

ROUGHLY EDITED COPY
ALL RIGHTS RESERVED

NAADAC

June 17, 2020

IDENTIFYING BARRIERS AND RESOURCES WHEN
WORKING WITH DEAF AND HARD OF HEARING PEOPLE
WITH SUBSTANCE USE DISORDERS

CAPTIONING PROVIDED BY:
CaptionAccess

* * * * *

This text is being provided in a rough-draft format. CART captioning, Communication Access Realtime Translation captioning is provided in order to facilitate communication accessibility and may not be a totally verbatim record of the proceedings. Any video that has been reproduced in text format is to comply with the Americans with Disabilities Act under the Fair Use Doctrine. This file is not to be distributed or used in any way that may violate copyright law.

* * * * *

>>: Hello, everyone. And welcome to today's webinar on identifying barriers and resources when working with deaf and hard of hearing people with substance use disorders presented by Dr. Deborah Guthmann. I'm the director of training and professional development for NAADAC. I'll be the organizer for training experience. Closed captioning is provided by Caption Access. Please look for the link for the closed captions. We house everything you need to know about that particular webinar. Immediately following the live event, you will find the quiz link on the exact same website you used to register for this webinar. Everything you need to know will be permanently hosted at www.NAADAC.com. Take a look at the screen shot you see on our slide here for more information how to access the online quiz. It will be in the handouts also. We are going to go to the webinar for this live event. You can use that orange arrow to minimize or maximize the control panel. If you have any questions for the presenter, type them into the questions box. We'll gather your questions and give them to our presenter during the live Q and A. Any questions that we do not get to we'll collect directly from the presenter and put them on the website at a later date. Under the questions tab, you will see a tab that says handouts. You can download the Power Point slides in the handouts tabs. Please make sure to use the instructions in our handouts tab when you are ready to take the quiz. It's a new system. We want to make sure you guys know exactly how to get to where you want. Let me introduce you to today's presenter. Dr. Deb Guthmann is a nationally recognized reach educator. She is focusing on the mental health, career related in American Sign Language. Dr. Guthmann is the founding director of Minnesota Substance Abuse Program which is one of the first residential treatment programs of its kind. She was the director of student services at the California school for the deaf, school for the deaf in free month California, teaches online

classes and has made over 200 international presentations and has written multiple articles, books, book chapters focusing on ethical issues to use with HHD individuals.

Deb, whenever you are ready, I'll hand this over to you.

>>DEB GUTHMANN: Great. Thank you so much. I am absolutely thrilled to be here and I have a lot of information to share with all of you today. You know there is more than we are probably more than what we are going to get to in an hour. As you may know, there is not a lot of opportunities to get this information, so I wanted you to have a resource you could keep for future republicans. My e-mail address is included up on the screen. I'm happy to get e-mails from any of you with questions or if you are looking for information for this presentation. At the end of the Power Point, you will see that I have included many resources, such as online readings that are available in American Sign Language, stories of recovery by deaf individuals which are signed, captioned, and voice. I have articles, how to access the big book in American Sign Language as well as other web sites that you may find of interest. So there's a lot of resources we won't go through the day during the presentation but I hope you will take advantage of later.

Many of you may have noticed since Covid has been affecting all of us that if you are watching your television, states updates, community updates you may notice more visibility with sign language interpreters than before. And you may not realize actually that some of the interpreters you are watching are actually what we call certified deaf interpreters. So some of the interpreters are hearing and some of them are deaf. When there's a deaf interpreter, they are actually watching a hearing certified interpreter in the audience and they are the one that is the expressing the information to you. We'll talk a little bit more about the use of interpreters later in the presentation, but I thought you might be interested in

that.

Some of the objectives for today that we hope to cover will be for you to learn more about barriers and resources related to assessment treatment and active care. Hopefully you will be able to identify treatment components that are used in specialized programs for deaf and hard of hearing individuals and you will be able to identify some of the resources I am going to share with our federal grant where we have screeners that all of you are able to access at no charge and use with the clients you work with. Our first polling question which would help me is how many trainings focused on worked with deaf and hard of hearing individuals have you previously attended. A, one to two? B, three to four. C, five or more, or you've never attended a training such as this one previously. It's always interesting to see people's past experiences and if they work with individuals either in your current setting in the field of addiction or maybe in some other avenue. So Samson, are we getting some responses in?

>>: Yes, we are. We already got half the audience so thank you so much. As a reminder if you have questions for our presenters, you can put them in the questions box. As a reminder in the go to webinar control panel, you can see the questions box and you will be able to see any questions you have for our presenter. I'm going to close the poll and chair the results and turn this back over to Deb.

>>DEB GUTHMANN: Great. Thank you. It looks like over half of those participating today have not attended a training on this topic before. That's great. I tried to prepare information keeping that in mind so hopefully you'll find this useful and get a lot of your questions answered.

The next thing that we're going to talk about will be the fact that no deaf, deaf blind, hard of hearing person is alike. Just like those of us who are hearing. The ability to hear, speak, use English, communicate or understand is very unique. So there

isn't one stereotypical way to identify and we'll talk about that during our training today. I think it's really important to talk about terminology do's and don'ts because often I'm asked how an individual should refer to someone. One of the more commonly used terms that is actually on our don't use is hearing impaired. Years ago hearing impaired was the preferred communication to use and still on some of the federal grants that I see that term is used. It is viewed as negative in the deaf community because it means something is wrong with that person. Deaf individuals, the only thing that is different is they are not able to hear. They are not impaired in other ways. So if possible, try and avoid the use of the word hearing impaired. Also, the word deaf mute is seen as very derogatory and actually most deaf individuals aren't mute. They may choose not to use their voice or to use speech, but deaf and mute are two separate areas. Just because a person is deaf doesn't mean that there's anything wrong with their vocal chords. So avoid the use of deaf mute. Also the term deaf and dumb for obvious reasons. So what I would recommend you use when referring to this population is deaf and hard of hearing. So on the left with a thumbs up, if you call a person deaf or hard of hearing, that's acceptable. But to encompass the population, deaf and hard of hearing is the preferred way to refer to the population. Late deafened is a person who grew up and lived the majority of their younger years as a hearing person and lost their hearing. You will understand what they are saying clearly, but they may have difficulty reading your lips. Keep in mind that only about 30 percent of what you lip read is visible on the lips. Think about some of the letters, a V, a P, and if you're making those movements with your mouth, they look alike. So we really do not want to depend on lip reading when we are working with a deaf individual. It's important to have a qualified sign interpreter. People might also be defined as deaf blind. That is broad. They may have no vision or low vision that they

are able to use. So their communication varies in that aspect. So deaf, hard of hearing, late deafened, and deaf blind are our do's for terminology.

I wanted to touch on health literacy issue. When we think about health literacy we need to keep in mind that because deaf people have limited access to sign language interpreters in health care settings, just because they are in a hospital for an appointment, doesn't mean they automatically have a sign language interpreter. They may show up for an appointment and an interpreter isn't available. So they are missing out on exposure to information. Even things that go on around us, radio, TV, a lot of information that is missed can limit literacy for individuals. You may think you need to add captions which is like English subtitles or provide a written English transcript. It's important to keep in mind that for many deaf people their first language is American Sign Language which is visual and not written and not English. So for some of these reasons, members of the deaf community miss the opportunity to engage with health providers, and actually it can be a contributing factor to increased hospitalization because of the lack of disinformation. So effective communication between providers and patients is really important and can actually lessen what we see happen with some of the hospitalizations that could have been prevented.

Needs and services, over all you may say how many deaf people actually have a problem with substance abuse disorder: If you think about the hearing population, generally speaking with we say one out of ten hearing people are in need of some kind of a treatment protocol, we would anticipate or estimate that at least equal to or greater than that number of deaf people would be in need of treatment and we do not see that happening. There should be thousands of deaf people in treatment at any given time and we have only a handful at one point in time that we know of. There's few specialized treatment programs left designed to meet the needs of this population. There's

actually less than three on a national basis where all staff are fluent in sign language and can communicate directly with the deaf individual. This means that most people can only access services designed for hearing people. So if a deaf person goes into a treatment program with all hearing people and there are not sign language interpreters, that person is missing out on that treatment experience. The lack of knowledge about alcohol and other drugs and available resources for this population results in all kinds of consequences that can happen. In one example where a deaf individual went through treatment, and then went off to college, because there was no treatment for them available, they needed to leave that college and go to some other environment where they would get more support. So these are important to keep in mind. You also may not be aware of the fact that actually 90 percent of deaf children are born to hearing parents. These families may struggle with feelings of guilt and this may cause family members to overlook or avoid addressing some of the signs and symptoms of alcohol or other drug use. The person's hearing loss may be seen by those parents as the reason for behaviors related to substance use. As a result, these family members may have a difficult time holding their deaf child to the staple standard as a hearing sibling. Also, think about dinner time conversation. You are sitting around at dinner. Think about things or siblings or children pick up from those conversations, things they should do, things they shouldn't do, things that are good for them, things that are bad for them. Imagine that you weren't able to pick up any of that communication information that is going on and that you were missing out and really don't even know that drugs and alcohol are bad for you because that information is not accessible to you not only in home but in media that goes around all the time our communities. Lack of comprehensive education prevention programs is another huge problem. There's a great deal of pressure placed on schools to achieve academically and prevention is

not always seen as a priority for inclusion in this curriculum and information. And in fact in some situations it may not be until 9th grade in health class when prevention material is provided at all. The Minnesota substance use disorder program which was mentioned as being one of the first inpatient programs for this population has been collecting demographic information since opening in 1989. So based on self reports we know that most of those 1600 clients started using around age 10. So the fact that prevention doesn't happen until at the earliest 9th grade, really meaning we have missed the boat with many of these situations. Difficulty with peer relationships, what better way to be accepted by your peers than to do things in excess. There was actually years back an article in the newspaper by the associated press about drug dealers targeting deaf mutes and deaf individuals because they knew the authorities would be less likely to hold them accountable for their actions. We see a great deal of enabling that goes on not only within families, because of the guilt but within our police. A couple examples. We had students where I worked that had been caught with ecstasy, and they had been dealing across state lines through the mail with students in another state that were deaf at another school. And the staff discovered the pills and caught them. This was turned over to the local police. We really did want consequences for the kids, think about all the different laws that were broken through these actions. So the police did come to campus, took this group of three or four students off campus. We figured they would take them to the police station, contact their parents and that there could be some consequences. Later on in the day the police came back with the students, these are good kids, they won't do this again. We picked up hamburgers and McDonald's, we sat, we chatted, they know they shouldn't do this. There were no interpreters. The police did not know sign language. You tell me how that kind of education actually happened. Unfortunately, we see this kind of

behavior happen all too often. Additionally, there's a lack of knowledge and support in the deaf community for some of the reasons that I've shared. And we see a lot of the activities in the deaf community involve alcohol. And speaking in general terms if a person chooses not to drink other individuals want to know what's wrong. There's a negative stigma associated with why a person may choose not to drink, especially if they have in the past. So in some ways the community is like a hearing community where there's a lot of pressure placed on a deaf individual who makes this decision for themselves.

As I've mentioned, we have a lack of accessible, evidence based programs. We have a lack of professionals. There are not a lot of training programs for people to go to, deaf or hearing where they can become addiction counselors, and because of this there are actually programs that have had to close because they were not able to have enough qualified staff work within the program. Because American Sign Language is visually based and most of the materials out there are English text, we need to have more materials developed. At the end of the presentation, you will find some online resources that send you to a website where we have posted a lot of different kinds of visual materials that you may be able to access. In addition to the lack of professionals, we also need to keep in mind that just because you hire a qualified interpreter doesn't mean that they understand the vocabulary surrounding substance abuse disorder. I often equate it if I were working with preschoolers, there is a specific vocabulary in that population, and in the same we have vocabulary that goes along with our work. If you were doing an assessment and the question you asked the person is have you ever had a DUI, the interpreter will translate that information directly in that way. And the individual may shake their head no. And it may be because they don't know what a DUI is. We talk a lot about in our field about expansion. That means asking the question in a way where you can expand

the information that describes what a DUI is, where the police stops the car for erratic behavior and then may be issue a citation. So if you expand the concept of your question, the interpreter will do so in American Sign Language, and you will see that you have better results. Most of the assessments we have out there are English based. They might be computerized. So I'm excited to be able to share with you today a website we have where we have validated nine different assessments related to mental health and substance abuse in American Sign Language, and it will tour the assessments for you as well. So it's a resource that's available for you at no cost.

One thing that's really important for people to be aware of is this deaf grapevine that goes along within our community. So misinformation about substance abuse in the deaf community results in damaging perceptions. One might face the attitude that something is wrong with the person who is using. That grapevine is how people from one state to another know a lot about you. If there are very few treatment programs that are specialized for an individual to go to, a person may go to a treatment program and find someone they have used with in the past. So there's a fear of confidentiality. So it needs to be dealt with and how to handle situations around confidentiality and spend a lot of time talking about what that means and to not use that as an excuse but to work toward the importance of maintaining confidentiality in the future.

Language in deaf community can impact after care. We talked about the fact that there's this negative stigma and concerns about confidentiality. There's a lack of after care as well which causes problem for a person's sobriety. With what is happening with Covid there are many more online 12 step programs in American Sign Language available using zoom and other platforms than ever before. There's also more ability to have sponsors who are deaf access someone else through online platforms. We still see issues in communities when an individual is trying to access a closed meeting

and the interpreter is there for the purpose of communication access. Some of the members may not want that interpreter present because they are not in recovery. So we need to remember the role of the interpreter is communication and that is the purpose for them being in the meeting. The factors that help with recovery are no different than for hearing people. You can glance at some of the things I've posted here. The main difference is the lack of these options being available for deaf people as compared to hearing individuals.

I want to talk a little bit about work with an interpreter. When you're scheduling a sign language interpreter it's really important to make sure you are only using certified interpreters, not family members or people who say they know some sign language because you don't know what that means. If a person is certified, that means they have gone through official training and they are able to converse fluently in American Sign Language. For your information certified interpreters are covered under HIPAA as business associates so you have that protection in terms of confidentiality. It is important they know the type of assignment they are accepting, and you should allow for extra time when an interpreter is present. On the day of the appointment, it's always helpful to give the interpreter an overview of what will be covered, copies of any paperwork, and have a plan if there is a communication breakdown and review special vocabulary or acronyms you may be using.

I will say when you are working with an interpreter, you and the client should try and figure out placement. Ask the client where they want the interpreter to sit and you to sit so they have the best line of sight. Typically the interpreter sits next to the non Sign Language user and the deaf person sits across. Always use first person language. Avoid same ask him, tell her. Know that the interpreter is only going to provide information about the client's language, no personal information. If possible, use

tools such as calendars, pictures, or anything such as that to expand on the concept. Also, the interpreter is not there to supervise the client so they are only there to interpret in the way you are there. The interpreter is going to interpret anything and everything that is said. So any side conversations you have will be interpreted.

Some of you may have placed a phone call to someone and someone answered saying that they will be interpreting for a person who uses sign language to communicate. This is called a video relay service. This is covered through the FTC. What happens is the deaf user is looking at a screen such that is shown on the far left top and the interpreter speaks to the hearing user through a phone, the hearing user speaks back to the interpreter and the interpreter signs to the deaf user visually. The bottom right corner shows a picture of a video phone. That's when two deaf individuals are able to communicate visually. In the old days we used to use a TTY that's where you typed back and forth and a piece of paper would print everything that is said. Now deaf people are able to communicate using American Sign Language which is their native language. The other thing some of you may have had some exposure to is video remote interpreting. Where video relay services is free, we all pay for it through taxes through phone usage. It's monitored by the federal communication commission. Video remote interpreting is also a paid service. So you have a deaf user and a hearing user, and you have someone online, an interpreter. Now, video relay service has requirements that you need to be in a different location in order to use that service. Video remote is typically used where the deaf and hearing person are in the same room. It should be used for short-term purposes, medical kinds of emergencies. It's not ideal in situations where it's an all day conference or a long meeting. Look at the bottom left picture, imagine that you are an individual looking at this small iPad and there are eight or ten people having a conversation

going on. First of all, what if the screen freezes? What if there is a technology issue? What if you want to add a comment? Because of the lag time it's going to take awhile for you to be able to do that. On the right bottom side of the screen, you will see a picture where you have the patient and you have a nurse or doctor talking to them and an interpreter on the screen. If there are short questions or check ins that are happening in the hospital, this is a nice approach to use. The preference is to always have a live sign language interpreter when possible. Here I have outlined a few of the differences. The main difference is video remote is a paid service. Video relay service there is no charge. It's publicly funded and you need to be in a separate room.

So keep in mind that there are pros and cons to everything and some of the biggest challenges I think again with Covid we are all seeing and that has to do with technology issues, and things can freeze, they can be too slow, when you are working with sign language, that is even more evident. If your upload speed is not fast, things are going to be freezing, and it can be very frustrating if there's a situation involving mental, medical health or sub abuse, you want to have clear communication at all times. I've included video for your future information, one that talks about the role of the interpreter and one giving an example of video remote.

What barriers have you seen most often in your work? A, knowing how best to work with sign language interpreters, B, the cost of sign language interpreters. C, the lack of accessible materials for assess 789 and treatment. Or D, after ware options. We are interested in hearing about some of the barriers you may have encountered. And since more than half of you haven't had a lot of training like this, it will be interesting to see if these are barriers you have experienced. Are we getting some responses, Samson.

>>: Yes. You will see four option answers on your screen. Continue to send those answers in. Any

questions you have for Deb, you can send them to the questions box. We will ask those questions to Deb during a live Q and A or we will have them on a Q and A document that we will post on our website. I am giving you a few more seconds to answer this poll question. I'm going to close the poll. I will turn this over to the presenter.

>>DEB GUTHMANN: Thank you so much. It looks like the majority of you recognize that a primary barrier would be lack of accessible material for assessment and treatment. That is a huge issue. Hopefully you will be able to take advantage of some of what I've shared. We need to have more materials developed in this area and really what you'll see from some of the examples I'm going to show is some of the materials could be used with a lot of clients you work with yourself. I'm going to touch on the limited research we have out there. Actually there are very few, if any, well controlled estimates of drug and alcohol use among deaf and hard of hearing people. Most of the estimates are from small, restricted or nonrepresentative samples. Many years ago I looked at 100 individuals and we were interested in what contributed to them maintaining sobriety. We looked at a hundred different factors and three things make a difference, one, attendance at self help recovery meetings. I've told you that is a problem. We don't have a lot of accessible meetings out there. Having family members and friends to talk about their sobriety. We talked about those barriers as well. And the last one is employment. Which is interesting. Because a number of individuals who entered the Minnesota program are actually on some kind of public assistance and not employed. So this is something that we need to think about when looking at what contributes to sobriety.

The next thing that we are going to look at is the Minnesota program itself. If you think about this program, what would you state clients listed as their preferred drug of choice. Again, we've collected data since 1989 when this program opened and they served

more than 1600 clients. Actually you will see that the results again are not that much different. Alcohol being first primary indicated self report, followed by marijuana. One thing that I did want to share that is interesting, if you look at the total number, 1200 have been males. Which means much less female population have entered treatment. And we can go on and talk about that but we won't for time sake. The other thing I want you to look at is the age. The age that the majority of these individuals enter treatment is somewhere between 25 and 43 years of age. The reason for that is because of the enabling that goes on. We have so many protections in place until finally the bridges are burned, kicked out of school, fired from different jobs, families getting distraught and the individual hitting bottom and seeking treatment. Here are similar numbers in terms. Age range for females and only 461 having entered the treatment program in Minnesota. Recently we actually did finally get some prevalence information done that is the first step toward getting a little bit of information to know what our numbers look like. So the national survey on drug use and health in 2016 for the first time asked are you deaf or do you have serious difficulty hearing. The only problem with this is I'm interested in the deaf population that uses sign language to communicate. Serious difficulty hearing can mean elderly population, noise induced hearing loss, it doesn't separate that population out enough but it's a start. But let's take a look at the results that this study gave us. Here it shows the population that was looked at, 18 to 34 on up to about 50, 5.2 percent had some type of a hearing loss. And the results did show that hearing loss was associated with a greater use of opioid abuse between 35 to 49. And individuals 18 to 49 are more likely to meet criteria for an SID. There was no difference for those 50 and older. These findings are consistent with individuals with hearing loss may abuse substances more frequently. So is there a substance abuse problem in the deaf community? Is it similar to the hearing

population? If so, why is there no scientific evidence of such. Let's take a quick look at assessment. First of all, as we talked about, most of them are not accessible. We don't always have qualified interpreters who have knowledge of the terminology. Using an interpreter is a third person which can cause some problems with communication efforts that are going on. So I talked about the example of DUI. I would like you to think about clients you work with if you are doing assessments and think about how you ask these questions and if you just naturally expand or if you stick to the actual question as such. Because most deaf individuals would not be assessed properly if these kinds of questions were not expanded. I have an actual example where an assessor, because they did not have an interpreter available tried to use written communication with the deaf individual. I want to advise you not to do this. This is not an accurate way to gather an assessment. I'll just skip through a few of these points to show you how we want to not have assessments done in this manner. You want to make sure you have certified sign language interpreter with you. If one isn't available, you need to reschedule that. Too many times I've been in court situations where the individual's interpreter hasn't shown up and they want to try using this and that is not appropriate. So in this situation what kind of drugs do you use. Pot. Do you use it every day. Sometimes. How much a day. I don't remember. If we skip down, do you use any other drugs? Alcohol. Only pot and beer. Frequently individuals I work with do not think of beer or wine as alcohol. So it needs to be very clear. Here it says when you drink beer how many do you drink in one day, two or four. I only buy a case in one day. You mean you drink one case in one day. Not all beer just until I got drinking and stop. So if you take anything away from here, do not do an assessment in written English and we need to have natural consequences created at times for the client we work.

I am going to touch on the grant. I have here a

list here of the different assessments that we have translated and validated into American Sign Language that are all available on line. Just to highlight we have the AUDIT, we have the DAST, we have the patient headlight questionnaire and we are just completing a suicide behavior questionnaire as well. I'm going to show you the process we use. I don't know if any of you have ever tried to validate something in another language but it's quite challenging, and there are very few things that have successfully been validated in American Sign Language. The first thing you do is you have your English statement. You have to write out losses in American Sign Language and then video that because your Target language is American Sign Language. First you have to come up with these individuals in American Sign Language. Then you do what's called back translation. You have people watch the video in American Sign Language and write down what they are seeing in English. Then you have people take that translation and see if the two English versions when compared are consistent in meaning and have the same equivalency. If they don't, then you have to do the video again. So this is what it looks like when we were going through the process. People would watch the video, write down what they see conceptually in English, and then in a spreadsheet we would do a comparison. So one of the question is feeling tired or having little energy. So you can see in red that quite a few people instead of saying little energy said motivation. So the sign choice that was used had to do a meaning of motivation. So this needed to be redone. Some of them were done more than five times. So we came up with equivalency. After that we have one on one meetings and then send them out for field testing. I'm going to go through a few examples of what it looks like, but if you are interested in using this clients or if you are interested for your own benefit and curiosity, we call it the ASL star and click on ASL star and register. You would see provider information and deaf and hard of hearing information. Everything

is captured in voice. And you also are able to get some training materials. So when you're on the site, if you are interested in learning more about the deaf communities, we have a training that focuses on that. You also are able to have a training on a little bit of background on each of the screeners that are used. And again everything is captioned in voice and sign. And when you register a client, they complete the screener, and you are able to review their responses with them. If you have them take the instrument more than one time, you actually have a graph here where you can compare the results and it gives you an indication of what the score may mean. So it's a great resource that is available for you.

Some people may want to know when you're deciding about referring a client to treatment what is the difference between an accessible and specialized treatment model and why should one be used over the other. Accessible treatment is when interpreters are provided and specialized treatment is when there is direct communication with staff at all times. One of the problems with accessible treatment is that sometimes interpreters are only available a couple hours a day during formal training. So that's something important to keep in mind. Again, American Sign Language is a visual gestural language with its own rules and syntax. So keeping that in mind when treatment is being provided is very important. I wanted to touch on funding issues. Accessibility is expensive. It could be less expensive to send a person to a specialized treatment program where all communication can happen in a direct mode: We are talking about a low incidence population. If you are in a rural area, there may be only one deaf individual. We know the experience of going to a group setting being in treatment with others is where we learn so much. So because of the nature of this population, the Minnesota program was set up with a national model in mind. Some states may have one state program but it's very difficult because of the cause and lack of finding

qualified people to keep these programs up and running.

The last thing I wanted to share briefly is some examples of how we have made material visual for this population. So here I have broken down some examples of some of the assignments that might be given as one example during treatment. One of the things that we may do is to talk about how to collect information from some clients when they have limited language or actually may have graduated from college. We find using a more visual approach really helps takes a person out of their head and be in a more feeling modality. The first thing we look at are consequences, so when I'm high or drink, bad things happen to me and we look at consequences across areas. This is one example for a client who may have less language access. So here would be an example of a drawing. This is when we are gathering information in a consequence that was financial. My car was towed. Here's an example of an incident at work. It's quite visual. These become part of the record for the client. This one is interesting because this person had no formal language. They became deaf through neglect ear infections, they could draw the shape of the container they were using but they could not label them. So we had to label for them and we did most of this individual treatment in this pictorial way. Step one we focus on unmanageability and powerlessness. Here are some pictures that show powerlessness and unmanageability. This person showing that they were tired and this one shows the tug of war that we see so often. We see signs that say beer and parties to the left, alcohol, pot, and struggling with the good way, sobriety, job, family. You can see that it's very, very visual. Then if we go on to step two, we call it the help and hope step. One of the assignments is to draw yourself a year from now if you continue using. So here's one example and here's another example what they would look like if they continued using. They are in the front in the coffin. Here is an example of a person who has friends and support and isn't alone and what they would

look a year from now if they stopped using. Then we go on to step three which is very difficult for a number of our deaf individuals. When they see the word God and look at the word higher powers, they think of it in a religious connotation. And a number of individuals may have grown up going to a religious setting where they had no access to communication so this is viewed in a negative manner. So a lot of time is spent explaining what higher power means. It can be God. It doesn't need to be God. We try to help the client to come up with where they gather their strength in. Here's are some drawings that individuals did in this area. Here's an example of AA being higher power. Here's an example of nature being this individual's higher power. And here's an example of something that is quite spiritual as an example for this individual of higher power. Now, before we do the polling question, I did want to share a couple of things with you from the online resources and then we'll go back to that. If you know of individuals who are deaf or hearing and fluent in sign language and they are in need of a 12 step meeting, here is something you can access. And going through this, you will see that on Wednesday night we have text chat meeting. The Monday meeting has an interpreter available. So if an individual like yourself is interested, these are open meetings, you can experience this for yourself. Then I'm going to go back now to the polling question. And ask you all to think about from what was mentioned today what do you think is important to consider when working with deaf and hard of hearing individuals, A, that writing back and forth is not a recommended approach to use. B, the importance of having accessible materials for treatment. C, the lack of treatment and after care options. Or D, I had not considered any of the information discussed today. I'd love to get some feedback from you and a little bit more about what you thought about as you've listened to a lot of information during this hour. Samson, what kind of responses are coming in?

>>: This is great. You guys are getting used to the polling feature. More than half of the audience has answered the polling question. It looks like the audience is leaning towards one dominant choice. We are going to give you five more seconds. Thank you for sending in questions. We will make sure they will be answered in a live Q and A or on a Q and A document shared on our website. I will share the results. I will turn this over back to Deb.

>>DEB GUTHMANN: Great. It looks like everyone is continuing to recognize the importance of having accessible materials for treatment. The website that is in the bottom of the Power Point is actually www.Me. If you go to website you will find that I have posted articles, videos, clinical approaches and even tobacco prevention material all available in American Sign Language that hopefully some of you will be able to access. I hope in the future that when you have an opportunity to get funding, write grants that you will include this population so that we get more material that is accessible out there. Samson.

>>: Great. Thank you, so much Deb. Some people were asking if we could put this slide back up. I'm going to leave this up for a moment. Those of you asking about the slide about meetings, it is up here. We have this on the slide deck that is available to you on our website or also in the handouts tab. You can download that PDF file. You may have to zoom in to see some of the information. We can send you the slides that are bigger. Our first question asks I'm concerned that wearing my mask during Covid-19 is blocking DHH persons being able to lip read. What do you recommend.

>>DEB GUTHMANN: Oh my gosh, that is a wonderful point. It has been a hot conversation going on all over. And maybe what I can do is send to Samson to share with all of you there actually are some masks that have been made that have plastic over the mouth. They are available online. They have been found to be helpful. They were originally developed by in consultation with deaf doctors who have had that same

issue when they are in surgery and need to be able to have lip reading ability. So when possible using the plastic opening on the mouth that is available, that would be helpful. I've even noticed when I've gone in stores and I have the mask on if there's a clerk or someone who is hard of hearing, there is a lot of what, what, what, because even without realizing it many of us are dependent on listening but also watching lips. So great question. I will be sure to share that information.

>>: That's great. Thank you, Deb. Yes, everyone any additional information, links, that document will be posted on our website at a later date. Here's also Deb's information. I will put it right back on the screen so you can see it. The next question comes from Devon, are there free resources for those individuals who are not financially able to pay for interpreter services?

>>DEB GUTHMANN: Same states do have funding available. The deaf individual would request it. For instance, if you are talking about specifically 12 step meetings and they would use those funds to go to a meeting. There are some expectations because of the Americans with Disabilities Act that some programs would financially provide the interpreters. But the ADA does not spell out exactly what equal access means so that's where we get into problems with having limited interpreter availability. So it depends on the state you are from. There is a lot of state funding out there to help fund interpreter: Responsibility does go to certain agencies or medical settings. Some hospitals are quite good, unfortunately because of lawsuits, about having access to interpreters. The problem is making sure they have the qualifications that would be necessary to accurately communicate for the deaf individual.

>>: Dr. Guthmann, thank you so much for your time and your expertise. Thank you for the great questions you are sending them in. We will add them all to the Q and A document. We will have them answered and on our

website as soon as we can. If you are wondering about your CE quiz or how to access the reporting the event, the web page has everything you need to know about the webinar. You will find online quiz link on the exact same website you used to register for this webinar. That means everything you need to know about this website will be permanently posted at [NAADAC.org/identifying barriers resources DHH webinar](http://NAADAC.org/identifying-barriers-resources-DHH-webinar). Continuing education is free to view for everyone. If you wish to get a continuing education certificate to validate your CE hours, that is only available for members. There is a small fee for validation. Also, if you click on the handouts tab in our go to webinar panel, there is a vital instruction guide to give you step by step instructions how to have access to the quiz and certificate. Here is the schedule. We have great presenters just like today. Please also visit our Covid-19 resources page. The web page is on my slide here. NAADAC has provided to you six excellent webinars covering concerns in the addictions field. The website as you see here is NAADAC.org. Also, NAADAC is offering two specialty online training series. You can visit NAADAC.org for more information. Of course we also have our supervision work book. You can see more at the website at our slide here. This is a six part series presented by Dwayne France who is a retired combat vet. As a NAADAC member there are a lot of benefits for joining with us. If you join NAADAC you will have access to free CES. You will received quarterly magazine and many other things becoming part of a NAADAC. Take sometime to give us your feedback, share notes for the presenters and tell us how we can improve. You will get a link to watch the recording and to take the survey. Thank you again for participating in this webinar, and Deb, thank you for your valuable expertise. I encourage you all to take some time to browse our website and learn more about how NAADAC helps others. You can stay connected with us on [NAADAC](http://NAADAC.org), Facebook, and Twitter. Be well. (End of lecture.)

