

Questions Asked During Live Webinar Broadcast on 6/17/2020



Identifying Barriers and Resources When Working with Deaf and Hard of Hearing People with SUD

Presenters: Deb Guthmann, EdD, NIC

What other technology is available besides the interpreter?

A: Some individuals may require interpreters who are fluent in American Sign Language, a language with grammar and syntax that is different from the English language. Others may require interpreters who use Signed English, a form of signing which uses the same word order as does English. Still others who do not know any sign language may require oral interpreters, who take special care to articulate words for deaf or hard of hearing individual, or cued speech interpreters, who give visual cues to assist in lip reading (also called speech reading).

Deaf and hard of hearing (DHH) individuals rely a great deal on different types of technology for communication. In the United States, video relay services and a variety of video phones are often used by DHH people to conduct telephonic communication with both hearing and deaf businesses as well as family and friends.

Devices such as the teletype (known as a TTY) an electronic device used for communication over a telephone line) are far less common, but are used by some DHH people who are without access to high-speed Internet or have a preference for these methods for their telephone communication.

Technology is even important in face-to-face social situations. For example, when DHH people meet a hearing person who does not know sign language, they often communicate via the notepad on their cell phone, or by using an iPad or laptop computer. There are also commercially-available electronic devices with two keyboards that allow two individuals to be in the same room and type conversations back and forth; these include UbiDuo and Interpretype.

Closed Captioning must be available on a television in order for a DHH person to fully appreciate the audio portion of the broadcast. Conflicts arise when establishments such as restaurants, airlines, or fitness centers fail to accommodate DHH people by turning on Closed Captioning. Movie theaters are increasingly compliant with providing visual access to first-run movies through stand-alone devices, glasses and open caption technology which allow DHH people to attend movies as they are released.

Alert systems such as fire alarms and alarm clocks must include vibrating pillows and flashing lights to be accessible rather than noise-based alarms.

Video Relay Services(VRS) enable Deaf, hard of hearing, deafened, and deaf blind individuals who use American Sign Language to communicate with voice telephone users through video equipment, rather than through typed text. VRS is for use by individuals who are in different locations. Video Relay Service or VRS uses a computer and a web camera as a form of communication and requires the use of a third party sign language interpreter. A third party interpreter verbally translates what is being said to the person that is receiving the call. When the hearing party responds, the translator uses sign language to relay the message back to the deaf individual using the web camera. This system may be used in a variety of settings and similar systems are also available for home use.

Video remote interpreting (VRI) is a form of sign language interpreting that allows people who are Deaf, hard of hearing, deafened, deaf blind to communicate with a hearing person at the same site via videoconferencing instead of live, on-site interpreting. VRI is especially useful when (1) there is a lack of available qualified interpreters, such

as at a rural location; and (2) when an interpreter is needed immediately and there is no available interpreter on-site.

VRI works by using videoconferencing equipment at both locations. The interpreter, who is typically at a call center, uses a headset to hear what the hearing person says. As the hearing person speaks, the interpreter signs everything said to a web camera. When the person who is deaf replies via their web camera, the interpreter sees and voices the interpretation. The person who is deaf and the person who is hearing can talk back and forth, just as if the interpreter was in the same room. VRI is provided on a fee-for-service basis by several interpreting agencies; costs may vary based on whether an interpreter is needed immediately or is scheduled ahead of time.

During the training, I talked about the use of Video Relay Service and Video Relay Interpreting (See powerpoint for additional information).

Is there a preferred term to use for folks who are deaf and who also cannot speak?

A: The deaf and hard of hearing community is diverse. There are variations in how a person becomes deaf or hard of hearing, level of hearing, age of onset, educational background, communication methods, and cultural identity. How people “label” or identify themselves is personal and may reflect identification with the deaf and hard of hearing community, the degree to which they can hear, or the relative age of onset. For example, some people identify themselves as “late-deafened,” indicating that they became deaf later in life. Other people identify themselves as “deaf-blind,” which usually indicates that they are deaf or hard of hearing and also have some degree of vision loss. Some people believe that the term “people with hearing loss” is inclusive and efficient. However, some people who were born deaf or hard of hearing do not think of themselves as having lost their hearing. Over the years, the most commonly accepted terms have come to be “deaf,” “Deaf,” and “hard of hearing.”

You may make an assumption that a DHH person “cannot speak” when in fact their preferred mode of communication may be to use American Sign Language (ASL) and not use their voice. According to the National Association of the Deaf (NAD): “Mute... means silent and without voice. This label is technically inaccurate, since deaf and hard of hearing people generally have functioning vocal chords. The challenge lies with the fact that to successfully modulate your voice, you generally need to be able to hear your own voice. Again, because deaf and hard of hearing people use various methods of communication other than or in addition to using their voices, they are not truly mute. True communication occurs when one’s message is understood by others, and they can respond in kind.”

What do you think about using video remote interpreting in a long-term case management program for a high risk person?

Video Remote Interpreting (VRI) is one possible means of providing interpreting services to ensure effective communication with deaf and hard of hearing individuals who communicate using sign language. VRI uses videoconferencing technology, equipment, and a high-speed Internet connection with sufficient bandwidth to provide the services of an interpreter, usually located at a call center, to people at a different location. VRI is currently being used in a wide variety of settings including hospitals, physicians’ offices, mental health care settings, police stations, schools, financial institutions, and workplaces. Entities may contract for VRI services to be provided by appointment or to be available “on demand” 24 hours a day, seven days per week.

The most controversial use of VRI has been in the medical setting, where use of VRI has been used without regulations of how VRI technology is used in this setting. Many medical providers are unprepared for this technology and do not have the benefit nor include the direct involvement of the deaf and hard of hearing community in deciding how to best provide this service. In the last few years, too many medical providers have suddenly chosen VRI as the sole auxiliary aid option in the healthcare context, and the limitation to a sole option is completely inappropriate. The deaf and hard of hearing

community has become increasingly concerned about the over-reliance on this new technology without a thorough examination and dialogue on the appropriateness of the service. Moreover, because so many deaf and hard of hearing individuals have had adverse experiences in hospitals that rely on VRI technology, there have been numerous lawsuits against hospitals seeking to curtail such overuse of VRI.

The National Association of the Deaf(NAD) established requirements for Video Remote Interpreting (VRI) in an effort to ensure the proper use of technology and equipment as well as the effective delivery of VRI services.

To ensure a successful video remote interpretation session, speak directly to the patient, not the interpreter. They will interpret everything that is said or signed. Everything communicated to the interpreter will be interpreted.

Use the self-view screen to ensure the interpreter can see you and the client clearly; they may briefly ask you to adjust your screen. In order to ensure accuracy, make sure you and the client are not backlit by another window or another light source. Some video remote interpretation platforms provide a digital white board that interpreters can use for written clarification. If appropriate, ask the interpreter to verify medication/information in the digital white board.

In assessing the appropriateness of VRI, the provider must consider the following factors. If any of these factors are present, the provider should refrain from using VRI and employ best efforts to seek an on-site interpreter. Primary consideration should be granted to deaf or hard of hearing individual's express request for a specific version of qualified sign language interpreting services.

- Whether the deaf or hard of hearing individual consents to the use of VRI, with the understanding that the initial consent does not constitute a waiver of right to effective communication via on-site interpreter.
- Whether the VRI provider offers the language that the deaf or hard of hearing individual uses: for example, standard American Sign Language (ASL) or other sign languages /visual communication systems;
- The deaf or hard of hearing individual's fluency in the communication system used;
- Whether the person's condition is serious and/or unstable;
- Whether the deaf or hard of hearing individual is limited in their ability to view the video interpreter, due to vision limitations, limited head/body mobility, physical obstacles, distance between the individual and the screen, their ability to stay still, or any other reasons;
- The video interpreter's ability to view the deaf or hard of hearing individual, due to limitations on the deaf or hard of hearing individual's ability to move their head, hands, arms; any physical obstacles; the distance between the individual and the screen, the ability of the deaf or hard of hearing individual to stay still; or for any other reasons;
- Whether the deaf or hard of hearing individual's state of mind impacts their ability to communicate;
- Any cognitive or consciousness issues, psychiatric issues, or pain issues that the deaf or hard of hearing individual may have;
- Whether the deaf or hard of hearing individual is under the influence of medicine or other drugs;
- Whether the deaf or hard of hearing individual's emotional state impacts their ability to communicate;
- Whether the degree of pain and/or discomfort the deaf or hard of hearing individual may be experiencing impacts their ability to communicate;
- Whether the deaf or hard of hearing individual's ability to focus on the VRI screen impacts their ability to communicate;
- Whether the deaf or hard of hearing individual is a minor;
- Whether there are multiple people present;
- Whether information exchanges are complex and/or fast;

- Whether the discussions involve high-risk situations, including but not limited to: informed consent discussions, discussions regarding surgery or other high-risk treatment options, discussions immediately prior to and after surgery or other high-risk treatment, and discussions about diagnosis, treatment, and prognosis;
- Whether the discussions involve highly sensitive communications, including but not limited to: diagnosis, treatment, prognosis of a life-threatening or life-changing illness, discussions regarding limb amputation or organ removal, and discussions regarding hospice and/or other end-of-life considerations;
- Whether the deaf or hard of hearing individual reacts negatively and/or becomes exceedingly stressed with the use of VRI;
- Whether the communication is taking place in areas of the facility that do not have readily accessible Internet access;
- Whether the treatment is taking place in a room where there are space restrictions that render the use of VRI difficult.

Although the NAD recognizes VRI as a technology that may be used by hospitals and other medical centers to ensure immediate communication access, it also clearly states that the ‘**use of on-site interpreters should always be paramount**’ and ‘when VRI is used in the absence of any available on-site interpreter, it must be used properly in terms of policy, procedure and technology’. When it comes to using VRI technology to communicate with a non-native English speaker, a similar position should be taken.

Any books recommended for social service providers to connect with clients?

A: There are many other books that may be of interest, but here are a few books that offer hands on clinical and other information and ideas that can be used when working with DHH clients.

Glickman, Neil. (2017) Preparing deaf and hearing persons with language and learning challenges for CBT: A Pre-therapy workbook. Routledge.

Glickman, N. (Ed.) (2013). Deaf mental health care. New York: Routledge.

Substance Abuse Treatment and Recovery: Adaptations to Best practices when Working with Culturally Deaf Persons, Debra Guthmann, & Cindi Sternfeld, (2013) Pages 234-267. In N. Glickman’s (Ed.). Deaf Mental Health Care, New York, Taylor & Francis,.

“Culturally Affirmative Substance Abuse Treatment for Deaf Persons: Approaches, Materials and Administrative Considerations.” Debra Guthmann and Kathy Sandberg in Glickman, N. and Gulati, S., Mental Health Care of Deaf People: A Culturally Affirmative Perspective. Mahwah, New Jersey: Lawrence Earlbaum.

Glickman, N. & Gulati, S. (Eds.). (2003). Mental health care of Deaf persons: A culturally affirmative approach. Mahwah, New Jersey: Lawrence Earlbaum Associates.

Are there free resources for individuals that are not financially able to pay for interpreter services?

A: Some states have funding set aside where a deaf individual can request money to cover the cost of an interpreter. An example of this may be for an individual to attend a 12 step meeting. These funds wouldn’t be used to cover interpreter costs in situations where that entity is legally mandated to provide these services. I would recommend you check with any state offices that provide services for deaf individuals in your state to find out if any funding may be available. These offices may include the state office of vocational rehabilitation or the state commission for deaf and hard of hearing (in many, but not all, states).

What does the ASL stand for?

A: American Sign Language. American Sign Language (ASL) is a complete, natural language that has its own linguistic properties, with grammar that differs from English. ASL is a visual language based on a naturally evolved system of hand gestures and their placement relative to the body, along with non-manual markers such as facial expressions, head movements, shoulder raises, mouth morphemes and movements of the body. ASL is used by people in the United States and Canada. ASL is used *to some extent* in quite a few other countries, but it is certainly not understood by Deaf people everywhere. For example, British Sign Language (BSL) is a different language from ASL, and Americans who know ASL may not understand BSL.

I am curious how many deaf SUD clients are in local community? And how to become a deaf clients specified therapist if there are not many clients available in our region?

A: We don't have specific numbers that would tell us how many SUD DHH clients live in particular communities. There are some areas of the country that have larger deaf populations i.e. Washington, DC, Rochester, NY, and in those areas as well as more urban settings, you can expect to have a larger deaf population and therefore more DHH individuals may have SUD issues. In terms of services for this population, as indicated during the training, we only have 2 or 3 treatment program that offer specialized programming with direct communication when working with DHH clients. If you have the ability to communicate in ASL and want to work with DHH in your area, I would suggest going on line to see if there is a Commission for the Deaf and Hard of Hearing in your area, a State Coordinator for the Deaf related to mental health or substance abuse services. Checking on the internet for these contacts, and then reaching out to them would be a way to start networking. The American Deafness and Rehabilitation Association (ADARA) is a large professional organization that has a conference every two years with a strong focus on mental health and substance abuse. If you attended one of these conferences, you would see that it is a great way to network with other professionals as well as attain excellent workshops. You can learn more about the organization by going to www.adara.org

Which company provides AA meeting that includes ASL interpreter during Zoom meeting and in person as well?:

A: There are more and more options for participating in 12 step meetings that are either in American Sign Language in all deaf meetings, or those that use an interpreter.

<https://www.sardiprogram.com/dodameetings/>

1. Online 12 step and Alanon meetings in text & ASL

Monday, 8:00pm (EST) (Men/Women, all signers welcome Deaf and hearing)

Tuesday, 8:30 pm (EST) Al-Anon (All signers welcome, Deaf and hearing)

Tuesday, 10:00 (EST) AA- ASL (All signers welcome Deaf and hearing)

Wednesday, 7:00pm (EST) AA - Text Chat (Deaf and hearing)

Wednesday, 8:00pm (EST) AA – ASL (All signers welcome Deaf and hearing).

Friday, 8:00pm (EST) AA - (Women Only, all signers welcome Deaf and hearing).

Sunday, 2:00pm (EST) NA - (Men/Women, all signers welcome Deaf and hearing).

Austin Deaf Access Committee: <http://austindac.org>

Minneapolis: <https://asldistrict8.com/asl-aa-meetings>

Alcoholics Anonymous Los Angeles Central Office:

<http://www.lacoaa.org/https://www.drclousangeles.org/reference.html>

Alcoholics Anonymous San Fernando Valley Central Office:<http://www.sfvaa.org/>

Online Intergroup: Alcoholics Anonymous” – Online Meetings for Deaf and Hard of Hearing Alcoholics:

http://www.aa-intergroup.org/directory_dhoh.php

Portland Deaf Access Committee: <http://pdacaa.org>

Rochester, New York: <https://www.rochester-ny-aa.org/meetings/?tsml-day=any&tsml-type=ASL>

San Diego: <http://www.aasandiego.org/>

Seattle, Washington: <https://www.seattleaa.org/online-meetings/>

Sober Fingers: <https://soberfingers.com/>

Each week, an open AA meeting in Eden Prairie, MN- Foxhall Chapter 7 Group - makes an ASL video and audio video of their meeting. This is a meeting people from the MN CD Program and those in the community have attended for many years. The AA group provide the interpreter and they are a larger meeting and truly self supporting. Here is the link to a meeting that was held in January:

https://drive.google.com/file/d/1yO_N_C-521kqbBmYBv6AYCCQ5bOy2Xq5/view

<https://www.youtube.com/watch?v=AZtQZeLhvPE>

The 12 Steps In American Sign Language-taking the 12 steps in ASL: signed by a certified interpreter. This is from the viewpoint of Dave A. from Austin, Texas, who is off camera to protect his anonymity.

I work in CDOC. We have a very high recidivism from the community back to CDOC regarding the offenders who have participated in our program. We don't have this issue with the hearing population. We use sign language interpreters and they are able to discuss the curriculum and treatment material we work with them on. I'm not sure if this is a common problem or if there is more we can be doing?

A: I would like to talk more with you about the specific program you have for deaf individuals(feel free to email me at: Dguthmann@aol.com). You indicate that there is a higher recidivism rate for your deaf offenders than those who are hearing. I would like to know more about the access you are providing and if the materials you use are adapted for the deaf individuals you are working with, or if you use the same materials and approaches with Deaf offenders than with hearing individuals. I have found that having direct communication, there are more positive outcomes. I am involved with a book being written about the criminal justice system and deaf individuals. We see the treatment that happens with the deaf individuals when incarcerated and the support provided when they are released, being far less than is typically provided to hearing individuals. A lot of that again is because of the lack of resources out there.

What are the age/cultural differences that have contributed to increase in Alcohol/Drug abuse of those in the past 3 to 4 decades as apposed to those individuals who are over 50 years of age?

A: As indicated during the training, deaf individuals who are in K-12 educational settings, are often enabled, and natural consequences don't always occur. Once out of high school, eventually consequences begin to occur. Studies show associations between hearing loss and certain medical conditions, one of which is arthritis, which may increase one's likelihood to use prescription pain medication. One small study found that 50% of patients with hearing loss reported chronic pain (e.g., fibromyalgia) requiring medications. Individuals with hearing loss also report higher levels of stress and trauma, possibly elevating the risk of somatoform and stress-related disorders. Furthermore, these individuals are four times more likely to report psychological distress than their hearing peers. Worse mental health is a risk factor for SUD and poorer overall pain management outcomes and may explain some of these findings among individuals with hearing loss. The increased prescription opioid use disorder among younger adults with hearing loss may be because of impaired clinician-patient communication surrounding pain management. Hearing loss impedes clinician-patient communication in healthcare settings. Clinicians treating older adults may be more prepared to assess and integrate hearing loss into their communications, explaining the lack of SUDs in older individuals. Poor clinician-patient communication results in numerous adverse outcomes, including reduced patient treatment adherence and less awareness of healthy behaviors and likely affects the

understanding of certain management and treatment approaches. This could reduce patients' ability to accept non-opioid treatments.

McKee, M., Meade, I., Zazove, P., Steward, H., Jannausch, M., Llgen, M. (2018). The Relationship Between Hearing Loss and Substance Use Disorders Among Adults in the U.S. *The American Journal of Preventative Medicine*. 2018;000(000):1–5. Published by Elsevier Inc.

Doesn't the ADA require that there are interpreters for all medical and treatment facilities?

A: The Americans with Disabilities Act (ADA) and Rehabilitation Act of 1973 require hospitals and medical providers to ensure effective communication with people who are deaf. For deaf people who communicate primarily in sign language, qualified sign language interpreters are often the only effective communication option in medical settings. Failing to obtain qualified interpreters for medical interpreting puts patients' health at risk, increases liability for hospitals and medical providers, and drives up medical costs. Miscommunication also increases overall liability among hospitals and medical staff. One way to minimize these risks is to provide a qualified sign language interpreter on-site or to hire sign language fluent medical staff. However, there are situations when this may not be possible. For example, qualified sign language interpreters may not be available for an appointment or there may be a need for urgent communication in an emergency situation with a medically unstable patient. Technology now provides for an interim solution in the form of off-site or remote interpreting services when in-person, on-site interpreting may not be immediately available. Interpreting services provided remotely through such technology is known as Video Remote Interpreting (VRI).

Because communication methods vary from person to person within the deaf and hard of hearing population, the medical provider must determine which communication method is most effective for the patient being admitted or seen. A deaf or hard of hearing individual knows best which auxiliary aid or service will achieve effective communication with their health care provider. Private medical providers must consult with deaf and hard of hearing persons to determine effective communication needs. Medical providers must give primary consideration to the communication requests of the deaf or hard of hearing individual

The provision of qualified sign language interpreters is critical to ensure that deaf and hard of hearing persons who rely on sign language are able to communicate effectively with health care providers. The U.S. Department of Health and Human Services, Office of Civil Rights has consistently required medical providers to provide qualified interpreters to deaf and hard of hearing clients, and has stated that "it would be extremely difficult for the health care provider to demonstrate in certain service settings, that effective communication is being provided in the absence of . . . interpreters.

Although the Department of Justice (DOJ) has developed regulations recognizing Video Remote Interpreting (VRI) as one possible auxiliary aid or service option, medical centers have mistaken this inclusion of VRI as license to use VRI exclusively to the detriment of effective communication, which is the paramount requirement when providing medical services to deaf and hard of hearing patients and companions. There have been numerous instances of medical providers insisting that they are only obligated to provide VRI, and not obligated to provide on-site interpreters at all. This insistence has led to communication failures not only because of a refusal to recognize that VRI is not appropriate for many medical situations but also because the VRI technology has often not worked as promised. As a result, medical providers' insistence on the exclusive use of VRI has led to numerous communication failures and lawsuits.

In its regulations implementing Titles II and Title III of the ADA, the DOJ issued the following minimum requirements for VRI use by covered entities:

[VRI must provide] real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication. [VRI must provide a] sharply delineated image that is large enough to display the interpreter's face, arms, hands, and fingers, and the participating individual's face, arms, hands, and fingers, regardless of [their] body position. [VRI must also provide] a clear, audible transmission of voices.

Without comprehensive technical guidance on the use of VRI, medical providers are at significant risk of facing liability because of miscommunication or because of a failure to allow the patient to fully participate in decision making about the health care. On-site interpreter services are more likely to result in effective communication than VRI services. On-site interpreters are advantageous in that they: have more mobility, have greater access to visual and auditory cues and information present in the environment, are not disconnected due to malfunctions, and are better able to respond immediately to communication events as they arise.

As a matter of model policy, medical providers should only use VRI: (i) while the medical provider is waiting for an on-site interpreter to arrive (which should be no more than two hours from the time of request for unscheduled medical events); (ii) if duration of the patient's stay is expected to be under two (2) hours; (iii) if a need to communicate with a patient and/or companion who has expressed a preference for an on-site interpreter arises outside of a planned schedule for an interpreter to be provided for a patient and/or companion; or (iv) either (a) the patient has not expressed a preference for an on-site interpreter or (b) the patient's and/or companion's expressed preference for an on-site interpreter has been considered and VRI results in effective communication.

If a client comes for their appointment and the interpreter is not available, they may be understandably frustrated. What should we do if they prefer to have the appointment anyway, via writing or whatever is available?

A: Exchanging written notes may be effective for brief and simple communication, however, written communication can be slow and cumbersome. If you are communicating less or providing less information in writing than you would provide when speaking to a client, this is an indication that writing to communicate is not effective in that context.

Understanding written material may also depend on the reading level or literacy skills of the individual. The reading level of deaf and hard of hearing individuals is as variable as the reading levels found in the general population. Additionally, for some deaf and hard of hearing people, American Sign Language (ASL) is their first language. Because the grammar and syntax of ASL differs considerably from English, exchanging written notes may not provide effective communication between a deaf or hard of hearing patient and a health care provider. For some deaf or hard of hearing individuals, the services of a qualified sign language interpreter offer the only effective method of communication. For many deaf individuals, the services of a sign language interpreter offer the only effective method of communication. However, some deaf or hard of hearing individuals who do not use sign language, such as individuals who have lost their hearing later in life, may communicate more effectively in writing with their health care providers.

Are small providers expected to shoulder the entire costs of an interpreter?

A: If a deaf person goes to your place of business and you are not able to effectively communicate without an interpreter (e.g., via writing) with the person in order to provide services available to the general public, or the communication is expected to be very important or complex (e.g., medical visit), then you are responsible for

providing an interpreter. There are few exceptions which the ADA discusses, such as if it is an undue financial burden or if it fundamentally changes the same service offered to the public.

Private companies or “Commercial Facilities”, are typically the ones who are confused as to whether they should provide an interpreter, as it is clear in Title II of the ADA pertaining to all state and local government organizations which states that the government is required to accommodate the deaf “...in all services, programs, and activities provided to the public...” – ADA Title II

Title III deals with Public Accommodations and Commercial Facilities, and in general, regardless of company size, section 36.201 of Title III states that: “No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any private entity who owns, leases (or leases to), or operates a place of public accommodation.”

Effective Communication for the Deaf

Regarding deaf people, the law enables them to receive “effective communication” in order to participate as any person from the general public would. The Americans with Disabilities Act (ADA) mandates that “title II entities (State and local governments) and title III entities (businesses and nonprofit organizations that serve the public) communicate effectively with people who have communication disabilities. The goal is to ensure that communication with people with these disabilities is equally effective as communication with people without disabilities.” Companies with 15 or more employees must follow fair hiring and employment practices when considering candidates with disabilities.

What may constitute an undue hardship for one company, may be a required reasonable accommodation for another. For example, a request for a full-time sign language interpreter for a customer service representative who works for a fortune 500 company, is likely a reasonable request. The company has lots of resources, the nature of the job requires a lot of communication with customers and financial resources are typically deep at a fortune 500 company. In this scenario, it would not be an undue hardship for the company to provide a full-time interpreter for the employee. The ADA does not require the provision of any auxiliary aid or service that would result in an undue burden or in a fundamental alteration in the nature of the goods or services provided by a health care provider. 28 C.F.R. § 36.303(a). However, the health care provider still has the duty to furnish an alternative auxiliary aid or service that would not result in a fundamental alteration or undue burden. 28 C.F.R. §36.30.

An undue burden is something that involves a significant difficulty or expense. Factors to consider include the cost of the aid or service, the overall financial resources of the health care provider, the number of the provider's employees, legitimate necessary safety requirements, the effect on the resources and operation of the provider, and the difficulty of locating or providing the aid or service. 28 C.F.R. § 36.104. Doctors, nurses, dentists, specialists, therapists, and other health care providers must communicate effectively to provide appropriate, effective, quality health care services. The Americans with Disabilities Act and Amendments Act of 2008 (ADA) and Section 1557 require that any provider who received federal funding, such as Medicaid dollars, take appropriate steps to ensure that communications with individuals with disabilities are as effective as communications with others in health programs and activities. Federal disability discrimination laws mandate equal access to and an equal opportunity to participate in and benefit from health care services, and effective communication with individuals who are deaf or hard of hearing. These laws include:

- Section 504 of the Rehabilitation Act of 1973 – applies to federal health care services and facilities; and health care providers who are also recipients of federal financial assistance, usually provided by direct funding (such as federal Medicaid funds) or by grants (such as a federal research grant).
- Title II of the Americans with Disabilities Act – applies to all public (state and local) health care providers.

- Title III of the Americans with Disabilities Act – applies to all private health care providers.

§ 36.303 Auxiliary aids and services.

- (a) *General.* A public accommodation shall take those steps that may be necessary to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services, unless the public accommodation can demonstrate that taking those steps would fundamentally alter the nature of the goods, services, facilities, privileges, advantages, or accommodations being offered or would result in an undue burden, *i.e.*, significant difficulty or expense.
- (b) *Examples.* The term “auxiliary aids and services” includes –
 - (1) Qualified interpreters on-site or through video remote interpreting (VRI) services; notetakers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunications products and systems, including text telephones (TTYs), videophones, and captioned telephones, or equally effective telecommunications devices; videotext displays; accessible electronic and information technology; or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing;
 - (2) Qualified readers; taped texts; audio recordings; Brailled materials and displays; screen reader software; magnification software; optical readers; secondary auditory programs (SAP); large print materials; accessible electronic and information technology; or other effective methods of making visually delivered materials available to individuals who are blind or have low vision;
 - (3) Acquisition or modification of equipment or devices; and
 - (4) Other similar services and actions.
- (c) *Effective communication.*
 - (1) A public accommodation shall furnish appropriate auxiliary aids and services where necessary to ensure effective communication with individuals with disabilities. This includes an obligation to provide effective communication to companions who are individuals with disabilities.
 - (i) For purposes of this section, “companion” means a family member, friend, or associate of an individual seeking access to, or participating in, the goods, services, facilities, privileges, advantages, or accommodations of a public accommodation, who, along with such individual, is an appropriate person with whom the public accommodation should communicate.
 - (ii) The type of auxiliary aid or service necessary to ensure effective communication will vary in accordance with the method of communication used by the individual; the nature, length, and complexity of the communication involved; and the context in which the communication is taking place. A public accommodation should consult with individuals with disabilities whenever possible to determine what type of auxiliary aid is needed to ensure effective communication, but the ultimate decision as to what measures to take rests with the public accommodation, provided that the method chosen results in effective communication. In order to be effective, auxiliary aids and services must be provided in accessible formats, in a timely manner, and in such a way as to protect the privacy and independence of the individual with a disability.
 - (2) A public accommodation shall not require an individual with a disability to bring another individual to interpret for him or her.
 - (3) A public accommodation shall not rely on an adult accompanying an individual with a disability to interpret or facilitate communication, except –
 - (i) In an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no interpreter available; or
 - (ii) Where the individual with a disability specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances.

- (4) A public accommodation shall not rely on a minor child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no interpreter available.
- (d) *Telecommunications.*
 - (1) When a public accommodation uses an automated-attendant system, including, but not limited to, voicemail and messaging, or an interactive voice response system, for receiving and directing incoming telephone calls, that system must provide effective real-time communication with individuals using auxiliary aids and services, including text telephones (TTYs) and all forms of FCC-approved telecommunications relay systems, including Internet-based relay systems.
 - (2) A public accommodation that offers a customer, client, patient, or participant the opportunity to make outgoing telephone calls using the public accommodation's equipment on more than an incidental convenience basis shall make available public telephones, TTYs, or other telecommunications products and systems for use by an individual who is deaf or hard of hearing, or has a speech impairment.
 - (3) A public accommodation may use relay services in place of direct telephone communication for receiving or making telephone calls incident to its operations.
 - (4) A public accommodation shall respond to telephone calls from a telecommunications relay service established under title IV of the ADA in the same manner that it responds to other telephone calls.
 - (5) This part does not require a public accommodation to use a TTY for receiving or making telephone calls incident to its operations.
- (e) *Closed caption decoders.* Places of lodging that provide televisions in five or more guest rooms and hospitals that provide televisions for patient use shall provide, upon request, a means for decoding captions for use by an individual with impaired hearing.
- (f) *Video remote interpreting (VRI) services.* A public accommodation that chooses to provide qualified interpreters via VRI service shall ensure that it provides –
 - (1) Real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication;
 - (2) A sharply delineated image that is large enough to display the interpreter's face, arms, hands, and fingers, and the participating individual's face, arms, hands, and fingers, regardless of his or her body position;
 - (3) A clear, audible transmission of voices; and
 - (4) Adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the VRI.
- (h) *Alternatives.* If provision of a particular auxiliary aid or service by a public accommodation would result in a fundamental alteration in the nature of the goods, services, facilities, privileges, advantages, or accommodations being offered or in an undue burden, *i.e.*, significant difficulty or expense, the public accommodation shall provide an alternative auxiliary aid or service, if one exists, that would not result in an alteration or such burden but would nevertheless ensure that, to the maximum extent possible, individuals with disabilities receive the goods, services, facilities, privileges, advantages, or accommodations offered by the public accommodation.

A health care provider must communicate effectively with customers, clients, and other individuals who are deaf or hard of hearing who are seeking or receiving its services. 56 Fed. Reg. at 35565. Such individuals may not always be “patients” of the health care provider. For example, a deaf parent of a hearing child may require an auxiliary aid or service to communicate effectively with health care providers, participate in the child's health care, and to give informed consent for the child's medical treatment. Classes, support groups, and other activities that are open to the public must be also be accessible to deaf and hard of hearing participants.

Auxiliary aids and services include equipment or services a person needs to access and understand aural information and to engage in effective communication. For example, the rule includes qualified interpreters, computer-aided transcription services (also called CART), written materials, assistive

listening devices, captioning, or other effective methods of making aural information and communication accessible. 28 C.F.R. § 303(b)(1).

The auxiliary aid and service requirement is flexible, and the health care provider can choose among various alternatives as long as the result is effective communication with the deaf or hard of hearing individual. An individual who is deaf or hard of hearing likely has experience with auxiliary aids and services to know which will achieve effective communication with his or her health care provider. The U.S. Department of Justice expects that the health care provider will consult with the person and consider carefully his or her self-assessed communication needs before acquiring a particular auxiliary aid or service. 56 Fed. Reg. at 35566-67.

Auxiliary aids and services are often needed to provide safe and effective medical treatment. Without these auxiliary aids and services, medical staff run the grave risk of not understanding the patient's symptoms, misdiagnosing the patient's medical problem, and prescribing inadequate or even harmful treatment. Similarly, patients may not understand medical instructions and warnings or prescription guidelines.

The ADA does not require the provision of any auxiliary aid or service that would result in an undue burden or in a fundamental alteration in the nature of the goods or services provided by a health care provider. 28 C.F.R. § 36.303(a). Making information or communication accessible to an individual who is deaf or hard of hearing is unlikely ever to be a fundamental alteration of a health care service. An individualized assessment is required to determine whether a particular auxiliary aid or service would be an undue burden. An undue burden is something that involves a significant difficulty or expense. For example, it might be a significant difficulty to obtain certain auxiliary aids or services on short notice. Factors to consider in assessing whether an auxiliary aid or service would constitute a significant expense include the nature and cost of the auxiliary aid or service; the overall financial resources of the health care provider; the number of the provider's employees; the effect on expenses and resources; legitimate safety requirements; and the impact upon the operation of the provider. 28 C.F.R. § 36.104. Showing an undue burden may be difficult for most health care providers. When an undue burden can be shown, the health care provider still has the duty to furnish an alternative auxiliary aid or service that would not result in an undue burden and, to the maximum extent possible, would ensure effective communication. 28 C.F.R. § 36.303(f).

References:

1. McKee, M., Meade, I., Zazove, P., Steward, H., Jannausch, M., Llgen, M. (2018). The Relationship Between Hearing Loss and Substance Use Disorders Among Adults in the U.S. *The American Journal of Preventative Medicine*. 2018;000(000):1-5. Published by Elsevier Inc.
2. See *US DOJ Effective Communication Regulations*, available at: www.ada.gov/effective-comm.htm
3. NAD Position Statement: VRI Services in medical settings. See <https://www.nad.org/about-us/position-statements/minimum-standards-for-video-remote-interpreting-services-in-medical-settings/> (last visited June 29,2020).
<https://www.nad.org/wp-content/uploads/2020/04/Model-Hospital-Policy.pdf> (last visited June 29, 2020)