OREGON MENTAL HEALTH SERVICES TASK FORCE

Oregon Association of the Deaf (OAD)

Recommendations & Report

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INTRODUCTION

By Steven M Brown, MA, NCC
OAD Vice President and Task Force Chair

The website for the State of Oregon Addictions and Mental Health Services Division[1] (AMH) states:

> *The mission of AMH is to assist Oregonians to achieve physical, mental and social well-being by providing access to health, mental health and addiction services and support to meet the needs of adults and children to live, be educated, work and participate in their communities*[2].

Additionally, the Division supports the need for Oregonians with addiction problems and mental health issues to be educated, work, and participate in their social lives and daily activities[3]. Unfortunately, that is not the case for Deaf[4][5], DeafBlind[6][7], Deaf-Plus[8], and hard of hearing[9] populations in the state of Oregon.

Currently, there are approximately 186,117 Deaf, DeafBlind, Deaf-Plus, and hard of hearing people residing in Oregon[10] who may need some mental health services in some point in their lives. The current system is designed for Oregonians who can talk, hear, and are comfortably employed, but not for the majority of the Deaf and hard of hearing population. The system needs to be fixed.

An example of a Deaf[11] individual who has not been provided appropriate services is a Deaf senior citizen who on several occasions entered the airport and declared, "I must be in Israel because God has told me!" She was diagnosed with schizophrenia[12], and has been arrested several times. Unfortunately, most of those times she was merely injected with sedatives by jail medical staff, simply to calm and keep her quiet, with no American Sign Language (ASL) communication access provided to ensure they were appropriately assessing and meeting her mental health needs.

1 http://www.oregon.gov/oha/amh/Pages/index.aspx
2 http://www.oregon.gov/oha/amh/Pages/about_us.aspx
3 https://www.olmsteadrights.org/
4 http://www.who.int/mediacentre/factsheets/fs300/en/
5 http://www.parentcenterhub.org/wp-content/uploads/repo_items/fs3.pdf
6 https://nationaldb.org/library/page/90
7 http://www.cde.state.co.us/sites/default/files/documents/cdesped/download/pdf/dbdeafblindness.pdf
8 http://www.handsandvoices.org/comcon/articles/pdfs/deafplus.pdf
9 https://www.nidcd.nih.gov/health/hearing-loss-older-adults
10 http://www.disabilitystatistics.org/
11 http://www.nchearingloss.org/deafcap.htm?fromncshhh
12 http://www.nami.org/Learn-More/Mental-Health-Conditions/Schizophrenia

Another example is a Deaf individual facing misdiagnosis for having Posttraumatic Stress Disorder[13] (PTSD) and disruptive behaviors. In fact, he has borderline intellectual functioning[1415] and is isolated with caretakers who do not know ASL. He simply needs therapists and caretakers fluent in ASL to assist him in expressing his feelings and behaviors in appropriate ways and in his native language.

Unfortunately, these examples are not uncommon experiences for Deaf individuals in Oregon. The Deaf, DeafBlind, Deaf-Plus, and hard of hearing communities are sorely neglected because there are systemic barriers that generate limited or no access to culturally and linguistically appropriate services.

13 http://www.nami.org/Learn-More/Mental-Health-Conditions/Posttraumatic-Stress-Disorder

14 https://en.wikipedia.org/wiki/Borderline_intellectual_functioning

15 https://aaidd.org/docs/default-source/annual-meeting/tasse-dsm5-id-definition-5-23-2013-aaidd-2013.pdf?sfvrsn=0

BACKGROUND

In June 2013, OAD President Chad A. Ludwig, MSW requested that the Oregon Mental Health Services Task Force be established. The Task Force's mission is to examine Oregon's current mental health services and needs for Deaf, DeafBlind, Deaf-Plus, and hard of hearing individuals.

The objective of the Task Force is to identify the components of the Oregon mental health system that are working for Deaf and hard of hearing individuals and those areas in which there are barriers or opportunities for improvement. Additionally the Task Force was asked to propose solutions to address any barriers and to suggest ways in which the mental health system can better meet the needs of Deaf and hard of hearing Oregonians.

President Ludwig asked Steven M Brown (OAD Vice President) to chair the Task Force and invite all known mental health professionals in Oregon who specialize in working with Deaf and hard of hearing individuals to participate in the Task Force. Those professionals included:

- Brad Houck, MSW, LCSW, Licensed Clinical Social Worker
- Dr. Brian Hartman, Psy.D., Licensed Psychologist
- Deborrah Hardwick, MA, LPC intern
- Lior Azen, MS, LPC, CRC, Licensed Professional Counselor
- Tracy Schaffer, MS, CRC, Certified Rehabilitation Counselor
- Sheila Hoover, MA, CRC, Certified Rehabilitation Counselor
- Kathryn E. Eckert-Mason, MS, Vocational Rehabilitation Counselor
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- Kim Poage, MS, CRC, Clinical Coordinator
- Dr. Julia Smith, Ph.D., LPC, CRC, Emeritus Professor
- Dr. Chung-Fan Ni, Ph.D., CRC, LPC, Associate Professor, Program Coordinator
- Dr. Denise Thew-Hackett, Ph.D., MSCI, Assistant Professor

The OAD President asked that one Task Force goal could be to examine the model that the National Association of the Deaf (NAD) encouraged states to adopt and determine if it could form a framework for services in Oregon. The Task Force was also asked to develop and draft a comprehensive blueprint that will give Deaf, DeafBlind, Deaf-Plus, and hard of hearing persons of Oregon mental health services.

The Task Force's primary goal is to develop solutions and make recommendations specific to Oregon's system of care, to inform legislators and policymakers and address current issues regarding access to mental health and addictions services for Deaf, DeafBlind, Deaf-Plus, and hard of hearing communities, and to increase access to culturally and linguistically appropriate services for the members of those communities.

Oregon mental health services that are comprehensive, provide consumer choice, are culturally and linguistically appropriate for the individual, provided in a cost-effective manner in the least restrictive environment relative to the consumer's risk and clinical needs.

This report is the result of three Task Force meetings over a period of appropriately 36 months to develop the proposals put forth in this document.

PROBLEM STATEMENT

According to the mental health directory[16] supplied by Gallaudet University in Washington, DC, there are 39 states in the United States, including the District of Columbia, which offer mental health services exclusively for Deaf, DeafBlind, Deaf-Plus, and hard of hearing populations. Ten states provide direct state mental health services (divisions or departments), including addiction services. Another eight states offer county-city services (public agencies, units, or programs) for Deaf, DeafBlind, Deaf-Plus, and hard of hearing populations. Additionally, there are approximately eleven states that offer inpatient psychiatric units for Deaf, DeafBlind, Deaf-Plus, and hard of hearing populations.

Overall, the directory reveals rough figures that include private practices in the United States, indicating 66 individual private mental health providers within 25 states. It is important to note that most of these private practice providers are masters-level, not doctoral-level providers. The figures also indicate a rough estimation from the Gallaudet University Research Institute directory that doctoral-level private providers total 38.

As for master's-level providers, there are approximately 36 individuals that possess Social Work, Mental Health Counseling, Counseling Psychology, Marriage & Family Therapy or Psychology degrees. Most of them are licensed by various states. It is important to note that there are still *unreported* providers in some states that are licensed but have not been listed in the Gallaudet Research Institute's directory.

For example, in the state of Oregon, the only reported listing in the directory is Northwest Human Services' Connection Program[17] in Salem. There are no names of individuals that offer mental health services exclusively for Deaf, DeafBlind, Deaf-Plus and hard of hearing populations. So far, this writer knows there are approximately two Deaf psychologists available in our state. Both are licensed by the state of Oregon. There is only one Deaf licensed professional counselor and one Deaf licensed clinical social worker available statewide. One licensed clinical social worker who knows ASL but is not Deaf, is also available.

Most of the other counselors are certified rehabilitation counselors, most of whom work in Salem, Portland, and Beaverton[18]. The writer confidently estimates there are approximately 20 to 25 Deaf certified rehabilitation counselors in the state of Oregon. These professionals are able to provide counseling treatment interventions in the areas of their scope of practice[19].

Additionally, one such set of services is designed for the hard of hearing population, while Deaf populations lack needed services that hard of hearing communities receive. The total of states that have similar problems among Deaf and hard of hearing populations is approximately four, including Oregon. There is only state-funded service available via the county services program in Salem, which is provided by Northwest Human Services' Connection

16 http://research.gallaudet.edu/resources/mhd/listings/

17 http://www.northwesthumanservices.org/Connection.html

18 http://oad1921.org/business/state-oregon-dhs-vocational-rehabilitation-services

19 https://www.crccertification.com/scope-of-practice

Program. They have only one Deaf staff person, a Deaf licensed professional counselor. Clearly, that is inadequate.

The next apparent problem is that Oregon has county-level funded systems. This state has approximately 16 community care organizations (CCO)[20] that contract with the 36 counties in Oregon. The state of Oregon's website[21] provides very nice summaries of the wealth of information on this topic, included below:

> *"A coordinated care organization is a network of all types of health care providers (physical health care, addictions and mental health care and sometimes dental care providers) who have agreed to work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid). CCOs are focused on prevention and helping people manage chronic conditions, like diabetes. This helps reduce unnecessary emergency room visits and gives people support to be healthy."*

> *"CCOs are local. They have one budget that grows at a fixed rate for mental, physical and ultimately dental care. CCOs are accountable for health outcomes of the population they serve. They are governed by a partnership among health care providers, community members, and stakeholders in the health systems that have financial responsibility and risk."*

CCO regional providers have to empanel providers, be the county mental health programs, individual private providers, or nonprofit organizations offering mental health services[22][23].

In order to sign up as private mental health providers with most CCOs, the process is somewhat complicated and competitive[24][25]. More likely, they would have to fill out what is called a provider interest form[26] and see if the CCO providers accept it. While mental health services provided by Deaf providers (or those who know ASL) are not guaranteed by CCO providers, they are currently contracted with private insurance companies (e.g., BlueCross BlueShield, Regence, Kaiser Permanente, etc.).

Too many individuals with disabilities fall either at or below the minimum income guidelines for Medicaid or Medicare, and individuals who become deaf before 22 years of age receive Social Security benefits[27].

20 https://comm.ncsl.org/productfiles/83403380/CCO_Service_Area_Map.pdf
21 http://www.oregon.gov/oha/OHPB/pages/health-reform/ccos.aspx
22 http://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/index.aspx
23 https://comm.ncsl.org/productfiles/83403380/CCO_Service_Area_Map.pdf
24 https://www.familycareinc.org/explore/contacting-familycare-health-provider-reps
25 http://www.healthshareoregon.org/for-providers/contracting-with-health-share.html
26 http://www.healthshareoregon.org/ or https://www.familycareinc.org/explore/Provider-team
27 https://www.ssa.gov/pubs/EN-05-10085.pdf

Current statistics[28][29][30] have shown that there are approximately 109,329 disabled workers that receive Medicare coverage while 31,180 low-income Oregonians receive Medicaid coverage. While the Social Security Administration (SSA) does not explicitly identify deafness as a disability, exact figures concerning Deaf, DeafBlind, Deaf-Plus, and hard of hearing Oregonians are not available nationwide. The Community Needs Assessment research and report (expected to conclude December 31, 2016) may provide a more complete picture of existing gaps in mental health services statewide[31].

In summary, there are several clear challenges, which are outlined as follows:

- CCO providers are choosing not to use providers who know ASL.
- There are an insufficient number of mental health professionals in Oregon who are fluent in ASL or who are Deaf native ASL users.
- Legal[32] questions regarding using telehealth access[33] to communicate via videophone service with Deaf patients and the providers/professionals who are Deaf or who know ASL.
- Limited referrals for Deaf mental health professionals to respond to emergencies, e.g. dealing such with crisis interventions.
- Lack of prompt responses to provide ASL interpreters in the event of an emergency.
- Complaints among Deaf patients and providers that ASL interpreters' translations are questionable.
- Some mental health professionals lack experience or knowledge of how to use ASL interpreters properly.
- Unqualified ASL interpreters who have little or no experience interpreting in mental health settings.
- Misdiagnoses from unlicensed mental health providers, e.g., Qualified Mental Health Professionals[34] (QMHP).
- Lack of staff trained to deal with Deaf clients with behavioral challenges in residential and hospital settings.
- Lack of mental health professionals and program staff equipped to deal with Deaf patients/clients in a culturally and linguistically appropriate manner.
- Exclusion of Deaf individuals from participation in needed mental health services.

28 https://www.ssa.gov/policy/docs/statcomps/di_asr/2014/sect05.pdf
29 https://www.ssa.gov/policy/docs/statcomps/di_asr/2014/sect01c.pdf
30 http://research.gallaudet.edu/Demographics/States/2010/OR.pdf
31 http://www.wou.edu/rrcd/home/cna/
32 http://arcweb.sos.state.or.us/pages/rules/oars_800/oar_833/833_100.html
33 http://apapracticecentral.org/advocacy/state/telehealth-slides.pdf?_ga=1.59862062.284569577.1473623627 or http://www.apa.org/monitor/2012/03/virtual.aspx
34 https://www.oregon.gov/oha/amh/docs/qmha-qmhp-faq.pdf

SUMMARY OF PROPOSALS

1. The OAD Mental Health Task Force first recommends that the state of Oregon establish a statewide Mental Health Coordinator for the Deaf. The safety and security of Oregon's citizens require that mental health services be provided across a continuum of care. The creation of this position will allow a means by which Deaf consumers can be identified and tracked to ensure that they are in the least restrictive environment and that they have access to culturally and linguistically appropriate services[35]. This position will ensure that Deaf Oregonians are given access to the same services offered to other mental health consumers and that their experiences are captured in the data collected for with the Oregon Performance Plan[36].

2. The OAD Mental Health Task Force also recommends that the statewide Mental Health Coordinator for the Deaf position be funded and provided by the Oregon Health Authority (OHA) under the Addictions and Mental Health Division (AMH). The Mental Health Coordinator for the Deaf shall follow the objectives outlined by the National Association of the Deaf (NAD)[37] on its website:

   > *The creation of a state mental health coordinator position within the State Mental Health Authority to establish and conserve the mental health continuum serving deaf consumers would be a key first step in developing those services (Gournaris, Hamerdinger & Williams, 2013)[38]. While it is not mandatory for this position to be within the State Mental Health Authority, as emphasized by these authors, working within the state system gives the coordinators a stronger position in defining optimal mental health services for deaf consumers with mental health needs living in their home states.*
   >
   > *The presence of a state mental health coordinator also provides the necessary visibility and an institutional presence within the state system that cannot be replicated by a non-state agency serving a smaller target population or a regional area (Gournaris, Hamerdinger & Williams, 2013). Again, whether the state provides the clinical services directly or develops contracts with providers in the private sector for service delivery, the statutory responsibility for mental health services in the public sector rests with the state. Employment within a state agency also gives the coordinators the authority to develop policies, procedures, and*

35 http://www.oregon.gov/oha/bhp/Pages/Oregon-Performance-Plan.aspx

36 https://www.oregon.gov/oha/bhp/Pages/Oregon-Performance-Plan.aspx

37 http://nad.org/issues/health-care/mental-health-coordinators/position-statement

38 Gournaris, M. J., Hamerdinger, S., & Williams, R.C. (2013). Creating a Culturally Affirmative Continuum of Mental Health Services: The Experiences of Three States. In N. Glickman (Ed.), Deaf Mental Health Care (pp.138-180). New York, NY: Routledge.

guidelines for serving deaf consumers, setting a statewide standard of care, as well as maintaining control in distributing grants as appropriate to private mental health agencies who meet these standards. It is also very important for the coordinators to be optimally placed within organizational hierarchy where these positions will have the authority to implement and manage a statewide system of mental health care for deaf consumers versus merely serving as consultants or subject matter experts.

The NAD wants to stress that that a coordinator must not be selected to assume the limited role of only providing resources, consultation, and technical assistance to mental health service providers. A state coordinator must be given the necessary authority to provide the necessary comprehensive programming and services as indicated earlier in this paper. The NAD encourages states to give the state mental health coordinators greater policy and fiscal authority in setting up and administering statewide mental health services for deaf consumers, defining the standards of care, and creating contracts or grants for private providers. It is also imperative that this position is not created as "window dressing" to appease the deaf community and their stakeholders, but part of a genuine effort to either establish or improve the statewide mental health delivery system for deaf consumers (Gournaris, Hamerdinger, & Williams, 2013). The wrong person in such an important role can easily disrupt the efforts to set up a true statewide mental health continuum.

Supervision: If feasible within the state mental health delivery system, the NAD recommends direct supervision authority is given to the state mental health coordinator ensuring culturally affirmative mental health services are delivered by trained staff and clinicians. As an alternative, shared supervision authority provided by both clinical directors within the local mental health centers and the state coordinator can be considered.

Outcomes Data: Once the statewide mental health service delivery system is in place, the state mental health coordinator should have the authority to gather clinical and programmatic outcomes data in order to demonstrate the effectiveness of the linguistically appropriate and culturally affirmative mental health services in their state. The absence of good outcomes data will make advocacy efforts much more difficult. Solid outcomes data will help strengthen the state mental health coordinators' conclusions about best treatment practices with deaf people and champion the

existence of specialized and culturally affirmative mental health services in their home states.

In conclusion, the NAD wishes to underscore that a state mental health coordinator must be selected based on specific criteria as listed above as well as giving this position with appropriate policy and fiscal authority to make positive changes within the state mental health delivery system for deaf consumers. The NAD strongly believes that deaf people have a fundamental right to access culturally affirmative and linguistically accessible mental health services in their home states. To make this a reality, deaf communities, state associations, and state commissions for deaf and hard of hearing people throughout the country should continually educate state legislators about the unique mental health needs of deaf people. State legislators may be more likely to support the creation of a state mental health coordinator position within the State Mental Health Authority if apprised that the provision of statewide mental health services will enable deaf individuals to become productive citizens.

3. The OAD Mental Health Task Force also recommends that the Oregon State Legislature authorize AMH to develop emergency "Policy Option Packages (POP)[39]" to develop state-agency contracts for immediate referrals, placements, and services that Deaf clients and patients urgently need.

4. With these specialized mental health services in such short supply, the OAD Mental Health Task Force recommends the number of licensed mental health professionals and providers who are Deaf (or who know ASL) should be increased. Therefore, an expedited comprehensive planning and placement process is necessary.

5. The OAD Mental Health Task Force recommends that all Deaf mental health professionals who wish to offer telehealth mental health services be required to take Distance Credentialing Counselor (DCC)[40] training workshops offered by either the National Certified Counselor Board (NBCC) or private providers[41] that are certified by NBCC to offer DCC training workshops. This is also referenced in the Oregon Administrative Rules[42] (OAR) on telehealth services for Licensed Professional Counselors. It would be good to incorporate the requirements of taking DCC to all disciplines as well.

39 https://www.oregon.gov/oha/Budget20132015/POP%20405%20-%20OEI%20Health%20Equity.pdf

40 http://www.cce-global.org/dcc

41 http://www.cce-global.org/Credentialing/DCC/Training

42 http://arcweb.sos.state.or.us/pages/rules/oars_800/oar_833/833_090.html

6. While acknowledging that current Federal regulations under Medicare insurance programs prohibit using coverage to offer telehealth mental health services[43], the OAD Task Force urges the US Congress to revise current federal statutes, permitting Medicare programs to be able to use telehealth mental health services[44]. In fact, the US Congress is considering such revisions currently[45]. The Task Force suggests that the Oregon State Legislature introduce a Senate (or House) resolution[46] and urges the US Congress to reconsider Medicare revisions.

7. In order to be certified health care interpreters by OHA[47], the OAD Mental Health Task Force also recommends that OHA provide mental health training opportunities for interpreters who wish to work with patients who have mental health issues. An example is the mental health training program called the Alabama Mental Health Interpreter Training Project (MHIT)[48]. Similar training program offered by MHIT could be created locally and should be recognized by OHA as approved training providers.

8. Additionally, the OAD Mental Health Task Force encourages OHA to provide peer support specialist training opportunities for Deaf and hard of hearing populations[49]. OHA also could add approved peer support training providers that work with Deaf and hard of hearing individuals with mental health issues[50].

9. The OAD Mental Health Task Force would like to add to the recommendation that a comprehensive system of care be established to meet the needs of a wide range of Deaf and hard of hearing individuals, beginning with the first detection of a mental or emotional disorder. The components of the proposed system of care includes the following:

    a. **State Personnel employed by AMH**: A Statewide Deaf Mental Health Coordinator, Licensed Psychologists (evaluators), Certified Peer Support Specialists, an Administrative Assistant, and support staff sufficient to attend to administrative tasks.

43 https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-realizing-the-potential-of-telehealth.pdf

44 http://mhealthintelligence.com/news/making-telehealth-a-priority-congress-mulls-changes-to-medicare

45 http://src.bna.com/bEV

46 https://www.oregonlegislature.gov/lc/PDFs/form-stylemanual.pdf or http://www.oregon.gov/osp/sfm/docs/legglossary.pdf

47 https://www.oregon.gov/oha/oei/Documents/2015-3-6_SIMPLIFIED%20HCI%20Requirements.pdf

48 http://www.mhit.org/

49 https://www.oregon.gov/oha/amh/pd/Pages/training.aspx

50 https://www.oregon.gov/oha/amh/pd/Pages/approved-training.aspx

b. **Diagnosis Intake Management**: Licensed Mental Health Professionals (on contract) will receive all referrals from PCPs for mental health services for Deaf and hard of hearing individuals.

c. Intervention Management:

i. **K-12 Mental Health Services for Deaf students**: The OAD Task Force recommends that school districts and the Oregon School for the Deaf (OSD) are required to contact AMH for mental health service referrals as needed.

ii. **Corrections:** Correctional programs should accommodate Deaf and hard of hearing inmates with mental health services by providing Deaf licensed therapists (or those who know ASL) to be available.

iii. **Emergency First Responders:** AMH should provide staff to agencies such as the Department of Public Safety Standards and Training (DPSST) and OHA, Emergency Management Services (EMS), and the Trauma Program in order to train all emergency first responders to deal with Deaf and hard of hearing individuals with potential mental health issues.

d. **Outpatient Management:** AMH should maintain a statewide mental health services directory for referrals. In the event of an emergency or when Deaf therapists are not available, ASL interpreters who are qualified[51] to interpret in mental health settings should be provided. This directory should include listings for:

i. **ASL Interpreters**
ii. **Private Practice Providers**
iii. **Contracted State Mental Health Providers**
iv. **Agencies, Services, and Programs that offer mental health services**
v. **Non-profit organizations that offer mental health services**
vi. **For-profit organizations that offer mental health services**

e. **Inpatient Management:** It is recommended that an inpatient psychiatric unit be established at Oregon State Hospital to provide specialized services to Deaf and hard of hearing individuals civilly or forensically committed and that admission be permitted directly from emergency departments with no requirement of placement in an acute care hospital unit. AMH staff should

51 https://www.ada.gov/effective-comm.htm

collaborate with state mental hospitals, community inpatient psychiatric wards, and correctional institutions to communicate current rosters of state-contracted mental health professionals who are available to work with Deaf and hard of hearing populations. Also, qualified ASL interpreters (or Video Relay Service providers) who work on contract are required to be available for those who are hospitalized or institutionalized, as needed.

f. **AMH Deaf and Hard of Hearing Advisory Committee:** An advisory committee should be established make recommendations to OHA and state lawmakers on how to improve the quality of Deaf and hard of hearing mental health services statewide.

10. Finally, the OAD Mental Health Task Force recommends that all of the above items become legislative concepts for state lawmakers to consider, and move that such recommendations be passed. In summary, the Task Force recommends several legislative proposals, primarily a new unit of Deaf and Hard of Hearing Mental Health Services within AMH to deliver a complete continuum of mental health care for Deaf and hard of hearing Oregonians.

CONCLUSION

Deaf mental health services must be determined, and based on, the demands for such services, not by bureaucratic requirements. The majority of Deaf and hard of hearing consumers suffer restricted access to effective communication and an inability to obtain the highest quality services they can receive from state, county, and private agencies. The mental health system needs immediate help assisting Deaf and hard of hearing consumers obtain the needed services to begin and maintain their recovery.

The proposals of the OAD Mental Health Task Force are potential solutions that can be enacted by legislators and state policymakers, largely within the current structure of Oregon's mental health system. We encourage lawmakers to consider these recommendations to increase the number of linguistically and culturally competent mental health professionals and generalist mental health professionals who know how to use ASL interpreters properly.

Finally, the OAD Mental Health Task Force acknowledges that the recommendations put forth in this report do not come without a price. We ask that in considering this, readers note that research with individuals who are not Deaf or hard of hearing has consistently demonstrated that treating mental illnesses at its initial manifestation or as soon as possible thereafter leads to decreased mortality and substantial long-term cost savings. There is no reason to believe that the results would be any less with Deaf and hard of hearing individuals, and it may actually be greater. Most importantly, Deaf and hard of hearing Oregonians will be afforded equal access to appropriate mental health services.

Respectfully submitted,

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Proposed Comprehensive Deaf Mental Health System of Care