> Some difficulty in getting interpreters for meetings, although MCDHH came through at the end. Some difficulty in getting therapist/counselors/ physicians that can work with Deaf MR clients. Difficulty in locating resources and funding for resources for special devices, i.e., fire alarm, doorbell flashers etc. for people not living in residential programs."
>
> [Staff] need skill at adapting existing environment to not further segregate and isolate deaf from rest of community.
>
> Staff at Area Office not able to use sign language.
>
> Non-professional staff do not readily use sign language--even after training and monitoring by speech and hearing staff.
>
> Access to staff who can sign; access to money to insure existing staff are trained in signing; access to psychologist and other specialists to evaluate.
>
> Lack of staff trained in alternative communication modes.
>
> Lack of knowledge of sign language by direct care staff.

The social needs of deaf clients were also of concern:

> Lack of social resources for deaf clients.
>
> Locating appropriate peers for deaf and hard of hearing clients (especially the deaf) [is a problem].

Equipment and training seemed to be lacking, according to one respondent:

> Our vendors provide their own specific services and our clients are placed as best as possible to serve their individual needs, but in no way are we doing the most we can as we do not have the best adaptive equipment or understanding needed to complete the service needs of the deaf and hard of hearing.

Several new programs to meet some of these needs were reported: a new four person staffed apartment for the hearing impaired; a community residential and day program

for individuals who are deaf or hard of hearing and blind [in planning]. But many respondents were interested in further help from MCDHH:

> It would be helpful if the MCDHH could act as a consultant/resource for information such as physicians/psychiatrists/counselors that can communicate with deaf/hard of hearing. Also in terms of sources of funds, for devices for deaf/hard of hearing that live alone. It is also helpful to know of specialized recreation resources for deaf MR or the deaf community at large.
>
> While we [DMR] would expect to retain primary responsibility for service coordination, access to specialist consultants through MCDHH would enhance our effectiveness.
>
> Social, recreation opportunities are limited and should be expanded.
>
> Technical assistance, consultation, evaluation service for deaf MR clients. Training for families with deaf MR family members living at home.

Training and information was a focus for some:

> [MCDHH should provide] perhaps more information on the deaf culture, general information on available resources.
>
> Training staff to train clients to use adaptive equipment.... Ongoing in-service training on communication and rehabilitative services to deaf and/or hard of hearing mentally retarded clients.
>
> All of the previously mentioned staff training including program development, resource accessibility and communication aides to assist in better serving and understanding client needs.

But in the opinion of two respondents, the low incidence of hearing disabilities made the need for such changes less urgent:

> The incidence is small and for the most part, working with mentally retarded individuals who are deaf or hearing impaired has not posed any major problems. We are aware of some of the services identified in the survey and access them when needed. We would however be interested in learning about any resources relevant to working

> with mentally retarded individuals who are dear or hearing impaired.
>
> If our deaf and hard of hearing population were to increase then MCDHH could be of great assistance to us.

And at least one respondent emphasized that DMR staff themselves, not MCDHH staff, should retain responsibility for service provision:

> Training should be provided to DMR staff who are familiar with mental retardation.

c. Department of Mental Health

The average level of interest expressed by DMH respondents in technical assistance or services was greatest, almost "definite," for interpreter referral and information materials. Other areas in which DMH respondents expressed an average of "some" interest were payment for interpreter service, in-service training, client assistance through consultation, advocacy or case management, independent living skills training and consultation on development of specialized policies/programs.

Several DMH respondents provided specific comments on the ability of particular DMH programs to serve the deaf and hard of hearing. The most extensive efforts occur at the Westboro State Hospital:

> [The] Specialized Mental Health Unit for Deaf People...has a full staff of specialized staff who have ongoing training in deafness, sign language and mental health. Capacity of 10 patients, age 18 and up (no upper limit but must be medically stable since we are not a medical hospital). Client must be dangerous to self or others, or unable to care for self by reason of mental illness in order to commit to a locked hospital unit and take away their civil rights. Should be able to benefit from a signing environment for treatment. Can stay on Mental Health Unit for Deaf People up to 90 days for evaluation, stabilization and transition to appropriate long term placement.

Other deaf DMH clients were served on an individual basis:

> Currently three deaf consumers being served within local residential programs. Not specific contracts solely for deaf; services built around individual needs.

> Typically, patients with hearing impairments who reside at this facility are elderly and experiencing concurrent medical problems associated with the aging process. Whenever the treatment team identifies a patient with an impairment that can possibly be expected to respond to an intervention, that service is obtained.
>
> Through one of our vendors we contract for interpreter services for one client.
>
> One state block psychologist reserved for clinician to work with deaf assigned to vendor; one state contract position for clinical services and outreach. Both individuals are clinicians who sign and are trained to work with the deaf.

Several problems in serving deaf clients were reported in DMH programs. One DMH vendor reported no special facilities for the hearing disabled in case management, residential, day treatment or outpatient programs. Another identified a

> Lack of appropriate programs or services for deaf-mentally ill; lack of financial resources to develop or purchase services for deaf-mentally ill.

One respondent reported that their case managers were trained in ASL and deafness, TDDs, and amplifiers, but there appeared to be a "lack of discharge options appropriate for deaf clients." Others remarked on the placement problem:

> Case management and timely transition back to appropriate environment has been the most difficult and frustrating due to lack of community resources.
>
> Lack of appropriate referrals for ongoing outpatient care in the area [is a problem].

The problem of placement extended to the need for quarter-way houses on hospital grounds:

> Many deaf clients need this transitional housing service. They are ready to leave the locked hospital unit but not yet ready for the community. DMH Central Office has no funding for this service yet and it is desperately needed.

The consequences of limited placement opportunities included inappropriate continuances of hospitalization:

> Clients improve and are stuck in hospital or forced to transition to hearing residences due to lack of resources. Many residences in process but need is identified at least 2 years before new program opens. Deaf unit was only 40% funded by Central Office. [The associated hospital] has given disproportionately of their resources to a statewide unit. When new resources are needed (specialized staff or supplies), difficult for the hospital to give more money....

Other respondents reported a different type of problem in residential settings:

> Need for social/recreational outlets. Our clients don't necessarily "blend" well into existing deaf clubs, given 'behavioral' differences.
>
> Very hard to find opportunities for the deaf client to socialize with other deaf persons.

Vocational rehabilitation counselors were trained in American Sign Language, but two difficulties with deaf clients were reported in employment-related DMH programs by one respondent:

> 1) Hard to train staff in many levels of pre-vocational and workshops in ongoing way re deafness.
>
> 2) Interpreters needed rarely and intermittently in different locations; interpreter there full time is not utilized much; clients often don't have skills, confidence or resources to tell staff when they need an interpreter.

Group therapy with deaf clients was difficult, since it was,

> difficult to engage clients or recruit adequate numbers to make group viable option.

Child and Adolescent Services at DMH received consultation on younger deaf clients from its Deaf Unit for adults. Two problems were reported:

> 1) Depending on maturity level, deaf clients 18-22 years old can have trouble benefitting from adult deaf unit.
>
> 2) Deaf teens on adolescent unit, even with interpreter, can have trouble in hearing therapy groups.

There were also some problems in serving older clients.

> [The] specialized geriatric unit has many elderly hard of hearing clients and staff who are used to dealing with them from experience but no specially trained staff and no amplifying devices for phone or ALDs. No ongoing training of geriatric staff on how to work with elderly hard of hearing.

Adequate assessment was not always possible:

> No capacity of psychological evaluations/testing by clinicians trained in this area.

> Acute psychiatric diagnoses are our foremost concerns of treatment.

Vendors were not always cooperative:

> Tendency in HMOs to limit/refuse to refer to specialized programs even though the HMO does not have clinicians with expertise in the field of deafness.

Several specific problems were reported with interpreter services:

> 1) Hard to find freelance interpreters on a crisis basis (e.g., new admission at 5pm-10 pm or later);

> 2) Hard to get outside agencies (clinics, hospitals, etc.) to pay us when our interpreters go with clients to medical appointments.

> Access to emergency services after hours only through TDD.

> Time lag in accessing interpreters; paperwork for payment of interpreters cumbersome.

Another respondent focused on the cost of interpreter services:

> Not extensive enough, but more than expensive enough; extensive coverage by interpreters is simply not feasible.

One respondent outside of Boston found that "going through MCDHH in Boston [for interpreter services] is a challenge," while "vendors we contract with are concerned with funding for interpreters."

And signing staff were not always the solution:

> At wages our vendors can pay, it is almost impossible to find signing staff. While many staffers are willing to learn some of the language, communication remains less than optimum.

Training was a problem, according to one respondent:

> Lack of staff trained in deafness and mental health. As new programs open, existing programs experience debilitating turnover and no pool of qualified applicants in the state--need long term training and recruitment to the field.

And, according to another respondent, simply seeking trained personnel would not solve the problem because a "dearth of specialized clinicians impedes hiring."

In contrast, another respondent who had reported few deaf or hard of hearing clients found the need for training to be less immediate:

> Although service systems do not identify difficulties at present, training would be helpful in preparation for anticipated needs.

Some special problems were identified in serving hard of hearing clients:

> Tendency for hard of hearing clients to be isolated, no true sense of community. Therefore, difficult group to reach. With HH clients who have no signing skills, communication often more difficult than with signing deaf clients. No audio loops etc. on the premises nor interpreters who could help with this communication issue.
>
> 1. No access to phone amplification or ALDs.
>
> 2. Mentally ill geriatric clients tend to lose or throw away hearing aids due to their mental illness.
>
> 3. Need specialized training in working with hard of hearing clients--most nurses do not have this special training and many clients have unidentified hearing losses.
>
> Lack of acoustically appropriate environment.
>
> Both of our hard of hearing patients hear well enough to manage with the assistance of a hearing

aid. It is, however, sometimes difficult to identify funding to replace lost hearing aids.

No access to assistive listening devices; lack of outpatient referral sources.

But these types of problems were not experienced at each service site:

Emergency services is the only component that has served deaf. They report no difficulties in serving this population due to easy access to interpreters. As situation presents so infrequently this has not been a problem. Hard of hearing clients have hearing aids and are able to communicate verbally.

The services are not delivered at the same level of effectiveness, but we have been able to serve our one client in whatever services have been appropriate. In fact, this client has made considerable progress and may soon be able to make do with greatly reduced levels of support.

The low frequency of hearing disability seemed to one respondent to impede service development.

Since we have so few deaf/hard of hearing patients we have not developed programs for them as such but have done our best to design appropriate individualized plans. We do not now have the degree of expertise and knowledge necessary, however, to be certain that we are doing all that we can.

Several DMH respondents pointed to some special considerations with DMH clients--stigmatization of mental illness and the need for clinical training to treat the mentally ill:

Concept of 'mental health services' seems new to deaf community--requires much education and outreach to de-stigmatize.

Stigma attached to receiving services in a mental health setting, which discourages clients fromutilizing these services; confidentiality concerns of clients. (This may be addressed by providing more public info and education re mental health issues and services. A collaboration of MCDHH, DMH and MSAD staff may be helpful in considering this problem.)

> Deaf mentally ill clients need DMH expertise and programming to be accessed effectively, rather than setting up a separate system under MCDHH without mental health expertise.
>
> With current [DMH] clientele, it gets confusing with many professionals involved. Real need to work through process re: "who does what, when." Need to keep messages/methods consistent with multi-agency consumers.
>
> Given the limited resources of the Commonwealth, MCDHH should be careful to <u>not</u> duplicate existing services, but should be working with agencies to augment existing programs to accommodate the deaf and hard of hearing.

But some were willing to give the MCDHH a role in providing some services to mentally ill deaf and hard of hearing clients:

> 1. Primarily residential supports to those who are experiencing problems adjusting to adult life/leaving home/having need to live with other deaf adults--independent living skills.
> 2. Local interpreter access/pool--thus creating long-term, stable working relationships.
> 3. Conduct training on a regular, well-publicized basis.
> 4. Increased hands-on case management to work in conjunction with mental health professionals.
>
> I would like assistance in assessing the needs of our patients and providing appropriate services and resources.
>
> 1. Continue/increase involvement in educating the public schools and advocating for improved programs in the schools for deaf and hard of hearing children.
> 2. Have active role in funding and recruitment of qualified professionals to work in specialized programs across the state.
> 3. Great need for research in the area of sex education and development of models.
>
> Orientation to needs for mental health services for deaf; how to do outreach to deaf.
>
> A pool of trained professional personnel who can be called upon to provide needed services on a part time basis.

Outreach efforts were the primary concern of some:

> Our office has had difficulty locating deaf or hard of hearing clients who are either retarded or mentally ill. We have also had difficulty marketing and advertising our services to the deaf community. MCDHH might assist by developing marketing techniques designed to introduce current services to the deaf and hard of hearing. Concurrently they could assist in outreach to the deaf community. A signing outpatient mental health clinicial would be a valuable tool for outreach and service delivery.

Another respondent elaborated on the outreach problem by noting that DMH needed "true access to/assessment of potential consumers" and that it could be difficult to define the clientele for DMH: "Many times needs presented are not mental health related, e.g., housing supports, need for peer contact/recreation, etc.

Several respondents suggested collaborative arrangements with MCDHH.

- family education (i.e., educating families to the realities and possibilities of deafness)
- work (i.e., in addition to the support our transitional employment program offers, other supports from MCDHH might well be helpful)
- social opportunities
- chances to become familiar with deaf culture
- issues of sexuality

> We provide on-going special programs (lectures, panel discussions etc.) as well as on-going clinical work in order to make available opportunities for discussion, debate, social interaction, access to information. MCDHH does this as well and should, we believe, continue to be involved in similar activities.

d. Department of Social Services

There was most interest at DSS in assistance for hearing disabled clients in the form of information materials and consultation, advocacy and case management. Slightly less interest, but still between "definite" and "some" interest, was reported in payment for interpreter services and interpreter referral assistance, assistance in finding specialized services, independent living skillls training and cofunding of specialized programs.

The Hayden School provides services for deaf, emotionally disturbed adolescents and is used by DSS for some children. However, the written comments of several DSS

respondents emphasized the lack of special facilities for deaf and hard of hearing children at DSS and with many vendors.

> Very few if any contracted agencies have any resources to work with the deaf.
>
> None of the contracts we have, have any services or programs for the deaf.
>
> There are few contracted or support programs who [sic] are equipped to meet the needs of the deaf/hard of hearing population.
>
> Therapy - no resources available who sign and have experience with/knowledge of deaf culture.
>
> Without specialized staff (which is not available within the office) and the needed interpreter coverage it is especially difficult to provide services. Additionally we need therapists who sign and are trained in deaf culture to treat the deaf population.

Of ten programs listed by one respondent, some special equipment was reported for hearing disabled children in only one program (foster care), although new special residential programs were expected. Another noted that residential services for emotionally disturbed adolescents or children with hearing problems were often a problem. At one office, a TTY was not available without a trip:

> Inconvenient to have to go to the library to use TTY to contact client.

Making arrangements for an interpreter sometimes created problems, several respondents noted.

> Limited direct communication capacity between the deaf client and the responsible caseworker. The case worker was reliant on an interpreter (i.e. foster parent) to communicate with the deaf child.

For others, the major problem was the lack of interpreters:

> A number of years ago when we had a deaf emotionally disturbed adolescent, we could not find interpreters to communicate with the child. At the same time, there was no placement in Massachusetts for this child or any children.

> Have had one case where we could not locate early childhood program with signing capacity for a four year old.

One respondent identified a lack of information as a key problem in serving deaf clients:

> Problem of not being familiar with special resources for the deaf; problem of not understanding deaf "culture."

What is needed, two respondents noted, is more information:

> If we had a listing of interpreters in the area and the cost of their use, it would be helpful if the need arose in the future.

> We would be interested in talking with someone from MCDHH to get information about possible services available for this population. A better understanding of services and agency purpose would be very welcome.

But some respondents felt that their office had been able to cope quite well with their few deaf or hard of hearing clients:

> Although this area office does not hold contracts specifically for deaf or hearing impaired services, we have been able to access various services (i.e. counseling, specialized foster care, day care, total communication resources, etc.) when needed. The limited number of deaf and hearing impaired clients that have been involved with this agency (3 in two years) precludes contracting for services exclusively for this population, however contracted providers have been responsive to providing services such as those identified above in ways that meet the needs of this client population.

> This agency has purchase agreements with a number of community residential programs which service deaf and hearing impaired children and adolescents. These programs include Hayden, Goodwill and Perkins School, and learning center for the multiply handicapped. We also have purchase agreements with respite care programs for both in-home and out-of-home respite services.

And the low incidence of hearing disability in the DSS population served to limit other potential problems.

> To date we have not yet experienced trying to serve adult D/HH clients. Should this situation arise I would anticipate considerable difficulty at all levels of DSS involvement (i.e. investigation, assessment, ongoing) and service referral.

But, noted another respondent, estimates of the needs of the hearing disabled were suspect.

> Unsure whether clients access services due to lack of planned outreach. Office does not know if there exists a population to outreach.

One respondent concluded that DSS clients with hearing disabilities had fared better than others in some respects:

> Ironically, in some ways these clients have experienced better access to some services. Because of their unique circumstances they have not had to deal with wait lists, etc.. On the other hand certainly some services are more inaccessible because of communication constraints. Again, these conclusions are being drawn from a very small sample.

In spite of diverse opinions about the extent to which serving hearing disabled clients presented problems, respondents offered many suggestions for improving services:

> Services to the deaf should be provided by contracted agencies, under DSS or MCDHH or other state agencies. These contracted agencies should have expertise in sign language, understanding of deaf culture, and a knowledge of other resources for the deaf.

> Access to supports, signing, other communication devices would help. Also we would/could use support in situations that require sensitivity and understanding of a deaf or hard of hearing person's situation.

> Develop a comprehensive network of intepreters; Provide training on deaf culture to staff; Monitor IEPs [educational plans] of hearing impaired children to ensure that the responsible school system meets the child's educational needs.

> [Provide] joint casework services and specialized services (i.e. Foster Care, and Parenting Classes).

> More information on MCDHH and other resources available to deaf and hard of hearing, especially community-based. Shared funding of residential placements and specialized equipment for the deaf and hard of hearing.

e. Executive Office of Elder Affairs

EOEA respondents rated most highly their level of interest in three types of assistance in serving the deaf and hard of hearing: information materials, in-service training and assistance in finding specialized services. EOEA respondents reported more than "some" interest in each of the other types of assistance listed.

Several comments highlighted the uniqueness of the needs of elderly hearing disabled persons.

> Not having enough time to spend with someone who needs encouragement and support as well as assistance in home. Need to work with MCDHH staff more. Safety concerns for people who live alone.

> Once [hard of hearing] clients get a hearing aid they often do not go for follow-up visits to have aid adjusted, cleaned, etc. People are easily frustrated and too apt to give up. Our nurses see poor hygiene particularly for men who use hearing aids--wax buildup which makes it harder for the person to hear and aid to work.

One respondent believed that older clients who have recently lost their hearing have different needs than other persons with hearing problems.

> Most deaf people we see as elders have been deaf since birth or most of their lives so the initial service planning and assistance has been done and people are well adjusted to their disability. Older people who have lost their hearing as a result of aging have different needs and must make different adjustments compared to young people, one would imagine. Technical assistance and support services would be useful to clients. Ways to communicate with clients that might not have been thought of.

Communications with hard of hearing clients were a problem:

> Clients don't always have adaptive devices. It is often difficult to communicate over the telephone.

> Case managers have to speak loud, especially over telephone. Client misinterprets conversations, if not spoken to face-to-face. Television volume is very high in many of our clients' homes.

A number of other problems were identified in providing services to deaf and severely hard of hearing EOEA clients.

> Difficulty providing ombudsman services to population in long term care facilities; difficulty securing volunteers, particularly those fluent in ASL.

> Misunderstanding re service delivery (time, frequency, personnel), services in general, communication with case manager. Concern re safety.

> Direct-service workers, i.e., homemakers, are not usually trained to communicate with deaf clients. Centers or clubs especially for the deaf are limited; transportation is also limited.

But at least one EOEA respondent felt that staff handled communications with the deaf effectively:

> No problems--clients usually write messages; family members are present when needed; case managers face client if they are able to speech read.

Some EOEA respondents highlighted the need for additional training.

> Would like to provide for in-service training for staff on issues relating to hard-of-hearing and special equipment and services available.

> It seems training for in-home workers (homemakers, etc.) would be a service that could be offered to vendor agencies. Also, training a corps of volunteers for Council on Aging friendly visitor programs would be useful. stablishing a contact person for each home care [Elder Affairs worker] at the Commission would make idea sharing easier. Conducting a workshop for home care program staff on assistive devices on a regional basis might be helpful, rather than individual requests.

Other EOEA respondents focused on the need for, and cost of interpreter services.

> Interpreters for special events are needed in order for event to be accessible to all. With a

recent 4.9% cut in our budget, we are unable to cover the cost of interpreter services. We hope that MCDHH will be able to continue assisting the aging network through sharing of specializations and coordinated service delivery.

Other resources from the MCDHH were also of interest:

Provide homecare as well as transportation for those who do not meet our income guidelines. Make available devices that could improve the quality of life for the deaf as well as the hard of hearing--e.g., Volume control on phones and visual alarms.

Provide devices for phones (to give to clients)--hearing augmentation device on payment free/extended loan basis.

We'd be willing to consider the use of a TDD if funding and training were provided.

Information on subsidized equipment for deaf/HH clients, particularly for safety purposes. Summary packet on services available to deaf/hearing impaired clients.

f. Department of Public Health

Almost all respondents from the Department of Public Health expressed "definite" interest in information materials on hearing disability. Interest in in-service training and assistance in finding specialized services was almost as great. On average, DPH respondents expressed "some" interest in interpreter referral assistance, loan of assistive listening devices, client assistance through consultation, advocacy and case management and independent living skills training, consultation on program development and cofunding of specialized programs.

One respondent in the case management unit at a DPH Health Office explained that a local public university provided many relevant support services:

[The university] provides technical assistance, advocacy, information and referral, case coordination for clients 0-18 who are handicapped, chronically ill or have special medical needs. [They could also] provide technical assistance, information and referral, advocacy, case coordination for a family with a deaf or hard of hearing child 0-18, although now we would likely refer to MCDHH. There may be times it would be appropriate to share a case with MCDHH.

Other DPH service delivery sites appeared to have problems in serving the deaf and hard of hearing.

> Lack of a television decoder. Our deaf inaptient was a young woman whose hospital stay would have been enhanced by this device. A TDD would not be useful as the patient would have to pay for phone installation in their room.

Respondents at DPH hospitals reported several problems had been encountered while serving hard of hearing clients:

> Alcohol and drug programs [are] less likely to accept those with severe communication problems as trained staff not available.
>
> Staff cooperation and knowledge regarding hearing aid care and patient management of long term care patients.
>
> [DPH needs] post discharge follow-up on patients and families about recommendations for purchase and use of hearing aids.
>
> In ENT clinic it is sometimes difficult to obtain an audiological test for patients without insurance. In the outpatient department ENT clinic it is difficult to secure hearing tests with hearing aids. Nursing staff frequently become frustrated at the continuity of patient care.

Deaf children with multiple needs encountered inadequate resources, according to another DPH respondent:

> Lack of programs that service children who are deaf with multiple impairments (i.e. autism, severe physical impairments). In program for education, limited to one facility and not all staff apparently are qualified in sign language. No facility to <u>fully</u> evaluate needs of deaf child re physical, psychological, functioning. Lack of special communications equipment and money for interpreters.

Some DPH respondents highlighted needs for additional training:

> a) Special needs of auditorily handicapped;
> b) Basic needs for functional ADL in the hospital setting;
> c) Care and management of the hearing aid.
>
> Audiovisual tapes for staff inservices; update nursing information in audiology.

Other DPH respondents identified other opportunities for assistance from the MCDHH.

> Where deaf and hard of hearing clients need our outpatient services, interpreters and other assistance may be very helpful.
>
> Whatever you may offer for supportive assistance in helping the geriatric patients improve their quality of life.

## Services Sought at Other Agencies

### Commission for the Blind

The MCB encountered several problems in serving deaf clients:

> Resources in the areas of respite care housing, mental health continue to be difficult to access; equipment needs are difficult to assess and define resources; interpreters are difficult to arrange for short term needs. Need to outreach to elderly [hard of hearing] persons with concomitant visual problems.

Needs at the Commission for the Blind varied between specific programs. While the social/recreation and independent living programs had a deaf-blind contact, funding needed to be improved. The employment day program, and the housing and mental health programs were delivered by a variety of vendors; improved training was the major need identified. The MCDHH could also help, one respondent suggested, by cosponsoring programs for deaf clients.

### Office for Children

Respondents from the Office for Children identified some specific problems:

> No area or regional residential (school) program can accommodate this young man, who is deaf, psychotic, very low educational skills and little to no signing skills. Proficiency in ASL is inadequate.
>
> Lack of educational programs for deaf or hard of hearing clients who are also emotionally disturbed.
>
> Different philosophy on education of deaf and hard of hearing can cause conflict with schools and parents.

If the service is needed for a child and there is no funding available and all resources are exhausted, OFC may be able to access IKM money for service.

We have to use parent or other advocate to interpret needs of client.

Foreign language and sign interpreters and psychological/educational testers (i.e. needed someone who could communicate in Russian and sign)--also someone who could do accurate educational testing in Russian and in combination Spanish/English/sign.

Office for Children respondents suggested that several services from MCDHH would be particularly useful; training was the service most frequently cited:

1. Camping services.
2. Respite services--it is hard to find respite providers who sign.
3. Training for staff who wish to understand the population better.

Training comprised of: identification of needs/profiles; services assessed/what kind, amount; resources available/entitlements; interagency cooperation. The training would be beneficial statewide; if not possible than regional training should be considered.

Training and technical assistance could be valuable to OFC staff. Area case management would be valuable to clients.

Case management; interpreter on as needed basis.

Technical assistance in interpreting; referral for specialized testing, especially in other languages; training.

Some respondents identified a role for the MCDHH in terms of educational issues:

[We] need monitoring of the educational plans of hearing impaired children to ensure that the responsible school system meets the child's educational needs.

Finding consultants for educational purposes; psychotherapy for hard of hearing and deaf clients.

> Assistance in educational advocacy, especially in the area of program evaluation.

Greater knowledge about the target population was the most important need identified by one respondent.

> Develop methods for my office to survey the areas deaf and hard of hearing children population and their service needs.

One respondent noted that the MCDHH had already been providing valuable services:

> MCDHH has been very helpful in lending support when this office is advocating for any client. Most clients would be shared and agencies would share responsibilities.

Department of Corrections and Parole Board

Respondents from the Department of Corrections reported few hearing disabled clients; they also observed few problems in serving these clients when they did appear.

> At present, there are no deaf inmates housed at [the correctional center]. In my experience in Corrections, I have only seen one deaf inmate; this encompasses ten years in the Department. If the MCDHH is needed, it would be a rare occurrrnce.... However...I feel it is important as citizens of the Commonwealth that we have knowledge of the needs and characteristics of deaf and hard of hearing persons.

> To date all [deaf] clients have been able to communicate by reading lips. No clients have required sign language. All hard of hearing clients have been provided with hearing aids, no communication problems exist.

> Two years ago, we had a patient who was deaf--issues of competency to stand trial/criminal responsibility. Then we had an interpreter, our staff worked with him (no special training).

> We have had only one hard of hearing client and we did not experience any problems with him in terms of service or programs.

Nonetheless, problems did develop when deaf or hard of hearing persons needed some services at some instituions.

> No interpreter always available (mostly for forensic issues); no clinician's knowledge [sic]

> of sign language and/or deaf/HOH services; no services or training.

And one respondent noted that the impressions of staff about hearing problems among their clients may not be accurate:

> [We] service developmentally disabled/mentally retarded parolees who often have physical, emotional or substance abuse problems. It is unknown how many parolees are deaf or hard of hearing but we need help, first in identifying and recognizing the number who may be hard of hearing or deaf. Then compiling the statistics and obtaining resources as necessary.

Several suggestions were made for support services from the MCDHH:

> Because of our infrequent dealings with the deaf and hard of hearing, our office does need training in this area.
>
> Providing funding for additional vocational programming upon release from institution, to include halfway houses geared for Deaf/HOH clients with felony and substance abuse records. Four of five of our clients have significant substance abuse issues, directly related to their criminal histories.
>
> Survey of our institution for the possible services; training/awareness to our clinical staff.
>
> General information regarding referrals.

Other respondents who had no experience with deaf inmates realized the need for having MCDHH resources available.

> If and/or when we have deaf or hard of hearing clients it would be extremely helpful to us to have MCDHH services available. It is difficult to specify services needed at this time due to a lack of experience in dealing with same.

And in the opinion of one respondent, it is an auspicious time to make improvements to increase the accessibility of DOC services to the hearing disabled.

> With new construction and renovations going on throughout corrections, it would appear now is the

time to install many of the "mechanical" devices in new buildings or renovations.

Department of Public Welfare

The Department of Public Welfare will pay for interpreters for clients if no such service is available from other agencies, one DPW respondent noted. However, this respondent also reported that contractors in the Education and Training program do not serve deaf clients.

DPW respondents at different offices provided contrasting views of their office's success in serving deaf or hard of hearing clients. Some identfied multiple problems in serving deaf and hard of hearing clients:

> Requires lengthy interview to communicate. Communication is usually written, misunderstandings are possible. Difficulty coping with deaf children. Communication is by charade; very time consuming. Telephone communications [are a problem] as most clients do not have TTY equipment.
>
> Interview [with hard of hearing] takes longer because of difficult communication which is written and verbal. Misunderstandings are possible. But in all instances services have been appropriately provided.
>
> Inability to effectively use telephones as a form of communication.
>
> Difficulty in payment of voucher for interpreter (has been resolved).
>
> We have a borrowed TDD but have had problems getting it operational.
>
> Knowing in advance that a client is deaf so that appropriate accommodations can be made [has been a problem].

Two respondents believed that service provision had been adequate:

> We have so few deaf or hard of hearing clients that this had not been a big problem. Most of the severely hearing impaired are probably on SSI and served by the Social Security Administration. We currently have only one client who must use sign language to communicate and he brings his own interpreter, usually one of his children. Our hard-of-hearing clients are able to communicate

without too much difficulty, and since most of them are on Medical Assistance only, they transact most of their business with us by mail.

We have not had major problems in servicing our deaf/hard of hearing population.

Suggestions for services that the MCDHH could provide or assist in providing focused on information and referral, interpreting services and training. Comments about the need for help with interpreting services were brief:

Provision of interpreting services as needed.

Provide signing services to state agencies.

Providing paid interpreters.

We would need the supports, devices and training to know how to deal with these problems.

Five respondents highlighted training needs:

Occasional training for staff on how to communicate with a deaf person when an interpreter is unavailable. This should be much less than signing but perhaps a simple basic communication technique that would enable a social worker to establish an appointment for the client when an interpreter is available.

Providing "awareness" training to our staff would probably be most beneficial in delivering services to our deaf and hard of hearing population.

Training in sign language in case need arises.

Training staff in work with the hard of hearing/deaf client.

Two DPW respondents sought information and referral assistance from the MCDHH and one suggested that MCDHH staff could accompany deaf clients to the (DPW) office and assist deaf clients in locating housing.

But one respondent did not believe that any assistance was necessary.

We only have an occasional applicant/client. They usually have someone with them to assist. Otherwise it means using paper and pencil or having them return with someone to assist. We have been able to assist the occasional client who has come in with no problem. We have not had an

applicant during the last year and have no deaf person on the roles.

Board of Regents

Several Massachusetts colleges and universities identified special services provided for deaf students. Tutoring, interpreting, notetaking, adaptive equipment and general counseling were mentioned by one respondent; independent living assistance, a Gallaudet University Regional Center and assistance in paying for specialized support services from the Mass. Rehabilitation Commission were mentioned by another. Another explained that "sign interpreters are hired for any program offered to employees, also for individual meetings and functions."

But even where these services were provided, problems arose in serving the hearing disabled.

> MASS REHAB has funded at least one signer for a deaf student in the Continuing Education Division. The student was not successful in carrying out her objectives. The problems are FUNDING, need of specialized signers on the Community College level, earlier decisions to come to College so that proper arrangements can be made.

> Retention of students [is a problem]--many leave because the academic standards are difficult for the deaf students; additional assistance for students after completion of English as a second language classes; recruiting deaf students who have the proper educational level to be successful in a university setting.

> Availability of qualified interpreters; procurement of funding for full time interpreter services; difficulty in obtaining specialized counseling services.

Problems in serving deaf students were more basic in those schools with few special services for them:

> FUNDING for signers and other expert staff to work in the area. Without the MONIES we can't really do anything for the deaf client if they choose to join our student body. Getting information about and funding the purchases of modern electronic equipment. Earlier decision making on the part of the deaf client to go to college. This should definitely be done in connection with the client's school of origination.

> Our college has limited "vocational" course offerings; funding prohibits the establishment of a college preparatory program for the deaf at night; we are still encountering problems in locating housing for some of our students because NILP has cut back their hours on campus; a visual fire alarm system is on order; curriculum modification not in place for all majors (For example, the adaptation of the Nursing program for hearing impaired students would require extensive adjustments within the program.
>
> Lack of funds for interpreters; lack of state funds for assistive equipment; deaf students wish to enroll at school with deaf community.
>
> Lack of training to work with deaf or hearing impaired and lack of awareness of tools available; no staff members who know signing; absence of staff support for dealing with issues other than crisis-related.
>
> Lack of central budget funds for services; advocate perceptions that agency has resources which it does not; advocate beliefs that a small agency can provide services at the same level that a large one can.
>
> Too few available interpreters; too much time to render eligible for Mass. Rehab Services; lack of sign language trained personnel/knowledge.

Several respondents focused on the need for more interpreters; one found the MCDHH interpreter service inadequate, another noted problems with faculty awareness of the needs of deaf students:

> Securing regular, dependable interpreters for students with full class load; assuring problem-free payment for interpreter services.
>
> Faster, more consistent and reliable scheduling of interpreters for deaf students. There have been instances when no interpreter was available for students during first week of classes, and other instances when interpreters have not met their appointments with students (though only occasionally, this is usually unnerving for the deaf student and student's instructor). Finally, it would help if deaf students had <u>one</u>, or as close to that as possible, interpreter for a particular class/time slot--that is, consistency. I should add that I am aware that interpreters are in short supply in Western Mass. and understand

the Commission's difficulty in supplying interpreters.

There is sometimes a problem providing accurate, detailed transfer of lecture material to the student. There has also been some difficulty getting faculty to understand that tests must often be signed/interpreted for their deaf students. This, of course, includes some confusion on the part of certain faculty members about the role of the interpreter in the classroom. All of this can to some degree undermine the quality of education the deaf student is receiving.

Unique problems in serving hard of hearing students were highlighted by several college/university respondents.

No adaptive listening devices in classrooms. Our one hard of hearing student who has identified herself is only now learning to speech read. Her hearing came and went and when it went, we had to communicate on paper. We did set her up with an audiologist at the Deaf School and she has been learning speech reading since last fall.

Having tape recorders in the classroom [is a problem].

Equipment budget does not cover repair of assistive listening devices.

Declaring handicap--most hard of hearing clients don't want to admit it for various reasons. They prefer to try things on their own, make their own arrangements in the individual classroom, accept no help. Late decisions--many hard of hearing clients, for a variety of reasons, don't make the decision to come to college until the last minute. If we had more TIME, we might be able to service them better. Funding for at least one very knowledgeable professional in the area. All of our budgets have either been cut or required to finance more costly projects. So unless the potential student is currently a client of some of the agencies they are not eligible for help. Many are not.

Students have multiple issues--academically underprepared, adult returning students, economically disadvantaged. Students do not self-declare--wish to "pass" as "temporarily able-bodied," are not always detected until in academic

trouble. Specialized training for all areas of College would be helpful.

Lack of oral/certified interpreters; difficulty in identifying hard of hearing employees on campus; lack of ALDs.

Respondents at some colleges and universities identified services that they currently provided but that the MCDHH should take over:

Co-funding of interpretive services would be helpful; career development services and information; free signing instruction workshops/classes.

Hard of hearing support groups; case management; training on available ALDs.

Advocacy training; independent living skills.

Most college/university respondents sought some type of support services from the MCDHH.

Contract services for Independent Living Skills and Assistance; improved programming and services at high school level; advocate for increased budget to support our efforts to serve hearing impaired students.

We could use a lot of help in expanding the services that we already offer. This takes FUNDING. Interpreters and signers on a part-time basis is a very insurmountable obstacle. This takes not only FUNDING but the obvious availability of such experts. Getting more information to us about what is available [would help]; how does one secure the services--the need of working closer together on behalf of the deaf or hard of hearing client.

Technical training and support to staff would be very helpful. Coordination of support and advocacy services would help too. For the uninitiated, the plethora of advocates and aencies is confusing.

Basic adult education--incoming students register and complege English as a second language classes. Often, they need more assistance during and after these courses.

Keeping open line of established communication and referral services. It would be extremely helpful

> to have a contact who could deal directly with this institution to assist in answering questions we may have regarding available services and procedures for obtaining assistance.
>
> Funding for and referral to appropriate qualified interpreters; faculty in-service training.
>
> We would like to have some awareness workshops given to our faculty. We would like to be able to offer serices and accommodate any special needs of our deaf/hard of hearing students and staff. [We] are beginning to put together programs and services for all handicapped students, including the hearing impaired. I hope your office [MCDHH] can help us develop a more comprehensive program for the hearing impaired on our campus.
>
> More vocational assistance; more workshops and written materials that can be disseminated to faculty; access to special equipment on a loan basis; instruction in use of equipment.

Department of Youth Services

Due to the low frequency of deaf or hard of hearing youth encountered at DYS offices, some respondents felt that assistance from MCDHH was not needed.

> [This] program is a detention program for violent juvenile offenders. In my experience with the program over the past five years, there has not been one situation where a deaf or hard of hearing person was referred to us. Should a serious crime by hard of hearing or deaf juveniles become statistically significant, then we would explore all resources available to us.
>
> At this time I think some written material would be beneficial. I do not believe any in-house training would be appropriate at this time.

But several DYS respondents emphasized their willingness to improve their readiness to serve hearing disabled youth:

> Should the need arise a number of difficulties would present themselves. Not having had the need we would be at a great disadvantage in handling the situation which would result in an inability to deliver necessary services. Should the situation occur we would need total assistance if the resident's stay were to be successful [ranging from assistance in] identification of proper

listening devices to in-service training for staff]..

A resource list for information/services would be helpful in case we ever do receive a deaf or hard of hearing client. We would then would be interested in whatever program modifications would be needed to serve such a client in this short-term setting. Specific needs might include: basic communication guidelines for staff, teacher assistance, interpreter availability to assist with psychological assessment process.

I have been in the Youth Services field now for 15 years and during this tenure I have yet to have a deaf or hard of hearing child referred to any program I have directed for services. I think this kind of child in our particular environment would be exploited by his/her peers. The courts must realize this as well and also realize that we are not equipped to deal with this problem since I have never heard any of my compatriots discussing a court referral of this nature. Certainly if we did receive a deaf or hard of hearing referral, we would be looking for the highest degree of support and training we could receive from your agency so that the needs of the referral client would satisfactorily be met.

Summary

Experience with deaf and hard of hearing clients differed markedly between the 13 agencies surveyed, as did the availability of special service and communication accessibility arrangements for the deaf and hard of hearing and interest in enhancing these arrangements. The Massachusetts Rehabilitation Commission and the Commission for the Blind, both with special programs and specialized staff for deaf clients, reported particularly high levels of experience with hearing disabilities; these two commissions with special staffing also tended to have more equipment and to make more efforts of other types for the hearing disabled than other agencies. At the other extreme, five agencies reported relatively little experience with deaf and hard of hearing clients, offered little special equipment or staff, and made little use of MCDHH or other resources for the deaf and hard of hearing: the Departments of Corrections, Youth Services, and Public Welfare, the Office for Children, and the Parole Board.

Mass. Commission for the Blind. MCB offices had small numbers of staff, a few who were deaf or hard of hearing, and relatively large caseloads. Deaf clients were very common; hard of hearing clients were not. Overall, one in

every five clients were hearing disabled; these clients were seen most often in case management and advocacy programs, somewhat less in social rehabilitation and counseling.

MCB received high scores in provision of special equipment, specialized staff, the use of MCDHH and other efforts for the deaf and hard of hearing. The training in hearing disability-related issues reported by MCB respondents was the third most extensive among the agencies surveyed; MCB respondents perceived relatively little need for more such training. MCB respondents were somewhat more likely to report that their deaf clients were served more poorly than other clients, compared to other agencies, but did not express a high interest in assistance as a solution for this. Some MCB respondents highlighted various resource inadequacies and the need for more training of the vendors used by MCB.

Office for Children. OFC offices were very small, with high caseloads concentrated in information/referral and advocacy. There were almost no hearing disabled staff and very few deaf or hard of hearing clients, although some sites reported hard of hearing clients in their advocacy program. OFC had little special equipment or specialized staff and rarely used the MCDHH or made other efforts, including staff training, for hearing disabled clients. However, OFC representatives expressed a high level of interest in training about hearing disability and in support services available from the MCDHH. Their comments highlighted inadequate educational opportunities for deaf children and indicated openness to MCDHH assistance with this problem.

Department of Corrections. DOC service delivery sites tended to have many staff and a large number of clients. Almost no staff were deaf or hard of hearing. There were very few deaf or hard of hearing clients reported (less than an average of one per site); only the health service at one site had reported more than one hard of hearing person, on average, in FY 1986 and 1987. DOC had little special equipment for deaf or hard of hearing clients and almost no specialized staff; respondents were not aware of their sites ever using the MCDHH and other efforts for the deaf and hard of hearing were very rare. DOC respondents reported almost no training about hearing disabilities; they tended not to be interested in such training or in other forms of assistance with the hearing disabled.

Elder Affairs. Elder Affairs offices were of modest size, with some hard of hearing and no deaf staff. Services were delivered primarily through vendors; the number of clients per office was large, though case loads were moderate in size. EOEA offices reported many hard of hearing clients and had the third largest number of deaf clients of all the

agencies; most hearing disabled clients were in the large EOEA programs.

Efforts made by EOEA for the hearing disabled were moderate in terms of equipment, specialized staff, training and other efforts. Overall, EOEA representatives expressed a moderate interest in assistance, most frequently in terms of information materials, training, and assistance in finding specialized services. In written comments, some pointed out special difficulties with the elderly hard of hearing--primarily inadequate attention to hearing aids--and with adjustment problems of the elderly deaf who acquired their deafness in later adult years. The need for training and for help with interpreters and special equipment from the MCDHH was emphasized.

Department of Public Health. DPH service delivery sites tended to have a large number of staff; no deaf staff were reported, but some staff were hard of hearing. Caseloads were small, although the total number of clients per site was moderate. Vendors were used less frequently to deliver services than was the case in other agencies.

Few deaf clients were reported at DPH sites, but there were many hard of hearing clients; many of these clients were in the health services program. DPH had few specialized staff but a moderate amount of special communications equipment and a relatively high level of use of the MCDHH and other sources of assistance for hearing disabled clients. Training in hearing disability had been moderate but there was a high level of interest in further training. Interest in assistance from the MCDHH was moderate, with a focus on information materials, training, and funding specialized services. Written comments highlighted problems in the assessment of hearing disabled clients and the limited program options available to them.

Regents (Higher Education). Large numbers of staff were reported in these institutions, although few were deaf or hard of hearing. Caseloads in the disabled student centers were small, with some use of vendors to deliver services. More deaf and hard of hearing clients were reported than in most other agencies.

The colleges and universities reported more special equipment and specialized staff and use of the MCDHH than many other agencies; they also relatively frequently made other efforts on behalf of hearing disabled students. Staff training about hearing disability was relatively frequent and interest in further training was high. Difficulty in finding interpreters in emergencies was reported and respondents expressed a high level of interest in assistance from the MCDHH, including training for faculty, interpreters, and advocacy. Some schools had made many

accommodations for hearing disabled students; problems reported in other schools included the difficulty of retaining deaf students, often related to inadequate availability of interpreters on appropriate schedules, the lack of equipment for hard of hearing students, and the reluctance of hard of hearing students to acknowledge publicly their hearing problem.

Department of Mental Health. DMH offices tended to have many staff, some of whom were deaf or hard of hearing. The number of clients and caseload sizes tended to be moderate, with vendors used frequently. Deaf and hard of hearing clients, whose numbers were moderate, were concentrated in case management, day activity, inpatient treatment and day treatment services, many at a special residential unit for the deaf.

DMH representatives reported more specialized staff for hearing disabled clients than did most other agencies; the availability of special communications equipment, frequency of training, and the use of the MCDHH and other efforts for the hearing disabled were moderate. The ability to serve hearing disabled clients compared to hearing clients at DMH was reported to be low, compared to other agencies. Moderate interest in assistance was expressed, particularly in interpreter referral and information materials; DMH representatives were less likely than others to believe that the MCDHH itself should provide services directly to DMH clients. Written comments highlighted the existence of the new specialized inpatient unit for deaf people at the Westborough hospital and the ability of some offices to make successful arrangements for hearing disabled clients on an individual basis. Limited residential placement options, inadequate resources of various sorts, and restricted social opportunities for deaf clients were pointed out. Several respondents emphasized that DMH staff with mental health expertise must retain primary responsibility for all DMH clients, but help from the MCDHH was of interest to many, particularly in terms of providing interpreters, advocacy, outreach and collaboration on special programs.

Department of Mental Retardation. DMR offices had a moderate number of staff but fewer clients than many agencies and relatively small caseloads. Vendors were used extensively. Although there were few deaf clients, many hard of hearing clients were reported; most were in case management, transportation, and residential programs.

DMR respondents reported a moderate level of training but a high level of interest in additional training about hearing disability. A moderate degree of interest was expressed in assistance from the MCDHH; this interest was greatest in terms of information materials, in-service training, and finding specialized services. Written

comments highlighted the unique problems involved in serving the mentally retarded hearing disabled: difficulties in assessing hearing disability, limited ability to develop communication skills, and improper use of hearing aids. Facilities with full communication accessibility for the deaf and hard of hearing reported no special problems, but other respondents experienced difficulties in serving the hearing disabled and complained about limited resources with which to improve services.

Mass. Rehabilitation Commission. MRC offices had few staff; few were deaf and almost none were hard of hearing. With a moderate number of clients, caseloads were relatively high, with heavy reliance on vendors. MRC reported more deaf clients per site than any other agency; the reported number of hard of hearing clients was more moderate. Most hearing disabled clients were in training, guidance counseling, diagnostic evaluation and/or physical/mental restoration programs.

MRC had a high level of special equipment and specialized staff; it was the most frequent user of MCDHH services and also often made other efforts on behalf of its deaf clients. There had been more staff training at MRC about deafness than at other agencies; interest in further training was low. MRC reported difficulty in finding, but not in funding interpreters; its interest in assistance was higher than in most agencies, primarily in interpreter referrals and independent living skills training. Written comments pointed out the need for training for deaf clients and the lack of enough interpreters.

Department of Social Services. DSS had a moderate number of staff per site; almost none were deaf or hard of hearing. The number of clients per site was also moderate in comparison to the other agencies. Caseloads were small and few clients were deaf or hard of hearing. The deaf were primarily in the case management program.

DSS had a moderate amount of special equipment and specialized staff, but was an infrequent user of MCDHH or other services for the hearing disabled. Training efforts had not been common, but there was a high level of interest in further staff training and in other assistance from the MCDHH. Some written comments highlighted inadequacies in the availability of intepreters and information/training, while others reported satisfaction with current arrangements for hearing disabled clients.

Parole. Few staff were reported at each site; almost none were deaf or hard of hearing. Caseloads were of moderate size but almost no deaf or hard of hearing clients were reported. Little special equipment or specialized staff was available and few other efforts had been made on behalf of

hearing disabled clients. Respondents believed that hearing disabled clients were served less well than hearing clients, but interest in assistance was low.

Department of Public Welfare. DPW offices had a moderate number of staff but relatively large caseloads. No deaf staff were reported but there were a few hard of hearing staff. Some deaf clients and a few hard of hearing clients were identified; most of these were in the vocational education program. DPW had a moderate amount of special equipment for the hearing disabled but few staff considered to be specialists; little use had been made of MCDHH technical assistance or other services. There was almost no training about hearing disability reported and little interest in additional training or in other forms of assistance with hearing disabled clients. In their written comments, some DPW respondents reported difficulties in communicating with deaf clients.

Department of Youth Services. DYS offices had a moderate number of staff; none were deaf and few were hard of hearing. Few clients were assigned to each office and caseloads were small; almost no deaf or hard of hearing clients were reported. Special communication equipment and specialized staff were generally not available and the MCDHH was used very infrequently. No training about hearing disabilities was reported and interest in training and other forms of assistance was very low.

## THE REGIONS

Due to the low incidence of hearing disability in many agencies, it is unlikely that each agency office or institution can maintain service arrangements that are required for meeting the needs of deaf or hard of hearing clients. These services may be made available most efficiently on a regional basis. For this reason, it is important to examine the distribution of clients and services across geographic regions.

Most state agencies and commissions, including the Massachusetts Commission for the Deaf and Hard of Hearing, divide the Commonwealth into five or six service regions; service responsibilities of most agency offices and institutions are distinguished accordingly.

Since the number and boundaries of regions vary between agencies, the five MCDHH regions are used in the analysis of survey results by region. The distribution of agency offices across the MCDHH regions is somewhat unequal, ranging from a high of 25 percent of the offices in the Northeast Region to a low of 14 percent in the Western Region. Nonetheless, there are a sufficient number of offices in each region to support interregional comparisons; these comparisons may identify some regions that have particularly low levels of hearing disabled clients or that have been less able to secure services or equipment for these clients.

### Staffing

Although the number of offices is greater, on average, in the eastern regions (including metropolitan Boston), there were more staff per office in the Central and Western regions (table 30). There was less interregional variation in the proportion of staff with advanced degrees and with Bachelor's degrees: Metropolitan Boston and the Southeast Region had somewhat less educated staffs, with 60-70 percent of their service delivery staff possessing at least a Bachelor's.

30. STAFFING BY REGION
MCDHH SURVEY, 1987
MEANS

| STATE REGION | Total Staff | Prop. Advanced | Prop. Profl | Deaf Staff | HH Staff |
|---|---|---|---|---|---|
| MET. BOSTON | 41.89 | .2361 | .6449 | .11 | .27 |
| NORTHEAST REGION | 37.66 | .3826 | .8570 | .15 | .43 |
| SOUTHEAST REGION | 85.93 | .2653 | .6775 | .03 | .52 |
| CENTRAL REG. | 118.40 | .2863 | .7284 | .51 | .90 |
| WESTERN REGION | 120.46 | .3206 | .6820 | .35 | .60 |
| m | 707.00 | .0806 | .1344 | 0.00 | 0.00 |
| TOTAL | 81.72 | .2942 | .7179 | .20 | .53 |

The average number of deaf staff was less than the average number of hard of hearing staff in each region; in each region the average number of both deaf and hard of hearing staff per service site was less than one. In the Central and Western regions, the numbers of both deaf and hard of hearing staff were slightly higher than in other regions. In the Southeast, on the other hand, there were almost no deaf staff persons.

Clients

Both the total number of clients per office, almost 2500, and the caseload, 110 clients per service delivery worker, were highest in the Northeast Region (table 31). Central and Western offices had the least clients, just over 1000 per office, but the caseload in the Western Region was substantially higher than in Central (76 versus 30).

31. CLIENTS AND CASE LOAD BY REGION
MCDHH SURVEY, 1987
MEANS

| STATE REGION | Clients 1986-87 | Case Load | Profl Load |
|---|---|---|---|
| MET. BOSTON | 1915.419 | 50.5460 | 86.4145 |
| NORTHEAST REGION | 2415.961 | 109.6617 | 129.8144 |
| SOUTHEAST REGION | 1736.979 | 38.6521 | 55.9345 |
| CENTRAL REG. | 1103.452 | 29.7590 | 35.6295 |
| WESTERN REGION | 1262.160 | 76.3450 | 55.3240 |
| Region missing*(m) | 325.0000 | .4597 | 3.4211 |
| TOTAL AVERAGE | 1763.172 | 60.2071 | 73.8785 |

*One case was not identified by region.

The proportion of offices reporting any hearing disabled clients was similar in four regions to the overall mean of .84 (table 32). In Metropolitan Boston, however, just 65 percent of the offices reported any hearing disabled clients; this region's number of deaf and hard of hearing clients was also lowest on an office-by-office basis due to a particularly low number of hard of hearing clients. Boston was the only region in which the mean number of deaf clients per office exceeded the mean number of hard of hearing clients. Overall, Central and Western reported somewhat higher proportions of hearing disabled clients than did the other three regions.

32. DEAF AND HARD OF HEARING CLIENTS BY REGION
MCDHH SURVEY, 1987
MEANS

| STATE REGION | Any DHH Clients | Deaf Clients | Hard of Hearing | Hearing Disabled | Prop Disabled |
|---|---|---|---|---|---|
| MET. BOSTON | .65 | 10.3253* | 3.4778 | 16.1304 | .0294 |
| NORTHEAST REG | .92 | 7.8400 | 23.8538 | 31.0287 | .0825 |
| SOUTHEAST REG | .88 | 3.7210 | 26.6855 | 29.8894 | .0262 |
| CENTRAL REG | .84 | 5.2159 | 30.9453 | 40.4913 | .1192 |
| WESTERN REGION | .86 | 6.0727 | 29.4315 | 36.0377 | .0181 |
| m | 1.00 | m | m | m | m |
| TOTAL | .84 | 6.7024 | 22.7660 | 30.2753 | .0548 |

*The number of deaf clients in Metropolitan Boston is inflated considerably by the number reported (226) at one office of the Mass. Rehabilitation Commission that has a specialized unit offering services to the deaf.

m=Missing

Programs and Vendors

Vendors were used to provide services in about two-thirds of the offices in the Metropolitan Boston, Northeast, and Central regions (table 33). The proportion for the Southeast Region was somewhat lower than the average, while it was somewhat higher than average in the Western region.

33. PROGRAMS AND VENDORS BY REGION
MCDHH SURVEY, 1987
MEANS

| STATE REGION | Numb Progs | Vendors/ Program | Exclusiv Vendors | Any Vendors | Progs w/ Deaf/HH |
|---|---|---|---|---|---|
| MET. BOSTON | 3.7228 | .6686 | .4659 | .7799 | 3.1180 |
| NORTHEAST | 5.5010 | .7261 | .4867 | .7975 | 4.6185 |
| SOUTHEAST | 5.3126 | .5354 | .2871 | .6981 | 4.9057 |
| WORCESTER | 6.4959 | .6675 | .3902 | .8149 | 5.3984 |
| WESTERN REG | 5.3716 | .8476 | .4947 | 1.0000 | 5.4739 |
| m | 10.0000 | .7000 | .2000 | 1.0000 | 3.0000 |
| TOTAL | 5.3521 | .6631 | .4042 | .7946 | 4.7154 |

Special Equipment and Staffing

The availability of special equipment and other resources varied little between regions (table 34). On average, offices in the Boston Region had the least special equipment. The Central Region had used the MCDHH most often, while agency offices in Metropolitan Boston reported the most other efforts for hearing disabled clients; of the institutions, the most special efforts for hearing disabled clients were also reported in Metropolitan Boston. Overall, the Southeastern and Western regions reported relatively few special efforts for hearing disabled clients.

34. EQUIPMENT, STAFF, AND OTHER EFFORTS BY REGION FOR DEAF AND HARD OF HEARING CLIENTS
Index Means

| MCDHH REGION | Special Equipmen | Interp & Spcl Sta | Use MCD | Efforts for DHH | Instit Efforts |
|---|---|---|---|---|---|
| MET. BOSTON | 1.0673 | 1.1313 | 1.7988 | 5.1291 | 5.3474 |
| NORTHEAST | 1.4536 | 1.1303 | 2.3127 | 4.3504 | 3.6106 |
| SOUTHEAST | 1.2721 | 1.1570 | 1.8400 | 3.0955 | 4.3802 |
| WORCESTER | 1.4594 | 1.3818 | 3.0493 | 4.3787 | 4.2630 |
| WESTERN REG | 1.4300 | 1.5147 | 1.4771 | 3.4829 | 3.9096 |
| m | 3.0000 | 2.0000 | m | m | m |
| TOTAL | 1.3498 | 1.2431 | 2.1451 | 3.9950 | 4.1758 |

Staff Training

Offices in the Northeastern and Central regions had provided staff training most often; those in Metropolitan Boston were least likely to have provided training (table 35). Desires for further training were somewhat lower in the Metropolitan Boston and Western Regions than in the other regions.

35. TRAINING: PROVIDED AND NEEDED BY REGION
MCDHH SURVEY, 1987
MEANS

| MCDHH REGION | Provide Training | Need Training |
|---|---|---|
| MET. BOSTON | 1.0754 | 5.2438 |
| NORTHEAST REGION | 2.0347 | 7.0972 |
| SOUTHEAST REGION | 1.4910 | 6.9922 |
| CENTRAL REG . | 2.0838 | 6.6682 |
| WESTERN REGION | 1.7180 | 4.8762 |
| m | 5.0000 | 5.0000 |
| TOTAL | 1.7278 | 6.3445 |

Ability to Serve Deaf and Hard of Hearing Clients

There was little difference between the MCDHH Regions in the proportion of offices reporting difficulty in hiring

interpreters on a regular basis (table 36). One region, the Southeast, reported that hiring interpreters on an emergency/short-term basis was between "very" (coded as 2) and "extremely" difficult (coded as 1).

36. DIFFICULTY FINDING & FUNDING INTERPRETERS BY REGION
MCDHH SURVEY, 1987
MEANS

| STATE REGION | Diff. Finding | Diff. Emerg. | Diff. Funding |
|---|---|---|---|
| MET. BOSTON | 2.89 | 2.07 | 3.53 |
| NORTHEAST REGION | 2.28 | 2.59 | 2.84 |
| SOUTHEAST REGION | 2.56 | 1.69 | 3.18 |
| CENTRAL REG . | 2.96 | 2.10 | 3.51 |
| WESTERN REGION | 2.68 | 2.20 | 3.12 |
| m | m | m | m |
| TOTAL | 2.68 | 2.08 | 3.21 |

Difficulty in other aspects of serving the hearing disabled varied more between regions: Metropolitan Boston and Western offices reported somewhat less difficulty serving both deaf and hard of hearing clients than did offices in other regions (table 37). Interest in assistance with deaf and hard of hearing clients was somewhat lower in Metropolitan Boston than in other regions. In addition, offices in the Central and Western regions were less interested in having the MCDHH provide some of their services to deaf and hard of hearing clients than were office representatives in the other three regions.

37. ABILITY TO SERVE DEAF AND HARD OF HEARING CLIENTS BY REGION
MCDHH SURVEY, 1987
MEANS

| STATE REGION | Serve* Deaf | Serve* HardH | Want Assist | MCDHH** Provide |
|---|---|---|---|---|
| MET. BOSTON | 1.90 | 1.85 | 7.6094 | 1.44 |
| NORTHEAST REGION | 1.43 | 1.65 | 11.0303 | 1.25 |
| SOUTHEAST REGION | 1.47 | 1.77 | 10.8315 | 1.56 |
| CENTRAL REG . | 1.47 | 1.68 | 12.0744 | 1.92 |
| WESTERN REGION | 1.65 | 1.93 | 11.1181 | 1.79 |
| m | 2.00 | 2.00 | 3.0000 | m |
| TOTAL | 1.54 | 1.76 | 10.5230 | 1.56 |

*1=Serve deaf less well; 2=Serve deaf as well; 3=Serve deaf better.

**1=Yes; 2=No.

Summary

There was considerably less variation between regions than between agencies in experiences with and arrangements for the hearing disabled, but some differences were large enough potentially to be important. Metropolitan Boston reported fewer hard of hearing clients per office than other regions, although the proportion of its total clients who were either deaf or hard of hearing was not particularly low. Boston also had fewer deaf and hard of hearing staff per office than other regions. Offices in the Central region, on the other hand, had a higher proportion of hearing disabled clients than offices in other regions (almost 8 percent) and a higher proportion of staff who were deaf or hard of hearing--over 6 percent.

The availability of special equipment and special staff for the deaf and hard of hearing varied little between regions. The Central region tended to use MCDHH services more frequently than other regions, while offices and institutions in the Boston region were more likely to have taken other special actions on behalf of deaf and hard of hearing clients.

Interregional differences in reported difficulty in serving deaf and hard of hearing clients were slight. Offices in the Boston region were less likely than those in