client recognize and change the behavior. If the behavior continues or becomes worse, a behavior contract might be an appropriate second-level intervention.

Behavior contracts may be utilized for incidents such as: the violation of unit rules, arguing about staff directives, failure to complete work on time, failure to focus on treatment or focusing on the needs and/or issues of other patients. Behavior contracts specify the behaviors for which they are given as well as the changes that are expected.

Another behavior management technique is the probation contract. Probation contracts may be used to help a client recognize behaviors which seriously threaten the success or quality of his/her treatment experience. It is used as a follow up to a behavior contract in the event that the client does not respond positively or is openly defiant to the terms of a behavior contract. Probation contracts also specify expected changes in the client's behavior, and may include an assignment which helps the client identify and change his/her behavior. Failure to adhere to the probation contract may result in the client being asked to leave the Program.

Phase III: Aftercare/Extended Care Phase III is focused on aftercare planning and services. For clients who come from outside of Minnesota, staff members attempt to set up a comprehensive aftercare program in the client's home area including offering education and support to services providers there. For local clients, the Program offers individual aftercare sessions and connects clients to other local resources such as Twelve Step meetings, a Relapse Prevention group, therapists fluent in American Sign Language, an interpreter referral center, vocational assistance, halfway houses, sober houses and other sources that provide assistance and support. Networking with other service providers both locally and nationally is an important activity related to aftercare. Aftercare for clients residing outside of Minnesota continues to be a challenge. Few Twelve Step meetings provide interpreters. Shortages of professionals trained to work in this discipline exist on a national basis. Developing an aftercare plan for out of state clients might be compared to putting together a puzzle--sometimes with many of the pieces missing.

Relapse prevention may be addressed in primary treatment, or in a later stage of treatment such as aftercare. It is important to understand that relapse is a process of changing behaviors that culminates in the return to mood altering chemicals. Clients are offered information about

warning signs of relapse in terms of feelings, behaviors or environment. Clients are taught to recognize and respond to warning signs in ways that are likely to support ongoing sobriety.

Final Comments

The number of services emerging to meet the needs of deaf substance abusers is increasing. Existing resources are gradually attempting to make their services accessible to deaf people. Prevention and education programs especially for deaf people are becoming available but more work is needed.

Ideally, individuals who successfully complete an alcohol/drug treatment program should be able to return to their home area. However, that environment must provide a sober living option, family/friend support, professionals trained to work with clients on aftercare issues and accessible Twelve Step meetings. The exact prevalence of substance abuse within the Deaf Community remains unresearched. Risk factors that are linked to the development of chemical dependency in deaf people are still open to much speculation. What is known is that deaf people face many barriers in learning about and seeking help for substance abuse problems. The need for ongoing research and improvements in substance abuse services is clear. We will not fairly measure the risk factors of deaf and hard of hearing individuals becoming chemically dependent until they receive the same consideration as hearing persons in regard to prevention, intervention, accessible treatment and adequate aftercare.

The story of a young woman named Jane provides an example of the roadblocks and triumphs chemically dependent deaf people experience. Jane is profoundly deaf. She began using alcohol and other drugs at the age of twelve when her parents divorced. From that time on, Jane used alcohol, marijuana, LSD, cocaine, crack and anything else she could find. She knew that without help, she would end up in a mental hospital, in prison or dead. She attempted treatment at two programs designed for hearing people. Even though those programs provided sign language interpreters for lectures, groups and therapy sessions, they really didn't seem effective. She admitted that she used her deafness as a way to avoid painful or unpleasant therapeutic situations. Finally, a counselor at the residential school she attended found out about the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals and made the referral to the Program. Initially, Jane tried the same techniques she had used before to avoid full participation in the program, but found that they didn't work very well. Instead of being able to use her deafness as an excuse, she was challenged by counselors and peers who could communicate and could relate to her as a deaf person. She was able to participate in groups consisting of other deaf and hard of hearing addicts with whom she could share language, culture and experiences. She finally let her guard down and successfully completed treatment.

Now, four years later, Jane is back at the Program---this time as a chemical dependency counselor taking it one day at a time. But challenges remain for Jane and others like her which means it is imperative to continue educating professionals in the field of chemical dependency about the importance of making the continuum of services accessible to deaf and hard of hearing people.

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Better Service Provision for Deaf and Hard of Hearing Clients

- **Use a qualified interpreter.** If you are not fluent in sign language, always use a qualified interpreter for assessment, evaluation or counseling related to substance abuse services. A qualified interpreter means someone who is trained, certified by the Registry of Interpreters for the Deaf or the National Association of the Deaf and who is familiar with vocabulary and concepts related to substance abuse.

- **Use local deafness resources.** Access information from local resources about agencies in your area that serve deaf and hard of hearing persons.
- **Training.** Take advantage of training opportunities to learn more about the needs of deaf and hard of hearing people in relation to substance abuse. Provide training opportunities for deaf and hard of hearing persons who want to work in the substance abuse field.
- **Know and communicate.** Be aware of the special needs of deaf and hard of hearing persons who need to access services in the substance abuse continuum of care. Accessible meetings, captioned video materials and the provision of interpreter services can help deaf and hard of hearing people access crucial aftercare services.
- **Support.** Support the provision of funds that support special programming for deaf and hard of hearing persons.
- **Phone access.** Be aware that any agency attempting to work with deaf and hard of hearing persons should be accessible by TTY. Agencies should purchase or lease TTY equipment and see that staff members are trained in appropriate use of the equipment.
- **Refer.** Using the principles of cross-cultural counseling, be sure to refer deaf and hard of hearing persons to qualified professionals or agencies if you are not able to meet their communication and cultural needs.

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Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals is a part of Fairview Recovery Services located at 2450 Riverside Avenue, Minneapolis, Minnesota.

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