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Social Workers' Experiences With Deaf and Hard of Hearing People With Mental Illness

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Walden University
2019

Abstract

Social Workers' Experiences With Deaf and Hard of Hearing People With Mental Illness

by

Makoto Ikegami

MSW, Gallaudet University, 2009

BA, Waseda University, 2002

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Social Work

Walden University

May 2019

Abstract

The social work practice problem for this study was a lack of knowledge about social workers' experiences of working with deaf and hard of hearing people with mental illness. This study was needed to fill a practice gap by increasing an understanding of the experiences of social workers to inform best practices and address the needs of deaf and hard of hearing population through culturally and linguistically competent mental health services. The research questions focused on the experiences and challenges of social workers working with deaf and hard of hearing people and best practices identified by these social workers. Ecological systems theory was used to guide this study. Data were collected from a focus group comprising 9 social workers working with deaf and hard of hearing people with mental illness at a healthcare provider on the east coast of the United States that offered culturally and linguistically therapeutic services. Themes identified through thematic analysis of the data were cultural competence, empowerment and advocacy, professional education, and leadership to advance cultural competence. The findings of this study may be used to help healthcare providers identify key components of program design and service delivery that support culturally and linguistically competent mental health services for the population. This knowledge may also be used by social work practitioners and administrators to bring about positive social change by enhancing social work practice related to deaf and hard of hearing clients with mental illness, improving mental health outcomes, and supporting recognition of the importance of culturally and linguistically competent mental health services.

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Dedication

I dedicate my capstone project to my family. A special feeling of gratitude to my loving parents, Yo Ikegami and Yumiko Ikegami, whose words of encouragement and push for excellence continue to motivate me to work to achieve my dreams. While I am Deaf, I was born to hearing parents and have a hearing sister. My parents never treated my deafness as a disability; rather, they valued me as a unique individual and raised me to be a whole and complete person. They always encouraged me to work much harder than my peers, and at the same time, taught me not to be full of myself because of my achievements. And they've always taught me to express my gratitude to people who have helped me. I also dedicate this to my sister, Ai Nakagawa, who loves music, singing, playing piano, dancing, and theater and has always been by my side to share her joys with me. She has always figured out how we can enjoy them together. She would always interpret for me so that I would always be included in society. My being Deaf makes our bond deeper and stronger. I appreciate my family for being the enormous and priceless part of my life that they are and have always been. I also dedicate this dissertation to my friends and coworkers, past and present, who have supported me throughout the entire doctoral program. I have made it this far because of the generous and enduring support from those people. I thank them for their support and guidance over the past 5 years, and I never forget this degree isn't about me, but rather enables me to better serve the deaf community. I look forward to continuing to work with the deaf community to make a positive difference in people's lives.

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Section 1: Foundation of the Study and Literature Review

The social work practice problem was a lack of knowledge about the experiences of working with deaf and hard of hearing people with serious mental illness. Through this study, I hoped to gain further understanding of the experiences of working with this population in order to develop and preserve culturally and linguistically competent mental health services for deaf and hard of hearing people in different locales. In order to gain an understanding of the experience of social workers working with deaf and hard of hearing people with serious mental illness, a focus group was conducted with social workers working with deaf and hard of hearing people with serious mental illness at a healthcare provider that provides linguistically and culturally relevant therapeutic services for the population. The study's findings may contribute to the overall social work knowledge base about linguistically and culturally relevant therapeutic services for deaf and hard of hearing people with serious mental illness. The findings may also suggest ways for other social workers to become linguistically and culturally competent to work with deaf and hard of hearing people with serious mental illness and increase the number of appropriate mental health services available to deaf and hard of hearing people.

There are four sections in the overall organization of this paper. Section 1 starts with a problem statement and provides information on issues at three levels of systems that may cause or significantly influence the problem. Additionally, Section 1 encompasses the primary purpose of this capstone project, research questions, concepts that are important to understand in the context of this action research study, and

contributions of the study. Moreover, Section 1 covers the nature of the doctoral project, the significance of the study, and the theory that was used to guide this study. In Section 1, I also explain the significance of this study in accordance with the National Association of Social Workers (NASW) Code of Ethics. Last, Section 1 includes a review of the professional and academic literature.

Section 2 starts with the research design, including the plan for constructing meaningful research. Next, Section 2 provides information about the methodology for this action research study that includes data collection procedures, participants, instrumentation, and strategies for validation. Section 2 also encompasses data analysis and ends with ethical procedures.

Problem Statement

A lack of knowledge about the experiences of working with deaf and hard of hearing people with serious mental illness is a social work practice problem. This study was needed to further understanding of the needs of social workers in order to develop and preserve culturally and linguistically competent mental health services for deaf and hard of hearing people in various locales.

The National Association of the Deaf (NAD) has provided nine official position statements related to health care and mental health (NAD, n.d.). For example, the NAD issued a position statement on mental health services for people who are deaf and hard of hearing in 2003. The NAD stated that it is important and necessary for deaf and hard of hearing people to have full access to communication and receive mental health services that are sensitive to the psychosocial impact of hearing loss in every state throughout the

country (NAD, 2003). The NAD issued a position statement on mental health services for deaf children in 2008. According to the position statement, deaf children require appropriate cultural and linguistic access to mental health services for their psychological development, which still has not been addressed both nationally and locally (NAD, 2008). Recently, a position statement on preservation of mental health services for deaf people in an integrated health care system was issued (NAD, n.d.). In its most recent position statement, the NAD acknowledged that the deaf community is concerned about the preservation of culturally and linguistically competent mental health services for deaf and hard of hearing people (NAD, n.d.).

While the NAD has made every effort to promote full access to culturally and linguistically competent mental health services for deaf and hard of hearing people and has provided formal position statements expressing the deaf community's needs and concerns about mental health services, there are still a host of unresolved problems that the deaf community has to face and address (NAD, n.d.). A lack of mental health service providers who are linguistically and culturally competent for deaf and hard of hearing people with serious mental illness remains a significant problem (Crowe, 2017; Fellinger, Holzinger, & Pollard, 2012; McKee & Paasche-Orlow, 2012; Quan & Lynch, 2010).

It is vital for mental health service providers to understand and address such issues to be able to preserve culturally and linguistically competent services for deaf and hard of hearing people with sensitivity to their needs and preferences.

Issues With Micro Social Work

In *micro social work*, social workers work with individuals or families to solve problems (Swick & Williams, 2006). For example, social workers assist individuals in finding appropriate resources and services that help to solve problems such as those related to housing, food, benefits, and health care. Most deaf people experience complex communication challenges when they deal with hearing/speaking people (Pollard & Barnett, 2009). Serious mental illness may hinder people's efforts to use communication skills effectively to varying degrees; these communication challenges are greater for deaf people who have serious mental illness. There are not many social workers who can use American Sign Language (ASL) fluently and understand the deaf culture sufficiently to provide culturally and linguistically competent mental health services for deaf and hard of hearing people (Sheridan, White, & Mounty, 2010).

Glickman (2013) stated that it is challenging for clinicians to conduct assessments for deaf and hard of hearing people with serious mental illness because there are differences in views about some issues between deaf people and hearing people. For example, deaf people tend to keep eye contact when they communicate with each other. Hearing clinicians who do not know deaf people's communication style may offend a deaf patient when they lack eye contact in communicating with the patient (Glickman, 2013). That is an example of a microaggression and a lack of culturally competent practice. Although deaf and hard of hearing people with serious mental illness should have the right to receive culturally and linguistically competent mental health services, many social workers do not have necessary knowledge and skills to meet the needs of

deaf and hard of hearing people who have serious mental illness (Greco, Beresford, & Sutherland, 2009).

Greco et al. (2009) argued that it is critical to train staff to become specialized in this population and thereby increase the number of professionals who are trained in ASL and the deaf culture. Although little data are available to estimate how many social workers state that they are fluent in ASL, Sheridan et al. (2010) reported that only about 250 deaf and hard of hearing people had completed a graduate program in social work in the United States. A lack of social workers who can use ASL fluently and understand the deaf culture has been a significant issue at the micro level.

Issues With Mezzo Social Work

In *mezzo social work*, social workers work with groups such as neighborhoods, schools, or other local organizations (Swick & Williams, 2006). For example, social workers may organize communities, manage social work organizations, and focus on organizational or cultural change. At the mezzo level of social work, there are at least two issues regarding providing culturally and linguistically competent mental health services for deaf and hard of hearing people: (a) a lack of behavioral healthcare organizations that offer culturally and linguistically competent mental health services for deaf and hard of hearing people and (b) lack of educational specialization programs for social workers who are interested in addressing the needs of this population.

There is a lack of healthcare providers who offer culturally and linguistically competent mental health services for deaf and hard of hearing people (Harmer, 1999; Kuenburg, Fellinger, & Fellinger, 2016; Pertz et al., 2018; Sheppard, 2014). Healthcare

providers generally have little understanding of the complex language and communication needs of deaf and hard of hearing people, as well as little knowledge of how to implement program design and service delivery appropriately. As a result, deaf and hard of hearing people experience communication disparities in healthcare systems. Further, communication disparities may lead to poorer healthcare in areas including mental health, as well as lower quality care and increased mortality (McKee & Paasche-Orlow, 2012). Therefore, healthcare providers must consider the provision of appropriate language access for deaf and hard of hearing people in healthcare settings in order to prevent disparities affecting this population (Quan & Lynch, 2010).

Additionally, each healthcare provider must provide services directly to each deaf and hard of hearing individual to meet patients' personal communication needs, rather than using sign language interpreters as the first solution. In several groundbreaking court cases, it has been declared that services in which interpreters are used as the first solution do not offer equal access to healthcare services relative to services provided by signing mental health professionals (NAD, n.d.). The NAD (n.d.) has stated that existing healthcare providers or programs that provide services by direct communication need to continue to be run and/or replicated in order to avoid producing communication disparities.

A lack of academic institutions that train people to provide culturally and linguistically competent services for deaf and hard of hearing people has been an issue of concern (Sheridan et al., 2010). During the 1970s and 1980s, there were graduate-level social work programs that trained deaf and hard of hearing students. Universities that

offered specialized programs for deaf and hard of hearing students included University of

Maryland, Boston College, and Ohio State University (Sheridan et al., 2010). Those

programs were offered through funding from various sources, such as a federal grant

from the Rehabilitation Services Administration and a training grant from the Department

of Mental Health (Sheridan et al., 2010). Graduates of social work programs specializing

in deaf and hard of hearing people were in high demand by employers throughout the

country because of federal laws such as Section 504 of the Rehabilitation Act of 1973.

Unfortunately, during the same period, deaf and hard of hearing students experienced

discrimination based on their hearing loss at other schools. There were universities that

did not provide sign language interpreters for deaf and hard of hearing students. This

moved Gallaudet University to conduct a needs assessment for graduate-level social work

education (Sheridan et al., 2010). As a result, the university established its Master of

Social Work program in 1989 with an advanced year concentration in deaf and hard of

hearing populations, which is now the only such graduate program in the United States

(Gallaudet University, n.d.).

Issues With Macro Social Work

In *macro social work*, social workers intervene in large systems to help

individuals or families (Swick & Williams, 2006). For example, social workers may

lobby to change a law, organize a statewide activist group, or advocate for social policy

change. Social workers who engage at a macro practice level often have experience with

micro or mezzo social work practice, as well as social work research. Swick and William

(2006) stated that the macrosystem is the most powerful among social work systems and

acts as a source of both negative and positive energy. For example, the macrosystem includes the passage of several important laws such as the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 (Geer, 2003). These acts have impacted deaf and hard of hearing people by enabling them to protect themselves from discrimination in everyday life. However, deaf and hard of hearing people are often denied access to businesses, hospitals, schools, workplaces, and many other locations, including mental healthcare providers. A lack of understanding of cultural and linguistic needs of deaf and hard of hearing people results in a prejudiced population. Often, and artlessly, the rights of deaf and hard of hearing people are deprived. In some cases, the lives of deaf and hard of hearing people are put in jeopardy (Lane, 2005).

Before the 1960s, deaf and hard of hearing people lacked access to necessary mental health services (Vernon & Leigh, 2007). Before the Rehabilitation Act of 1973 was passed, many deaf and hard of hearing people struggled to access private and public services, including mental health services. Even recently, a lawsuit was filed in the state of Missouri. Deaf people in Missouri sued the Missouri Department of Mental Health (MDMH) and the Missouri Department of Social Services (MDSS) in April 2011, stating that MDMH and MDSS had violated deaf people's rights by discriminating against them based on their hearing disability. The deaf plaintiffs stated that MDMH and MDSS had violated two federal laws: the Rehabilitation Act of 1973 and the Americans With Disabilities Act of 1990. According to the settlement reached in the lawsuit, all deaf and hard of hearing people would be eligible for mental health services from MDMH and MDSS (MDMH, n.d.). As evidenced by the fact that the lawsuit happened in the state of

Missouri in recent history, there are still barriers that need to be removed in order for deaf and hard of hearing people to have equal access to mental health services in the United States (NAD, n.d.). The NAD (n.d.) has made several position statements about mental health services for deaf and hard of hearing people. The NAD has stated that deaf and hard of hearing people need to have access to mental health services through direct communication throughout the country. At the state level, there has been a lack of recognition of the cultural and linguistic needs of deaf and hard of hearing people with serious mental illness in accessing healthcare providers, as well as a lack of coordination with academic institutions that educate and train social workers to become culturally and linguistically competent to meet the needs of this population. These deficiencies in state policies have been significant issues at the macro level.

In conclusion, all of the evidence on the micro, mezzo, and macro levels points to a lack of culturally and linguistically competent mental health services for deaf and hard of hearing people. Mental health services for deaf and hard of hearing people still represent a needed social work specialty. Further research to address the lack of mental health services for deaf and hard of hearing people needs to be conducted. It is of critical importance to gain an understanding of the experiences of social workers working with deaf and hard of hearing people with serious mental illness because a better understanding of these experiences may help other social workers learn and work around issues at all levels, as well as try to implement best practices in their own agencies as much as possible.

Purpose of the Study

The primary purpose of this capstone project was to gain an understanding of the experiences of social workers working with deaf and hard of hearing people with serious mental illness. To address this purpose, I used action research and conducted a focus group with social workers working with deaf and hard of hearing people with serious mental illness.

Research Question

For this capstone, I gathered data from social workers who serve deaf and hard of hearing people with serious mental illness about their experiences of working with this population. The main research question and subquestions are outlined below:

RQ: What are the experiences of social workers working with deaf and hard of hearing people with serious mental illness?

Subquestion 1: What are the challenges identified by social workers who work with deaf and hard of hearing people with serious mental illness?

Subquestion 2: What are best practices identified by social workers who work with deaf and hard of hearing people with serious mental illness?

Concepts

Deaf and hard of hearing people are a diverse group (Szarkowski, 2017; Whitaker & Thomas-Presswood, 2017). The concept of a diverse group is related to hearing status and degree of integration in the community (Holcomb, 2012). It is also important to

consider other aspects of diversity, such as geographic location, age, race, and socioeconomic status. While deaf people have common experiences that come from spending life as a person with reduced hearing ability, they also have experiences that differ from one another. As a result, there is variation among the definitions of deafness that are used within the deaf community.

How the terms *deaf* and *hard of hearing* are defined depends on several factors that have a significant impact on a deaf or hard of hearing person's functioning (Szarkowski, 2017). Examples of these factors include hearing status (how much one is able to hear, classically described along a continuum from mild to profound hearing loss), the time of onset of reduced hearing (whether one has reduced hearing at birth or experiences hearing loss later in life), the age at which reduced hearing is identified, and access to supports for communication (how one communicates with hearing people, e.g., sign language and/or the use of technologies such as hearing aids or cochlear implants; Szarkowski, 2017). Additionally, there are people who identify themselves as *Deaf* and consider themselves part of the deaf community (Holcomb, 2012, Szarkowski, 2017). The capital "D" in *Deaf* is used to emphasize that people who adopt this designation do not consider deafness to be burdensome or a disability; instead, they see themselves as part of a cultural and linguistic minority group (Holcomb, 2012; Kusters, De Meulder & O'Brien, 2017; Szarkowski, 2017). Deaf people communicate with each other with a visual language, ASL, and they share customs, norms, and cultural traditions (Barclay, 2017; Holcomb, 2012; Szarkowski, 2017).

For this action research study, I have used the terms *deaf* and *hard of hearing people*. I have defined both terms by using the concepts introduced above. Whether a person identifies as deaf or hard of hearing is up to him or her, as the distinction between these terms involves various factors that have a significant impact on his or her functioning and perspective.

In 1946, the World Health Organization (WHO) defined *health* as "a state of complete, physical, mental and social well-being" (WHO, 2001, p. 1). However, American social scientists questioned the rationality of this definition and refined it over the next several years (Larson, 1996). Definitions of mental illness have changed in U.S. health care and public health over the last half century (American Psychiatric Association, 2013).

For the purpose of this study, the term *mental illnesses* encompasses conditions that impact cognition, emotion, and behavior (American Psychiatric Association, 2013). Examples of mental illnesses include, but are not limited to, schizophrenia, depression, and autism. Perspectives on mental illnesses have moved from a reductionist approach to science, epitomized by molecular biology, to a more holistic approach (Prince, Comas-Herrera, Knapp, Guerchet, & Karagiannidou, 2016). The holistic approach is based on the idea that a person with mental illness should be treated as a whole person by recognizing the mental, emotional, physical, social, and spiritual aspects of his or her well-being, rather than just viewing him or her as having a brain-based disease. A focus on the stigma toward mental illnesses has transitioned to the recognition that mental health is important to overall health (Corrigan, Druss, & Perlick, 2014). Traditionally, a

person with a mental illness was defined by diagnosis alone, and the dignity of the person was often ignored (Croft et al., 2015). People with mental illnesses were generally stigmatized and institutionalized. Deinstitutionalization began in the mid-1950s and accelerated during the 1980s and 1990s (Pinch, 1988). More and more people with mental illnesses were released from state mental hospitals and have been served by community mental healthcare providers (Marcussen & Ritter, 2016). The National Institute of Mental Health (NIMH), recognizing that diagnosis alone is not an appropriate way to define mental illness, added concepts of disability and duration to definitions of this term. These concepts were used to define people with severe and persistent mental illness (Grob, 1994). Later, the NIMH extended its efforts to include populations with mental illnesses associated with lesser disabilities and removed duration from the definition.

Today, the person is viewed first when considering mental illness. That is, strengths are emphasized, and weaknesses are deemphasized. It is believed that people with serious mental illnesses are able to achieve recovery and full participation in community life regardless the presence of permanent symptoms and disabilities (Slade et al., 2014). The primary manuals used by healthcare providers and clinicians for mental disease classification are the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM), now in its fifth edition (American Psychiatric Association, 2013), and the WHO's *Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death* (ICD), currently in its 10th edition (WHO, 1992). Previous versions of the DSM and ICD did not fully correspond

with one another so that the same diagnoses would be listed in both systems. However, insurers and practitioners have come to be familiar with both systems, especially with new evidence on interactions between physical and mental health (Kupfer, Regier, & Kuhl, 2008). Accordingly, the DSM Task Force developed the fifth version of the manual to more closely align it with the 10th edition of ICD (Kupfer et al., 2008).

It is also important to note that there are several terms that refer to serious mental illness. Examples include, but are not limited to, *chronic mental illness*, *serious and persistent mental illness*, *severe and persistent mental illness*, and *severe mental illness*. They are often used interchangeably. However, the terms used to refer to serious mental illnesses that require an intervention and treatment are *serious mental illness* and *severe and persistent mental illness* (Goldman & Grob, 2006). Federal agencies previously used the terms *chronic mental illness* and *serious and persistent mental illness*, but they were removed because consumers and advocates felt that the terms had negative implications that some forms of mental illness are unmanageable (Goldman & Grob, 2006). Not all forms of a serious mental illness are chronic, and people with serious mental illness can experience recovery by intervention and treatment. The definition of a serious mental illness was created by the U.S. Department of Health and Human Services for states to apply grant funds to support mental health services (58 Fed. Reg. 96, 292425, 1993). According to the federal regulation, a *serious mental illness* is defined as a condition that affects

persons aged 18 or older who currently or at any time in the past year have had a

diagnosable mental, behavioral, or emotional disorder (excluding developmental

and substance use disorders) of sufficient duration to meet diagnostic criteria specified within DSM-IV (APA, 1994) that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities. (Substance Abuse and Mental Health Services Administration, 2013, p. 11)

Moreover, definitions of *serious mental illness* vary depending on what the term is used for, such as legal purposes, clinical purposes, or epidemiological purposes. Legal definitions can vary with the context, such as eligibility for disability or Supplemental Social Security benefits. Epidemiological definitions must be based on standardized measures and remain unchanging over time. In the epidemiological context, it may be necessary to track the prevalence and incidence of a mental illness over time; in this context, a serious mental illness may be defined by answering questions from the National Survey of Drug Use and Health. For clinical purposes, a serious mental illness needs to be defined with a more multidisciplinary, biosocial approach.

In this action research study, I discussed social workers working with deaf and hard of hearing people with serious mental illness. The term *people with serious mental illness* refers to those who have been diagnosed with a serious mental illness from the DSM-5 and/or ICD-10 and who have received clinical intervention and treatment from a healthcare provider. Recovery, full participation in the community, and other aspects of mental illnesses such as disability and physical health are not discussed in this study.

Contributions of the Study

      This capstone project is important because the findings from this project offer new knowledge about the experiences of social workers working with deaf and hard of hearing people with serious mental illness. This new knowledge may be helpful to social workers seeking to become culturally and linguistically competent to work with this population. Moreover, the new knowledge may be beneficial to healthcare providers seeking to reduce communication disparities in the healthcare system. Additionally, this capstone project highlights the need for more studies about mental health services available for deaf and hard of hearing people in different locales to call attention to academic institutions. Furthermore, the findings may be used to educate and train social workers to improve or ensure the quality of mental health services for this population. My goal is to publish the findings, provide presentations at NASW conferences at both the national and state levels, and present at conferences hosted by the NAD and state chapters of the NAD. I would also like to work with NASW chapters and academic institutions including Gallaudet University, using the findings to help to educate the community about clinical issues of mental health services for deaf and hard of hearing people as well as developing a curriculum to train students who have a desire to become social workers who work with the population.

Nature of the Doctoral Project

      The design of this capstone project was an action research study. Action research is

a form of collective self-reflective inquiry undertaken by participants in social

situations in order to improve the rationality and justice of their own social or

educational practices, as well as their understanding of those practices, and the

situations in which the practices are carried out. (Kemmis & McTaggart, 1988, p.

5)

The participants for this action research study were social workers who worked at one

healthcare provider that provided culturally and linguistically competent mental health

services for deaf and hard of hearing people. Examples of job titles of the participating

social workers included, but were not limited to, therapists, case managers, residential

advisors, and any other positions that provided direct practice with the population.

Participants did not need to hold a social work degree, as long as they functioned in a

social work capacity according to the organization. Hearing status was not among the

inclusion/exclusion criteria to participate. Therefore, hearing social workers could be

participants in this study, as long as they worked directly with deaf and hard of hearing

people with serious mental illness.

An action research study allowed me to empower participants to identify their

own problems and discuss solutions to these problems. As an action researcher, I was

responsible for providing support to participants to identify problems by themselves and

discuss solutions to the problems. An action research study was a beneficial way to gain

an understanding of the experiences of social workers in various positions who were

working with deaf and hard of hearing people with serious mental illness. An action

research study was the most appropriate research design for this capstone project.

I used a focus group to collect data on the experiences of social workers working with deaf and hard of hearing people with serious mental illness. The focus group generated data about the experiences of social workers working with deaf and hard of hearing people with serious mental illness. I then organized and analyzed the data by identifying codes, categories, and themes on the three levels: micro, mezzo, and macro. I drew discussion and conclusions from the repeated themes pertaining to the experiences of social workers working with deaf and hard of hearing people with serious mental illness.

Significance of the Study

The study's findings may enable social workers to learn about the experiences to become culturally and linguistically competent to work with deaf and hard of hearing people with serious mental illness. Healthcare providers may use the knowledge produced from this study to reduce communication disparities in the healthcare system through providing culturally and linguistically competent services to the population. Moreover, the study's findings may contribute to overall social work knowledge about the experiences of social workers working with deaf and hard of hearing people with serious mental illness. This study may inform academic institutions and draw attention to the need for more studies to further understand mental health services available for deaf and hard of hearing people in different locales and educate and train social workers to become culturally and linguistically competent to meet the needs of the population in each locale. There are some states that provide services that support deaf and hard of hearing people in receiving full access to mental health services. These states could use

the findings to learn how to train social workers and healthcare providers to become more culturally and linguistically competent to work with deaf and hard of hearing people.

Since the 1990s, the accessibility of mental health services for deaf and hard of hearing people has been improved (Critchfield, 2002; Vernon & Leigh, 2007). The number of mental health services for the population has increased (NAD, n.d.). However, research studies about experiences of social workers working with deaf and hard of hearing people with serious mental illness are still limited. Mental health for deaf and hard of hearing people is still a new social work specialty. Advocacy strategies for deaf and hard of hearing people with serious mental illness to address a lack of culturally and linguistically competent services need to be explored and implemented. The findings from this study may contribute new knowledge and provide clues about addressing problems on three levels (i.e., micro, mezzo, and macro) to address the circumstance in which deaf and hard of hearing people suffer from a lack of culturally and linguistically competent services.

Theoretical/Conceptual Framework

I used ecological systems theory to frame this study. Ecological systems theory offers a framework to examine individuals' relationships within communities and the broader society (Bronfenbrenner, 1992). Ecological systems theory was developed by Urie Bronfenbrenner. Bronfenbrenner is most known for his ecological systems theory to frame a study of human development. Bronfenbrenner examined the process of human development and stated that human development is shaped by the interaction between an individual and his or her environment (Bronfenbrenner, 1992). Additionally,

Bronfenbrenner stated that human development results from the impacts of an individual's surroundings, including parents, friends, school, work, culture, and so on (Bronfenbrenner, 1992).

Bronfenbrenner (1992) stated that there are multiple levels of environmental factors that can affect human development, starting with the microsystem and continuing into the mesosystem and macrosystem. The microsystem refers to individual interactions that most directly influence human development—those most closely surrounding an individual, including family, schools, neighborhood, and the immediate environment (Bronfenbrenner, 1992). The mesosystem refers to interconnections between two or more microsystems, such as relationships between the individual's family and school, family and organizations, and an organization and the immediate environment (Bronfenbrenner, 1992). Finally, the macrosystem refers to the culture, subculture, or social context to which the individual belongs (Bronfenbrenner, 1992). Examples of cultural or social contexts include, but not limited to, country, geographic area, age, race, disability, and socioeconomic status. Although Bronfenbrenner identified additional systems such as exosystem and chronosystem, due to the nature of the topic under study, I do not address those system levels in this document.

The goal of ecological systems theory is to facilitate an understanding of complex phenomena by gathering information and clarifying relationships among different components that impact human development (Bronfenbrenner, 1992). The concepts of ecological systems theory are applicable to this study. Microsystems can include mental healthcare providers, departments and employees within mental healthcare providers,

families, and schools where social workers interact with deaf individuals. The social worker, the subject for this study, impacts not only those systems, but also the deaf community by providing culturally and linguistically competent services for deaf and hard of hearing people. Mesosystems involve relationships between social workers and families of deaf and hard of hearing people with serious mental illness. Mesosystems can also include relationships among social workers, schools, and organizations that involve deaf and hard of hearing people with serious mental illness. Examples of organizations include social service providers such as the Social Security Administration, state departments, courts, churches, hospitals, and so on. Social workers who work with deaf and hard of hearing people with serious mental illness work with such organizations to advocate for them in order to meet their financial, legal, religious, and medical needs and help them maintain their mental health stability. The relationship between social workers and their employers can impact deaf and hard of hearing people with serious mental illness. For example, if social workers experience burnout or are not satisfied with their employment, they may not be able to provide appropriate services for deaf and hard of hearing people with serious mental illness. Macrosystems may include the deaf culture and the community to which deaf and hard of hearing people with serious mental illness belong. The deaf community can also include mental healthcare providers, social workers who work for healthcare providers and schools for the Deaf as members of a cultural group who share a common identity, custom, and values.

 In order to achieve social justice equality by promoting tangible changes in policies or services for deaf and hard of hearing people with serious mental illness, a

comprehensive understanding of the experiences of social workers working with deaf and hard of hearing people with serious mental illness is needed. Achieving this goal requires the deaf community to be involved with academic institutions to advance the social work knowledge base related to experiences working with the population. It was important to engage the deaf community in this action research study, and it will be important to disseminate the findings to the community. Ecological systems theory enabled me to facilitate an understanding of experiences working with deaf and hard of hearing people with serious mental illness by gathering information about relationships among different surroundings that can impact the human development of deaf and hard of hearing people with serious mental illness, such as mental healthcare providers; social workers who work for mental healthcare providers; families; schools for the deaf; organizations that provide the population with social, legal, vocational, and medical services; and the deaf community. Additionally, ecological systems theory allowed me to organize the findings of this action research study by three levels of environmental factors that can affect human development of deaf and hard of hearing people with serious mental illness (i.e., microsystem, mesosystem, and macrosystem).

Values and Ethics

I conducted this action research study to produce knowledge about the experiences of social workers working with deaf and hard of hearing people with serious mental illness. The NASW Code of Ethics (2017) holds service up as one of social work's six core values and states, "Social workers' primary goal is to help people in need and to address social problems." The purpose of this action research study was to gain a

better understanding of the experiences of social workers who offer culturally and linguistically competent mental health services for deaf and hard of hearing people. This action research study was conducted to stand by the value of service and the ethical principles of the social work profession by learning about the experiences of social workers. This knowledge may inform suggestions that could be used to increase the number of social workers and healthcare providers who can provide culturally and linguistically competent mental health services for deaf and hard of hearing people.

In addition, the NASW Code of Ethics (2017) holds competence up as another value and states, "Social workers practice within their areas of competence and develop and enhance their professional expertise." Moreover, according to Section 1.05 (a) of the NASW Code of Ethics, "Social workers should have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups" (NASW, 2017). This action research study may provide information to support the ability of social workers and healthcare providers to provide culturally and linguistically competent practice with deaf and hard of hearing people.

This action research study supports the value of social justice and the ethical principle that indicates that social workers challenge social injustice. The NASW Code of Ethics states, "Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people" (NASW, 2017). This action research study may enable healthcare providers and their employees to gain an understanding of experiences working with deaf and hard of hearing people with serious

mental illness. Additionally, this study may inform academic institutions and draw attention to the need for more studies to further understand mental health services available for deaf and hard of hearing people in different locales. Ultimately, this study may produce knowledge that will be used to address these changes so that more and more social workers will be able to provide culturally and linguistically appropriate services to deaf and hard of hearing people with serious mental illness, which supports values regarding the dignity and worth of the person and the ethical principle that "social workers respect the inherent dignity and worth of the person" (NASW, 2017).

Review of the Professional and Academic Literature

A literature review was conducted to understand a theoretical framework for the experiences of social workers working with deaf and hard of hearing people with serious mental illness. I started the literature review by conducting a comprehensive bibliographic search of articles and books in social work. The abstracts of relevant articles and books were skimmed to define key terms and identify claims, conclusions, and findings to gain an understanding of the experiences of social workers working with deaf and hard of hearing people with serious mental illness. Databases that I used to find articles and books included, but were not limited to, SocINDEX, PsycINFO, and PsycARTICLES from the Walden University library. The key terms used to find appropriate articles and books for this literature review were *deaf*, *hard of hearing*, *mental health*, and *social worker*. Most sources for this literature review had been published within the last 5 years and were peer reviewed.

Understanding Deaf Culture

There are two viewpoints on deaf individuals (Holcomb, 2013; Ladd, 2003; Lane, Hoffmeister, & Bahan, 1996; Leigh, Andrews, & Harris, 2016; Padden, Humphries, & Padden, 2009). One is the medical/pathological model. Those who support this viewpoint consider a deaf individual as someone who cannot communicate by speaking and hearing and who is incomplete in some way just because of his or her hearing ability (Munoz-Baell & Ruiz, 2000). The focus of this viewpoint is what a deaf individual cannot do, rather than the other positive traits and abilities of a deaf individual (Munoz-Baell & Ruiz, 2000). This viewpoint supports an idea that deaf individuals need assistance and that deafness should be fixed (Thumann & Simms, 2009). The other viewpoint is the cultural model. This viewpoint is promoted by not only deaf persons themselves, but also activists and professionals working within the deaf community (Lane, 2005). The cultural model supports an idea that society should not define deaf people as having a disability (Holcomb, 2013; Padden et al., 2009). That is, the cultural model suggests an inclusive approach to seeing deaf individuals for what they can do rather than what they cannot do (Heucer, 2007). Activists and professionals who support this viewpoint argue that deaf people can normally and easily communicate with each other using ASL; deaf people are not lessened in the context of communication ability (Holcomb, 2013; Lane, 2005; Lane et al., 1996; Padden et al., 2009).

During the first half of the 20th century, the proponents of deaf education supported the oral method (Barron, 2017). The focus of the oral method was teaching deaf children to speak and read lips to understand what was being said to them. This

approach was not helpful for all deaf children, especially those who were profoundly deaf (Lynas, 2005). It is difficult for deaf children to acquire spoken language skills with the oral method as hearing individuals do. As the lip-reading method is considered complex and variable, it is an unreliable skill set (Chininthorn, Glaser, Tucker, & Diehl, 2016). The aim of the oral method was to make deaf children function in the same ways that hearing children do.

ASL plays an important role, just as all spoken languages do. A language is important in understanding the culture of the people who use it to communicate. Sign language is not universal; deaf people throughout the world have developed their own countries' unique and different sign languages (Emmorey, 2000). There are even regional languages in geographically different areas within a country (Valli & Lucas, 2000). ASL is a distinct language (as is English), and it is recognized by governmental and educational institutes as a language just like any foreign language (Miller, 2008). Leading universities offer ASL classes as an option for students to take to meet their foreign language credit requirements.

Deaf culture exists in the deaf community and is associated with members' own language and social norms, which are considerably different from the ones in the hearing world (Ladd, 2003; Lane et al., 1996; Leigh et al., 2016; Padden et al., 2009). Deaf people tend to attend events where they can use their preferred mode of communication, which may be ASL (Lane et al., 1996). Deaf people also tend to avoid communicating verbally or in writing when there are communication alternatives available for them to

use as an option, such as ASL interpreters or video relay services that allow deaf people to communicate in their native or preferred language (Lane et al., 1996).

Nowadays, deaf people are active and contributing at every level of the state, public, and private sectors within U.S. communities. The only areas where deaf people cannot succeed are where the medical/pathological viewpoint is inflexibly rooted and deaf people are viewed based on misrepresented labels (Ayantoye & Luckner, 2016). There was a historically important event for the deaf community in 1988. The "Deaf President Now" movement, which represents the cultural model, occurred at Gallaudet University (Bergey & Gannon, 2016). Gallaudet University, which was founded for deaf students in Washington, DC in 1864, is still the world's only liberal arts college for deaf students. A huge protest started to occur once the hearing Board of Trustees announced that it had chosen a hearing candidate to be selected as the seventh president of the university rather than two other candidates who were deaf (Kensicki, 2001). The gates were locked, and the campus was taken over by deaf students and their supporters. After several days, the hearing candidate decided to resign from the president position, and the hearing board selected Dr. I. King Jordan, who had been a professor at the university (Kensicki, 2001). This historic event spread worldwide is recognized as the most influential civil rights accomplishment for the deaf community (Higgins & Lieberman, 2016).

Demographic Background of Deaf and Hard of Hearing People in the United States

The number of deaf and hard of hearing people in the United States is approximately 11,000,000 (Pape, Kennedy, Kaf, & Zahirsha, 2014). According to

Gallaudet Research Institute (n.d.), the number of people who are over 5 years old and "functionally deaf" in the United States is nearly 1,000,000, while the number of people who are over 5 years old and hard of hearing is about 8,000,000. "Functionally deaf" are those who have a profound hearing disability, and most of them need accommodations, such as sign language interpreting, to communicate with hearing people. People who have a severe to profound hearing disability tend to identify themselves as deaf (Lieberman, 2016). Deaf people in the United States use ASL as their primary language and create a tightly knit community (Lederberg, Schick, & Spencer, 2013; Leeson et al., 2016). On the other hand, hard of hearing people are individuals who have mild or moderate hearing levels and try to rely more on what they can hear with hearing aids (Andrew, 2010). Some of them may be able to understand normal, one-on-one conversation with the use of hearing aids while experiencing extreme difficulty in group conversation (Haynes, 2014). Others, with severe hearing disability, may not be able to communicate as effectively, even with the use of hearing aids. While hard of hearing people who are born from deaf parents who use ASL tend to be naturally deaf acculturated, hard of hearing people who are born from hearing parents tend to acculturate to the hearing culture of their families (Leigh et al., 2016). They often want to be "hearing" so they do not feel different from their families and friends (Leigh et al., 2016). However, they struggle in communicating with hearing people due to their reduced hearing ability. Some of them learn ASL when they are in high school or college to become part of the deaf community (Leigh et al., 2016).

In conclusion, there are differences in hearing ability, communication modes, and tools to support for access to communication between deaf and hard of hearing people. Concretely speaking, people with a reduced hearing ability have individually different needs for communication, depending on their hearing ability and their adaptation to using sign language and hearing aids.

Social Advocacy for Deaf and Hard of Hearing People

Deaf and hard of hearing people with serious mental illness are considered socially vulnerable. There is a culture that deaf and some hard of hearing people own, which is handed down from one generation to another. They live and function in this deaf culture (O'Brien & Placier, 2015). Deaf and hard of hearing people share values and experiences, and they communicate with each other in a visual language, ASL (Stapleton, 2015). As stated earlier, some hard of hearing people and most deaf people face a great challenge in communicating with hearing people, especially when they are with a group of hearing people (Pollard & Barnett, 2009). In this context, deaf and hard of hearing people with severe mental illness are challenged to a far greater extent when communicating with hearing people. Therefore, deaf and hard of hearing people with serious mental illness are socially vulnerable and disadvantaged. They have been left behind historically and even today due to these communication challenges. They are one of the vulnerable populations that need policy advocacy to address communication challenges.

In the past, deaf and hard of hearing people with serious mental illness did not have access to mental health services. Research shows that deaf and hard of hearing people

lacked access to appropriate mental health services before the 1960s (Glickman &

Pollard, 2013; Thomas, 2014). Specifically, there were no necessary accommodations for

deaf and hard of hearing patients provided by healthcare providers. Additionally, deaf

and hard of hearing practitioners, or hearing ones who were able to fully meet the

individual communication needs of deaf and hard of hearing patients, were rare. Not

surprisingly, deaf and hard of hearing patients often were misdiagnosed, and

correspondingly, they received inappropriate treatment (Glickman & Pollard, 2013). As

a result, deaf and hard of hearing people with serious mental illness may have been given

improper diagnoses and admitted to hospitals for a longer or shorter period than they

should have been hospitalized without clinically appropriate reasons (Vernon & Daigle-

King, 1999).

In the 1970s, there were changes in the social landscape of people with disabilities.

Several important laws to protect the rights of people with disabilities were passed. These

laws were the Rehabilitation Act (RA) of 1973, the Education for All Handicapped Act

of 1975, and the Americans With Disabilities Act (ADA) of 1990. The passing of these

laws made profound differences in lives of deaf and hard of hearing people, including

those with serious mental illness (Wilson & Schild, 2014). In other words, these laws

allowed deaf and hard of hearing people with serious mental illness to have better access

to necessary mental health services.

These historic and influential laws provided deaf and hard of hearing people access

to mental health services with fewer barriers (Vernon, 1995). Additionally, at just the

right time, Gallaudet University started to offer a bachelor's program in social work in

1970, and later offered a master's degree in social work in 1989 (Gallaudet University, n.d.). Gallaudet University was established for deaf and hard of hearing people in Washington, DC in 1864, and is well-known in the deaf community as well as the general public, not only in the United States, but also all around the world (Gallaudet University, n.d.). Since then, some deaf and hard of hearing graduates have been produced, and those holding degrees in social work have been active in various fields of social work in throughout the United States and internationally.

With the increasing number of deaf and hard of hearing graduates majoring in social work, research on the mental health of deaf and hard of hearing people has been increasing (Glickman, 2013). Unfortunately, the most recent research shows that deaf and hard of hearing people with serious mental illness still experience a great shortage of options for mental health services, especially in rural areas (Crowe, 2017). There are still health care providers that do not abide by the laws that protect the rights of people with disabilities (Krahn, Walker, & Correa-De-Araujo, 2015). Further, there are still not enough practitioners who have a strong command of the ASL language and seasoned knowledge of deaf culture (Anderson et al., 2017; Schild & Wilson, 2014; Thomas, 2014). Social workers who are themselves deaf and hard of hearing are often the best providers of culturally sensitive and accessible services for deaf and hard of hearing people because they use sign language fluently and have necessary communication skills (Glickman, 2013; Sheridan et al., 2010). In addition, they have unique cultural knowledge about the population at risk. However, deaf and hard of hearing people who have completed a graduate program to study social work often experience challenges of

their own with their professional development due to lack of full access to their professional organizations (Sheridan et al., 2010). Barriers to professional development make it more difficult for deaf and hard of hearing graduates to get job opportunities, build professional experiences, and enhance their knowledge and skills. Under these circumstances, it is undeniable that lack of access to mental health services for deaf and hard of hearing people with serious mental illness has remained a social justice issue.

As remarked above, knowledge of the historic events that have affected the accessibility and availability of mental health services for deaf and hard of hearing people is helpful in assessing the needs of this population for mental health services. Deaf and hard of hearing people with serious mental illness have continued to be underrepresented in practice and research. Unresolved social justice issues of this disadvantaged and vulnerable population need to be given serious consideration. To ensure the protection of the rights of deaf and hard of hearing people with serious mental illness, it is imperative to conduct research to assess the accessibility and the availability of mental health services as well as assess the needs for treatment and accommodation of this particular underprivileged population.

An informative and helpful reference, *Meeting the Mental Health Needs of Persons Who Are Deaf,* written by Critchfield (2002), advocates for this socially vulnerable population. The content of the recommendation that Critchfield made is almost the same as the settlement agreed upon among representatives of the deaf community, the MDHH, and the MDSS in 2011 (MDMH, n.d.). Both Critchfield's recommendation and the settlement agreed upon between the deaf community and the MDMH/MDSS show the

importance of every state improving the accessibility and the availability of mental health services for deaf and hard of hearing people.

The significant laws passed between the 1970s and 1990s to protect the rights of people with disabilities have resulted in some improvements in the accessibility of mental health services for deaf and hard of hearing people (Wilson & Schild, 2014; Peacock, Iezzoni, & Harkin, 2015). There are effective and substandard mental health services offered for this particular disadvantaged population in some U.S. states (Glickman & Pollard, 2013; Wilson & Schild, 2014). However, there is a lack of knowledge about experiences of working with deaf and hard of hearing people with serious mental illness. This study is needed to further understanding in order to develop and preserve culturally and linguistically competent mental health services for deaf and hard of hearing people in different locales.

In order to ensure mental health services for deaf and hard of hearing people and achieve social justice equality for deaf and hard of hearing people with serious mental illness, studies of experiences working with deaf and hard of hearing people need to be conducted. Without such studies, implementation of mental health services for deaf and hard of hearing people will be difficult.

Deaf and Hard of Hearing People With Serious Mental Illness

The U.S. deaf community consists of people with reduced hearing ability who identify themselves as deaf and use their own language, which is ASL. Unfortunately, the deaf community struggles to have access to health care, especially mental health care (Fellinger et al., 2012). About 1 million deaf people use ASL in the United States

(Mitchell, Young, Bachleda, & Karchmer, 2006). About a quarter of deaf people have additional disabilities and serious mental illness (Fellinger et al., 2012). Thirty-three percent of deaf people report having experienced either depression or anxiety, compared to only 6.8% of hearing individuals (Kvam, Loeb, & Tambs, 2007). Additionally, serious mental illnesses such as depression and anxiety occur among deaf people who sign at a much higher rate—specifically, 2 times higher—than in the hearing population (Anderson, Glickman, Mistler, & Gonzalez, 2016; Fellinger et al., 2012; Kvam et al., 2007). The differences in mental illness rates between deaf people and hearing people are attributed to congenital, environmental, and educational factors (Black & Glickman, 2006). Yet deaf people experience more barriers to mental health services than hearing people do (Kuenburg et al., 2016; Thomas, 2014).

Culturally and Linguistically Competent Services

When working with deaf and hard of hearing people, mental health service providers should accept hearing loss as an essential and valued part of the individual and understand and respect communication choice of the individual and the needs of their family. The National Association of the Deaf suggests that mental health service providers should provide cultural and linguistic affirmative approach for people who have hearing loss in the United States (National Association of the Deaf, 2003). The NAD outlines the skills that are required for mental health service providers to have for being culturally and linguistically competent providers (National Association of the Deaf, 2003).

- Ability to communicate directly with deaf and hard of hearing individuals, frequently requiring fluency in American Sign Language, but may include other modes of signed or visual communication systems used by deaf and hard of hearing people; and

- Appropriate use of services and adaptive technology as is best identified and utilized by the consumer and his/her family members, including qualified and certified interpreters, assistive listening devices and real-time captioning services, and;

- Intensive and extensive awareness of the cultural and linguistic differences, and psychosocial impact associated with hearing loss.

- The skills of cross-culturally trained providers include:

    o Appropriate use of services and adaptive technology as is best identified and utilized by the consumer and his/her family members, including qualified and certified interpreters, assistive listening devices, and real-time captioning services; and

    o Awareness of and sensitivity to the cultural and linguistic factors that impact the quality of the delivery of mental health services to this population.

Barriers to Implementation

Deaf people often experience communication and linguistic barriers in healthcare that is usually inaccessible to them. Deaf people who use American Sign Language as a primary or preferred language are often denied access to the health care services because

most providers do not provide appropriate communication access for deaf people,

through qualified interpreters. In fact, each and every deaf person has their own hearing

level, communication styles, and languages. Deaf people are concerned about access to

communication with healthcare providers (Olson & Swabey, 2017). As a result, it is

difficult for deaf people to find a health care provider that really can communicate with

them effectively.

Because of the inaccessibility to mental health services for deaf and hard of

hearing people, they have to advocate themselves to face communication barriers in

health care systems (Olson & Swabey, 2017). As deaf people have poor access to

culturally and linguistically competent mental health services, they experience poor

health care and increased mortality (Emond et al., 2015). However, deaf people have

been affected by language deprivation and a lack of access to effective communication

with family members and peers since they were children (Hall, 2017). Due to language

deprivation, deaf people have little health literacy and limited medical and mental health

knowledge. As a result, deaf people demonstrate mistrust of healthcare providers and less

help-seeking behavior (Anderson, Wolf Craig, & Ziedonis, 2017).

Moreover, there has been a concern that managed care organizations tend to

reduce cost by reducing critical supports for deaf people, such as language access (Rice,

2014). Managed care organizations that include the ones that provide culturally and

linguistically competent services for deaf people have to cut costs and trim budgets.

Managed care organizations tend to try to stop providing culturally and linguistically

competent services and replace them with least accommodations such as interpreters.

However, they need to recognize that it is more expensive and not cost-effective to make such accommodations in the long run. It is ideal and effective for managed care organizations if they develop their own regionalized specialized services for deaf people with serious mental illness and make their services sustainable and practicable.

Summary

There are not many social workers who can use American Sign Language fluently and understand the deaf culture to be able to provide the quality of services to deaf and hard of hearing clients (Crowe, 2017). This has led to the lack of culturally and linguistically competent services for deaf and hard of hearing people. As a result, there have been communication disparities for deaf and hard of hearing people in the healthcare system. It is feasible for the integrated health care systems to address communication disparities if they are committed to providing culturally and linguistically competent services for deaf people with serious mental illness. It is their human right to obtain full access to health care and mental health services (Kuenburg et al., 2016).

However, there have been limited research studies that supply a comprehensive review of the experiences of social workers working with deaf and hard of hearing people with serious mental illness. Findings from this action research study in regard to the experiences of social workers working with the population may give advice about how best to address culturally and linguistically competent services for the population.

In order to generate findings to address the challenges of providing culturally and linguistically competent services for deaf and hard of hearing people with serious mental illness, I will implement this action research study by conducting a focus group with

social workers from a healthcare provider that offers culturally and linguistically competent services for deaf and hard of hearing people with serious mental illness. Findings from this action research study may help social workers obtain an understanding of the experiences of social workers working with deaf and hard of hearing people with serious mental illness. Also, new findings may help healthcare providers train social workers to become culturally and linguistically competent to work with the population. Moreover, this study could inform academic institutions and draw attention to the need for more studies to further understand mental health services available for deaf and hard of hearing people in different locales. This study may produce knowledge that will enable healthcare providers to train social workers to become culturally and linguistically competent to meet the needs of the population in each local. Ultimately, this study may produce knowledge which will be used to contribute towards these changes. The next section will provide details about the study's design and methodology.

Section 2: Research Design and Data Collection

The social work practice problem that prompted this study was lack of knowledge about social workers' experiences of working with deaf and hard of hearing people with serious mental illness. This study is needed to further understand the needs to develop and preserve culturally and linguistically competent mental health services for deaf and hard of hearing people in different locales. In order to gain an understanding of the experiences of social workers working with deaf and hard of hearing people with serious mental illness, I conducted a focus group with social workers working with deaf and hard of hearing people with serious mental illness to collect data about their experiences when working with the population.

Section 2 starts with a description of the research design that I implemented in an effort to construct meaningful research. Section 2 also provides information about the methodology for this action research study, including data collection procedures, participants, instrumentation, and strategies for validation. Section 2 ends with data analysis and ethical procedures.

Research Design

Action research was used to conduct this capstone project. The data collection method used for this action research study was a focus group. A focus group with social workers working with deaf and hard of hearing people with serious mental illness was used to discuss the experiences participants had when working with the population. I analyzed the collected data from the focus group and identified repeated themes.

Constructing Meaningful Research

Participants involved in action research perceive and interpret a problem in different ways (Stringer, 2007). One of the purposes of action research is to collect participants' different perceptions and interpretations of a problem (Stringer, 2007). Action research is beneficial for social change as it is conducted by an action researcher empowering participants to identify their experiences, discuss perceptions of their experiences, and develop solutions to the challenges that they have encountered—in this case, the ways in which participants managed their work with deaf and hard of hearing people with serious mental illness. Extracting and illuminating solutions to such problems requires an action researcher to have advanced communication skills to facilitate discussion among participants effectively (Kaner, 2014). To be a supportive facilitator to every participant, it is essential for an action researcher to demonstrate appropriate listening skills, which include, but are not limited to, paraphrasing, drawing out, mirroring, gathering ideas, and validating. It is important for an action researcher to have positive listening skills to respect participants' pride and dignity. An action researcher is responsible for maintaining participants' feelings of harmony, control, and accountability (Stringer, 2007).

The purpose of this action research study was to gain an understanding of the experiences of social workers working with deaf and hard of hearing people with serious mental illness. I worked with a healthcare provider that offered culturally and linguistically therapeutic services for deaf and hard of hearing people with serious mental

illness to conduct a focus group with social workers to discuss their experiences about working with this population and develop solutions to identified challenges.

Methodology

Data Collection Procedures

For this action research, a focus group was used as a method of collecting qualitative data as participants were asked for their perspectives, thoughts, beliefs, and attitudes about the experiences of employees of a healthcare provider that provided culturally and linguistically competent services for deaf and hard of hearing people with serious mental illness. The term *people with serious mental illness* refers to individuals who have been diagnosed with a serious mental illness from the DSM-5 and/or ICD-10 and who receive clinical intervention and treatment from a healthcare provider. Participants were invited to discuss and interact with each other freely. The focus group allowed participants to describe their experience working with deaf and hard of hearing people with serious mental illness. The detailed description of the procedures to ensure dependability is as follows.

First, I contacted a healthcare provider who provided culturally and linguistically therapeutic services for deaf and hard of hearing people with serious mental illness to ask for permission to conduct a focus group with social workers working with the population. A focus group to collect data about experiences working with deaf and hard of hearing people with serious mental illness was used to address a lack of knowledge about experiences of working with deaf and hard of hearing people with serious mental illness and to further understand needs in order to develop and preserve culturally and

linguistically competent mental health services for deaf and hard of hearing people in different locales. I provided a letter of cooperation for a person with authorization authority to sign and email back to me.

Once I had obtained permission from the healthcare provider, I emailed the invitation to the person with authorization authority or that person's designee and asked the recipient to forward the e-mail invitation to employees who might be interested in participating in this action research study. In order to ensure that there were not any negative consequences for participating or not participating in this action research study, I emphasized the voluntary nature of the study and provided guidance and resources, including a reminder about how to access the agency's Employee Assistance Program for participants in case they experienced any negative consequence from this study.

Then, I visited the healthcare provider and met participants who were willing to participate in a focus group. I provided participants with a consent form and explained action research. I emphasized to participants that participation in this study was completely voluntary and that they could withdraw from this study at any time. I also explained to participants about potential risks (physical risks, psychological risks, and loss of confidentiality) of participating in this study. I encouraged participants to use the healthcare provider's Employment Assistance Program if they had upsetting experiences while participating in this study. Moreover, I explained to participants about confidentiality. I explained that all information obtained from this action research study would be kept confidential. For example, I did not use participants' personal information for any purposes outside this action research study and did not include their names or

anything else that could identify them in the study reports. I was giving back to the healthcare provider only a summary of the study's findings, excluding any specific information related to the relationship between an employee and the healthcare provider. I had participants sign a consent form on an individual basis prior to the focus group.

When I explained the consent form, I described the acknowledgement of video recording. I explained that video recording was needed because the focus group would be conducted in ASL and noted that video recording would be used for transcribing purposes only. I explained that the video would not have the participants' names on it, would be kept in a secure place at my residence under lock, and would be destroyed physically, not simply thrown away, once the transcription had been confirmed.

Before starting a focus group, I also provided participants with a demographic questionnaire (Appendix A) that I asked them to complete by selecting the responses that best addressed their current status. I explained to participants that information reported on this survey would remain confidential and would be kept on my password-protected laptop, and I assured them that any reports published would not contain identifying information.

Researcher Positionality

I am deaf and use ASL as a primary language. Additionally, I have been working with deaf and hard of hearing people with serious mental illness for nearly 10 years. I should be oriented to the situation so that the context is appreciated and understood. My extensive work within this field of practice and population supported my understanding of the topic and ability to successfully engage the participants. The healthcare provider

where I conducted a focus group provided culturally and linguistically competent services for deaf and hard of hearing people on the East Coast. The healthcare provider provided deaf and hard of hearing people with a variety of services such as case management, an outpatient program, a residential program, and day treatment. The healthcare provider accepted almost all health insurances, with coverage depending on the service that the client received and the county in which the client resided.

Participants

The participants who were the subjects of this action research study were social workers working for a healthcare provider that provided culturally and linguistically competent services for deaf and hard of hearing people with serious mental illness. As explained above, I contacted a person of authorization at a healthcare provider and asked that person to sign a permission form and email it to me. Once I got permission from the healthcare provider, I asked the person of authorization to send out an e-mail invitation to employees of the healthcare provider. Because I had worked for the healthcare provider from 2009 to 2017 and had maintained a positive relationship with the organization, the likelihood of difficulty in obtaining agreement from the healthcare provider was low. In the unlikely event of a problem, I would have consulted with my doctoral committee regarding alternate plans using other providers.

I welcomed all employees as study participants who provided culturally and linguistically competent services to deaf and hard of hearing people with serious mental illness on a daily basis. The positions of participants could include, but would not be limited to, case managers, therapists, counselors, and advisors. Because social workers

working with deaf and hard of hearing people with serious mental illness were asked to participate in this action research study, purposive and convenience sampling was used. Because the healthcare provider where I was conducting a focus group was one at which I used to work and I had been in a supervisory position when I left, any employees whom I had supervised were not able to participate in this study due to the existence of a dual relationship that presented ethical concerns. Moreover, any employees in supervisory or administrative positions were not able to participate in this study to avoid the possibility of dual relationships with potential psychological impact affecting fully voluntary participation.

Even if there are no rigid numbers for the number of participants or questions asked, it is ideal for moderators of focus groups to facilitate discussions with groups consisting of eight to 10 people (Groves et al., 2009). If there are more than 10 people in a focus group, a moderator may have difficulty controlling the group and obtaining meaningful interaction among participants. On the other hand, if there are fewer than eight people, a moderator may not be able to get a significant variety of inputs from the participants. I recruited eight to 10 people to participate in a focus group. I did one focus group and gave the maximum time of 2 hours. The length of the focus group, along with time spent in member checking, allowed for an exhaustive look at the experience of the participants, a strategy to increase the trustworthiness of the study.

Instrumentation

This action research study using a focus group enabled participants to share their experiences of social workers working with deaf and hard of hearing people with mental

health needs. Because a focus group with employees of a healthcare provider that

provides culturally and linguistically competent services when working with deaf and

hard of hearing people with serious mental illness was conducted, discussion was

conducted in ASL. Because ASL was used for a focus group, the discussion was

videotaped. When I started to run the focus group, I asked participants to sit in an ellipse

formation so that a video recording device could capture the sign language of every

participant in the room. Questions helped participants in identifying a problem, clarifying

a detailed picture of the problem, and extending an understanding of the problem

(Stringer, 2007). The questions that participants were asked were in a group interview

protocol (Appendix B). The first thing for an action researcher to do is to gain an

understanding of participants' experiences and perspectives on the problem of interest by

gathering data (Stringer, 2007). The group interview protocol helped me prepare for the

inquiry of action research. Additionally, the group interview protocol helped me

remember what I needed to ask participants in order to proceed with the inquiry

successfully.

  There are techniques that can be used so that an action researcher will be able to

gather as much information as possible and understand the identified problem better

(Stringer, 2007). To implement the group interview effectively and successfully, I

developed a group interview protocol (Appendix B).

  In preparing the interview protocol, I designed questions that would enable more

than one-word responses. Questions that are broad and open ended enable participants to

answer with their own experiences, feelings, and thoughts on the problem (Stringer,

2007). Put simply, the broader the question, the more detailed the response it will elicit. I developed the group interview protocol with broad and open-ended questions so that participants could share their experiences working with deaf and hard of hearing people with serious mental illness. My literature review and understanding of the theoretical framework also provided information that assisted me in the development of the interview protocol.

An action researcher needs to use six questions—why, what, how, who, where, and when—so that participants can provide their direct experience (Stringer, 2007). These six questions allowed me to obtain as much information as possible from participants. I ensured that participants had the opportunity to provide answers that were focused on acts, activities, and events related to the identified problem. An action researcher should ask questions carefully because participants can react negatively if they are asked questions that make them feel that they are being judged or criticized (Stringer, 2007). Therefore, I developed questions carefully to prevent offensive or judgmental wording. One of the questions that was asked in the focus group was "How would you describe cultural competence for deaf and hard of hearing people with serious mental illness?"

Strategies for Validation

An action researcher is responsible for working with participants to create a focus group where they feel comfortable considering their claims and providing useful feedback (McNiff & Whitehead, 2010). As an action researcher, I explained the purpose of this action research study in the e-mail invitation to employees of a healthcare provider

that provided culturally and linguistically competent services for deaf and hard of hearing people with serious mental illness to recruit participants who understood the purpose of this action research and were completely willing to be part of a focus group voluntarily. All employees of a healthcare provider received the email invitation in order to support the likelihood of a diverse sample. The email was intended to recruit individuals who could provide diverse perspectives on the experiences of social workers working with deaf and hard of hearing people with serious mental illness from participants. I sought participants representing various positions, such as case managers, advisors, therapists, and counselors, in order to incorporate different sources of information to enhance the study's credibility. Incorporating multiple perspectives was one strategy that I used to provide triangulation of the data.

Second, action researchers need to make judgments about the validity of their own action research studies (McNiff & Whitehead, 2010). Validity needs to be determined by an action researcher and participants' reasonable judgments. I facilitated the focus group for participants to feel comfortable enough to share their claims and feedback about their experiences working with the population. I actively listened to each and every participant and validated participants' emotions and feelings so that they could feel safe and comfortable enough to stay in the focus group and could continue to have a clear mind to share their perspectives. I facilitated the discussion in such a way that the participants could share their perspectives on each other's statements. Because of my plan to conduct the focus group at the healthcare provider for which I used to work, any employees who were supervised by me were excluded from the action research study to avoid any bias.

Member checking occurred once the transcripts were complete. After I had transcribed the discussion from ASL to English, I presented my initial analysis and themes in a summary email to participants and asked participants for clarification and correction. This type of member checking identified whether participants believed that the initial analysis accurately reflected their experiences in an impartial manner.

An action research needs to ensure that the outcome of their action research study is trustworthy (Stringer, 2007). It is not acceptable for an action researcher to demonstrate their own perspective, biases, view of the world, or set of values in their action research study. I tried not to share my own perspectives, biases, view of the world, or set of values during a discussion for a focus group. Given my position, I kept a research journal and engage in peer debriefing with my capstone chair to check potential bias or interpretation based on my personal experiences.

I facilitated the focus group. I used my ability to effectively facilitate a group of eight to 10 participants. I listened carefully and ask good follow-up questions for clarification, as needed.

I made sure to create an opportunity for each participant to share their perspectives and experiences related to the investigated problem in a much detail as needed. I ensured participants have the opportunity to share their perspectives and record key points of the perspectives in the Section 3 of presentation of findings. When I played back the videotape to work an act of translation and analyze data, I saw if there is anything happening to other participants while I paid attention to the person who was talking to consciously observe. I took notes of what is actually happening on the videotape, but not

try to describe from memory or interpret what I "think" happened. Through persistent observation, I was able to identify the characteristics and behaviors of the participants that are most relevant to answering the research question. I made sure a video recording device would be placed to capture the sign language of every participant in the room where the focus group was conducted.

After I transcribed the discussion from American Sign Language to English, I presented my initial analysis and themes in a clear understandable way to the participants and asked the participants for clarification and correction (referential adequacy). Reports with the initial analysis and themes were written in the terminology and language that participants use every day. I used an everyday language to report findings of this action research study and conclude application to professional practice and implications for social change so that participants and readers of this action research study will be able to understand. An action researcher also needs to invite peers to judge their action research study (McNiff & Whitehead, 2010). My doctoral committee reviewed and made judgments on whether I worked with the participants appropriately. When I started a focus group with participants, I explained how I would realize the purpose of this action research study. While I did not share my own personal bias when facilitating a focus group and analyzing data, I explained that this action research was conducted to address the lack of knowledge about the experiences working with deaf and hard of hearing people with serious mental illness and this study was needed to further understand the needs to develop and preserve culturally and linguistically competent mental health services available for deaf and hard of hearing people in different locals. In order to

achieve the purpose of this action research study, I needed to make my action research study public by publishing and sharing the outcome in conferences for social workers such as NASW conferences.

Data Analysis

The data from the focus group was analyzed through thematic coding to identify themes through the process stated below. Data analysis should be systematic, chronological, demonstrable, and constant in order to minimize the potential bias (Krueger & Casey, 2000). I analyzed data based on the research questions and the theory, identify codes and key themes, and described the themes in a way that readers can understand.

First, I translated the comments from ASL into English. I am able to translate appropriately as I completed the Master of Social Work program at Gallaudet University, which trains students to become bilingual social workers working with deaf and hard of hearing people. I secured an appropriate person to review and evaluate my translation to ensure objectivity and accuracy of information. This person played back the video tape to watch what was communicated and see if my translation was appropriate. I found the appropriate person among the colleagues with whom I work. The appropriate person should have ASL/English literacy and have some background working with deaf and hard of hearing people with mental health needs. I recruited the appropriate person outside of the participants, so there were not be any concerns about dual relationships between the appropriate person and the participants. Candidates for this position would be someone from an academic institution that train deaf and hard of hearing students to become

professionals in a variety of fields, such as Gallaudet University. I had the translator sign a confidentiality agreement as the translator viewed data that contains identifies.

A number of stages such as examining, categorizing and tabulating or recombining answers were used for data analysis to achieve the goal of a study (Yin, 1989). I examined the comments that were transcribed from ASL into English by identifying repeated codes, categorizing the codes into the themes, and identifying comments to illustrate the themes.

Data analysis should start with the purpose of the study in mind (Krueger & Casey, 2000). This concept enables a researcher to manage the data, make sense of what was discussed, remove extra and unrelated information, and clearly identify themes behind the answers. The purpose of this action research study is to examine the experiences of social workers working with deaf and hard of hearing people with serious mental illness. I removed the comments that are not related to the purpose of this action research study and identify themes behind the comments by considering the purpose.

I used thematic analysis, which is a process for coding qualitative information (Boyatzis, 1998). Boyatzis (1998) provided a method to code the thematic information by addressing five elements: (1) naming the theme, (2) defining the theme, (3) knowing how to recognize the theme in the data, (4) naming the data to be excluded, and (5) identifying an example. This technique helped me conduct thematic analysis as a process to make sense of the data and identify themes found from the collected and translated data. After identifying repeated key themes, I named each theme. Then, I defined the themes,

divided the comments into the themes, and demonstrated examples of how the comments fell into the themes.

The main ideas in the discussion during the focus group needed to be identified. In other words, the repeated common ideas that appeared in the generated data need to be identified. I examined if there are any of recurring main ideas to identify themes. Sometimes, more than one main idea is included in a theme. Reflection about the focus group and the non-verbal communication expressed by participants of the groups is valuable to the construction and analysis of data (Krueger & Casey, 2000). This was recorded in a videotape so I checked a videotape and examine if there were any important non-verbal communication expressed by participants of the focus group to be noted. Finally, I discussed how the findings are similar to, or different from, related previous studies and used the literature to explain the reasons behind the themes.

Ethical Procedures

The social work practice problem I was studying is the experiences of social workers working with deaf and hard of hearing people with serious mental illness. According to section 5.02 (d) of the National Association of Social Workers (NASW) Code of Ethics, "Social workers engaged in evaluation or research should carefully consider possible consequences and should follow guidelines developed for the protection of evaluation and research participants." Appropriate institutional review boards should be consulted (NASW, 2008). As an action researcher, I must protect participants who are willing to participate in this action research study by following ethical procedures such as rules and regulations developed by formal research institutes.

Stringer (2007) stated that it is usual for an action researcher to take specific steps to protect participants from any harm as a result of the conduct of one's action research study. According to section 5.02 (e) of the NASW Code of Ethics (2017), Social workers engaged in evaluation or research should obtain voluntary and written informed consent from participants, when appropriate, without any implied or actual deprivation or penalty for refusal to participate; without undue inducement to participate; and with due regard for participants' well-being, privacy, and dignity. Informed consent should include information about the nature, extent, and duration of the participation requested and disclosure of the risks and benefits of participation in the research.

First, I obtained a permission form signed by a person with authorization authority from the healthcare provider in order to recruit participants. The healthcare provider that I conducted a focus group provides culturally and linguistically competent services for deaf and hard of hearing people on the East Coast. The healthcare provider provides deaf and hard of hearing people with a variety of services such as case management, outpatient program, residential program, and day treatment. The healthcare provider accepts almost all health insurances, depending on the service that the client receives and the county that the client resides. After I obtained permission, I asked the organization to forward the E-mail Invitation inviting participation in this action research study to employees who would be interested in participating in this action research study. Participants were given a consent form that included the nature and purpose of this action research study. Also, participants were informed that participation is voluntary and

involves minimal physical risks such as physical discomfort and psychological risk such as anxiety, stress, fear, and confusion.

I explained to participants the purpose of this action research study clearly and emphasize the confidentiality of all the information that the participants shared in a focus group. Also, I explained to participants how group interaction opens the possibility for a breach of confidentiality. The Informed Consent document also addressed this potential and request respect for confidentiality. Any employees in supervisory or administrative positions and employees who I supervised were not eligible to participate in this action research study to avoid conflicts of interest. Participants were asked to provide informed consent in order to participate in this action research study. If participants feel distressed by participating in this action research study, they have the right to withdraw from the study, refuse to answer questions, or leave the focus groups. I also ensured the participants know how to access their Employee Assistance Program in the event of distress. The researcher's contact information was available in all research materials so participants were able to ask the researcher any questions that they may have.

All data collected from this action research was coded without using names and personal information of participants were kept confidential. All data collected including consent forms were accessible only to the researcher by saving all the information in the researcher's password-protected laptop, accessible only to the researcher. The information on the computer will be kept for at least 5 years, and it will be deleted or shredded after 5 years. A summary of the findings of this action research study was provided to the participants of the focus group. The findings will be shared with the

healthcare provider as well, excluding any specific information related to the relationship between an employee and the healthcare provider.

Summary

The focus group with participants discussed the experiences of social workers working with deaf and hard of hearing people with serious mental illness. The data collected in the focus group was analyzed by identifying repeated key themes on the three different levels such as micro, mezzo, and macro, and dividing the data into the themes. There has been the lack of culturally and linguistically competent services for deaf and hard of hearing people with serious mental illness (Anderson et al., 2017; Crowe, 2017; Wilson & Schild, 2014). I believe gaining an understanding of the experiences of social workers working with deaf and hard of hearing people with serious mental illness will enable me to divide information into identified themes on the three different levels such as micro, mezzo, and macro. On the micro level, it will be beneficial for social workers to understand the experiences of social workers working with deaf and hard of hearing people with serious mental illness in order to become culturally and linguistically competent working with the population. Also, on the mezzo level, this action research study may enable healthcare providers to train their employees to become culturally and linguistically competent to working with the population and reduce communication disparities in the healthcare systems. Moreover, on the macro level, this action research study may enable different locals to recognize and integrate the cultural and linguistic needs of deaf and hard of hearing people with serious mental illness in healthcare providers, and collaborate with academic institutions to educate and train social workers

to become culturally and linguistically competent to meet the needs of the population within a state or local.

The following Section 3 begins with data analysis techniques that I employed, findings from focus group interviews, and a summary of data analysis. Then, Section 4 contains information on how the findings apply to social work practice with participants' recommendations on culturally and linguistically competent services for deaf and hard of hearing people with serious mental illness. Last, my implications for social change based on the participants' recommendations are addressed at the end of Section 4.

Section 3: Presentation of the Findings

The purpose of this action research study was to gain an understanding of the experiences of social workers working with deaf and hard of hearing people with serious mental illness. The purpose directly related to the research questions posed at the beginning of the study:

RQ: What are the experiences of social workers working with deaf and hard of hearing people with serious mental illness?

Subquestion 1: What are the challenges identified by social workers who work with deaf and hard of hearing people with serious mental illness?

Subquestion 2: What are best practices identified by social workers who work with deaf and hard of hearing people with serious mental illness?

To explore this phenomenon, data were collected through a focus group with social workers working with deaf and hard of hearing people with serious mental illness. Section 3 includes data analysis techniques used in completing the action research study, findings, and a section summary.

Data Analysis Technique

To recruit participants for the focus group, the organization emailed the invitation to employees who might qualify to participate in the action research study on Monday, November 26, 2018. I visited the healthcare provider on December 21, 2018 and met nine participants who were willing to take part in the focus group.

First, I worked with the information technology (IT) technician, who helped me set up a video recording device to capture the sign language of every participant in the room. I learned how to use the video recording device. Then I provided the nine participants with an informed consent form and explained action research using ASL. The informed consent form included the purpose and rationale of the action research study, who was conducting it, and the potential risks (physical risks, psychological risks, and loss of confidentiality) of participating in this study. I explained confidentiality procedures to the participants. I also acknowledged the video recording and explained that the video would not have participants' names on it, would be kept in a secure place at my residence under lock, and would be destroyed physically, not simply throw into the trash, once the transcription had been confirmed. All nine participants completed the consent form. I also provided the participants with a demographic questionnaire (Appendix A) and asked them to complete it by selecting the responses that best reflected their current status.

When I started the focus groups, I gave the participants a copy of the group interview protocol (Appendix A). I ensured that the nine participants had the opportunity to share their thoughts, feelings, and perspectives by asking each person to respond to the questions. I noticed that participants appeared nervous about speaking and unsure of whether their comments were appropriate to each question. I told them that there were no right or wrong answers to each question and asked them to feel free to share whatever they had on their minds. When participants said something and then stopped, I provided support and encouragement to them so that they could share their thoughts and feelings

without hesitation. I gave full attention to their body language, facial expressions, and behaviors, and I asked periodically if they were feeling comfortable in discussing issues and moving forward. I actively listened to each and every participant and validated participants' emotions and feelings so that they could feel safe and comfortable enough to stay in the focus group and continue to share their perspectives. While I was facilitating the focus group, I was careful not to share my own perspectives, biases, views of the world, or set of values. Information about participant demographics is contained in the findings section. Based on the organization census, these participants were similar to those who chose not to participate even though they met eligibility criteria.

After I concluded the focus group and returned home, I played back the videotape to begin the translation into written form and analyze the data. There were some sign language quotations that I had a hard time understanding at a glance. The participants had different levels of ASL skills and expressing styles. I played back and watched the sign language several times to determine what had been said. Although it was challenging for me to translate the data because ASL and English have completely different grammars and syntaxes, I was careful to translate verbatim. I translated the data whenever I had available time and could be focused and relaxed. It took me about 15 hours to finish translating the data. I completed the translation within 2 weeks after I conducted the focus group. After I transcribed the data from ASL into English, I read the translation multiple times to analyze, code, and identify themes and subthemes in a clear, understandable way (referential adequacy).

After I read the initial analysis again, I realized that I needed to focus further on issues with social workers' experiences, challenges, and best practices with deaf and hard of hearing people with serious mental illness. I found it very interesting to learn about the participants' experiences, which made me feel that I wanted to use all of the information that the participants had shared. In other words, the more I read the initial analysis, the more times I found myself fascinated by what the participants had shared during the focus group. I realized that despite the fact that this was a demanding process, it provided me with an opportunity to contribute to my personal and professional growth.

Coding Procedures

First, I translated the focus group discussion from ASL into English. I then asked a person outside the participants from Gallaudet University, an academic institution that trains deaf and hard of hearing students to become professionals in a variety of fields, to review and evaluate my translation to ensure objectivity and accuracy of information. After receiving confirmation of its accuracy, I started the process of coding. First, I reminded myself that a researcher should begin data analysis with the purpose of the study in mind (Krueger & Casey, 2000). This concept helped me to manage the data, make sense of what was discussed, remove extra and unrelated information, and clearly identify themes behind the answers. I organized and analyzed the data by identifying codes, categories, and themes on the three levels: micro, mezzo, and macro. After I translated all of the data from ASL into English, I separated the data into micro, mezzo, and macro levels and placed the data in a way that followed the order in which the discussion occurred. I used thematic analysis with open coding to code the data. I

analyzed the data based on the research questions and the theory; this enabled me to identify codes and key themes. I examined, categorized, and recombined. I examined and identified the quotations to illustrate the themes and removed the quotations that were not related to the purpose of this action research study.

I started this process by reading distinctly each line of the translations. I did this for every line of the transcribed focus group. When I was unable to code anything from a particular line, I went to the next few lines until a code materialized. Data that I did not code included side comments, fillers, and off-topic responses. Once I had completed the first coding process for the focus group, I went through the process again and again. I repeated the process systemically several times, but I was alert not to code too much. During each coding attempt, I underlined thought-provoking words or phrases. I completed the coding process over 15 days. After identifying 110 initial codes, I grouped related words and phrases, resulting in 20 categories. I did not identify any codes that were inconsistent with one another or areas of disagreement. Categories included clusters of coded data with similar meaning. The categories were subsequently distilled into themes to answer the research questions.

I could see how the resulting four themes were created from the data I had coded, and further how the codes and categories were connected to one another and the research questions. At this point, I connected the overarching themes with ecological systems theory. Each overarching theme impacted social workers' experiences and best practices in responding to the challenges that social workers face in providing services for deaf and hard of hearing people with serious mental illness.

Validation and Legitimation

To ensure that my action research was credible, I first recruited participants who had experience working directly with deaf and hard of hearing people with serious mental illness. The participants were dependable sources who enabled me to identify the problem and discover solutions to it. Once participants had been identified, I explained that this action research was being conducted to address the lack of knowledge about social workers' experiences working with deaf and hard of hearing people with serious mental illness. I sought to identify strategies to preserve culturally and linguistically competent mental health services for deaf and hard of hearing people in different locales.

I tried to run the focus group so that the participants could make themselves comfortable and express themselves without any hesitation. I showed my appreciation to the participants after they made a comment and rephrased what was being said so that they felt that their participation was valued and respected. I asked the participants if they had any responses to the statements made by others so that a productive, constructive, and thorough discussion was continued. Because of the plan to conduct the focus group in the healthcare provider that I used to work for, I did not have any employees who were previously supervised by me participate in the focus group to avoid any bias.

Member checking occurred once the translation had been completed. After I translated the discussion from ASL to English, I presented codes, categories, and themes in a summary email to participants and asked participants for clarification, correction, or concerns. All participants confirmed by email that the analysis reflected their understanding of the discussion and, in their opinion, appeared free from bias. This type

of member checking helped me to determine whether I had accurately reflected participant experiences in an impartial manner.

To ensure that the outcome of the action research study was trustworthy, I did my best to avoid demonstrating my own perspectives, biases, views of the world, or set of values during the focus group. Given my position, I engaged in debriefing with my capstone chair to check potential bias or interpretation based on my personal experiences. These sessions included both email and telephone using Relay voiceover services.

Limitations

A limitation of conducting this study was the possibility of limited transferability and usefulness to other social workers working with deaf and hard of hearing people with serious mental illness. The sample consisted of nine social workers working for a healthcare provider that provides culturally and linguistically competent services for deaf and hard of hearing people with serious mental illness on the East Coast. In that the sample for this study may not represent all social workers working with the population, the findings of this study may not be transferrable to other social workers, especially those working for different types of healthcare providers on the East Coast or similar healthcare providers in other states. Social workers from other healthcare providers on the East Coast or other states may have different experiences, challenges, and best practices in relation to working with the population. Additionally, because the healthcare provider where the focus group was conducted was one where I had worked for eight years, it is possible that my presence may have impacted some participants with whom I was familiar. Although I stayed in my role as a facilitator and did not allow anyone

whom I had supervised during my tenure at the healthcare provider to participate, there were some participants with whom I was familiar. Therefore, it is possible that I injected my personal biases into the participants' exchanges of ideas. I may have led the participants toward certain assumptions or conclusions about an idea or product. Third, I recruited participants who did not hold a social work degree but functioned in a social work capacity according to the healthcare provider, so this study may not represent those who actually hold a social work degree.

Findings

The findings enabled me to answer the study's research questions. In presenting the themes in the section below, I share multiple quotes to illustrate how the participants described their experiences working with clients who were deaf and hard of hearing and had serious mental illness. The four themes identified were (a) cultural competence, (b) empowerment and advocacy, (c) professional education, and (d) leadership to advance cultural competence. The experiences, challenges, and best practices are further detailed below through my analysis of the themes discovered within the data.

Participants

Before starting a focus group, I provided the nine participants with a demographic questionnaire (Appendix A) and asked them to complete it by selecting the responses that best described their current status. I explained to the nine participants that information reported on this survey would remain confidential and that any reports published would not contain identifying information. I gave the participants pseudonyms to make the data

confidential (Sophia, Emma, Olivia, Ava, Mia, Jacob, Lily, Mason, and Addison) instead of using their real names. These pseudonyms are used for the quotations below.

Of the nine participants, three were hearing, one was hard of hearing, and five were deaf. The majority of participants (seven) were female. Most were Caucasian (seven), while one participant was Hispanic and one was Black. Three participants held a high school degree, two held an associate degree, one held bachelor degree, and two held master's degree. Only one participant held a social-work-specific degree. Length of employment with the healthcare provider among participants ranged from less than one year to 12 years; experience with the population of interest among participants ranged between one and 25 years. The participants represented five different positions at the organization: case manager, residential advisor, training coordinator, partial hospitalization therapist, and clinical coordinator.

Themes

Theme 1: Cultural Competence

When discussing their experiences, a frequent topic among participants was cultural competence. For the participants, cultural competence meant having specialized knowledge about deaf culture and understanding that is inclusive, but not limited to, the history, traditions, values, family systems, and artistic expressions displayed by some subcultures, such as those of race and ethnicity, religion, sexual orientation, social class; and mental or physical abilities .

This definition of cultural competence is evidenced through the following quotes. Jacob described the importance of having a "general knowledge of different backgrounds,

different personalities, different cultural experiences, and different ways of being exposed

of deaf culture." Sophia remarked about how she sought to demonstrate the "ability to

understand the unique challenges that deaf people experience and face in everyday life. If

you don't have the ability, you cannot help them." Intersectionality was introduced by

Emma as an alternative way of looking at cultural competence. Emma explained, "I think

we should incorporate intersectionality in mental health. This is because we have more

than one culture such as deaf, Black, and LGBTQ." Although the term *intersectionality*

was not used by other participants, many expressed agreement by nodding their heads.

Emma subsequently stated, "We have different experiences being oppressed by the

society by different cultures. Different cultural experiences impact our mental health so

we need to educate about intersectionality more so we can understand experiences being

oppressed by different cultures."

According to the participants, specialized knowledge about deaf culture and other

cultures was central to their experiences in serving this unique population, and they

sought to demonstrate cultural competence in each interaction with all clients, especially

those who were deaf and hard of hearing experiencing serious mental illness. In the focus

group, Mason offered an example of how one demonstrates cultural competence with

deaf and hard of hearing people. Mason stated, "I think it is very important for us to

understand where our clients have come from, where they grew up, what cultures they

have, what attributes they have, and what life experiences they have." He went on to say,

"We need to learn from them. Allowing clients to teach us about their lives helps us build

a relationship with them." Based on their nonverbal reactions, other participants agreed

with his comments. Learning from clients about their experiences of being oppressed based on characteristics such as race and ethnicity, religion, sexual orientation, social class, and mental or physical abilities is one way in which social workers can demonstrate cultural competence. Participants suggested that cultural competence is a best practice for working with deaf and hard of hearing people with serious mental illness.

Theme 2: Empowerment and Advocacy

Participants further described their experiences working with deaf and hard of hearing people with serious mental illness by focusing on empowerment and advocacy. When I asked the participants about their experiences, challenges, and best practices with deaf and hard of hearing people with serious mental illness, this theme emerged as participants spoke about the fact that those who work with the population are required to not only teach service providers about deaf people's rights (advocacy), but also teach their clients self-advocacy skills to protect their rights (empowerment). For the participants, while empowerment meant teaching deaf and hard of hearing people with serious mental illness independent life skills to assert and exercise their rights to receive services that they need, advocacy meant providing support to deaf and hard of hearing people with serious mental illness to preserve their right to be free from discrimination and to be provided reasonable accommodations. Emma shared, "I have to explain to my clients about their rights and responsibilities to ask for whatever they need from other agencies. Also, I have to explain to other agencies that they have to provide an interpreter for my clients." As a case manager, Emma had numerous experiences providing

advocacy and using empowerment with the population, and everyone in the focus group nodded their heads as she shared her experiences. She went on to describe "My clients don't know how to advocate for themselves and learn advocacy skills from me. I notice that our clients don't have assertive skills and are not sure how to communicate with people from other agencies."

Empowering clients with skills to care for themselves also provided challenges to the participants. Addressing serious mental illness while the client lacks skills to address their basic needs becomes problematic, and the development of life skills must take precedence with clients with serious mental illness who do not have independent life skills such as eating, bathing, bill paying, etc. Ava stated, "We have to teach…independent life skills. Maybe they learned skills one day but next day they forgot the skills that they learned and are back to the square one." Balancing support for the basic needs of their clients, the unique realities of being deaf or hard of hearing, and symptoms of serious mental illness required the participants to constantly be thinking about opportunities to empower their clients, advocate for their needs, and teach them to advocate for themselves.

Participants discussed how providers lack an understanding of deaf culture and are not competent to provide services by ASL. Social workers working with the population must have extensive knowledge about deaf and hard of hearing people's needs and have the skills to advocate for them to receive services with appropriate accommodations from service providers. The participants described using their skills with professionals and the community-at-large. Sophia emphasized "All of us, especially case managers, are

required to provide advocacy and education to the community to understand how to communicate with deaf people effectively." Olivia agreed and shared her experience working with police officers. She explained, "They don't even understand what an ASL interpreter is. They know about Spanish interpreters, but they don't know about ASL interpreters. They don't know ASL is a language as same as Spanish…Such situations happen in shelters and doctors' offices, as well."

Participants expressed frustration over having to help community professionals understand the importance of effective communication with persons who are deaf and hard of hearing. Sophia commented that "Many professionals out there think writing is good enough but it is not true. It is not good enough…lack of communication can cause serious situations." Others agreed how frustrating it is to work with community professionals. Emma shared her experience having her deaf client refused appropriate accommodations by service providers who stated they don't have to request one [an interpreter] or they…don't have money for it." Olivia added "I had a situation where client had to meet two police officers who looked at me with a facial expression that showed that they didn't know how to communicate with my client and expected me to act like an interpreter." Other participants shared the frustration of having to take on the responsibility to educate community professionals about the law and the requirement to appropriate accommodations.

The participants' comments suggest that advocacy and empowerment are critical when working with deaf and hard of hearing people with serious mental illness and service providers. These efforts happen on the micro and mezzo levels, as evidenced by

the examples shared by participants. At the micro level, the individual development of deaf and hard of hearing people with serious mental illness can be improved by learning independent life skills, which serves to protect their rights and to exercise their rights to receive services that they need. Also, learning self-advocacy serves to protect their right to be free from discrimination and to be provided reasonable accommodations from service providers. Without a willingness to advocate for clients and empower clients to learn independent life skills, getting the opportunity to address serious mental illness and make a difference in the lives of their clients becomes an even greater challenge.

At the mezzo level, social workers often advocate for deaf and hard of hearing people with serious mental illness as they connect with other organizations or service providers so the clients receive services with reasonable and appropriate accommodations. Social workers may also empower clients to learn self-advocacy skills, at the same time, which is other challenge evidenced by the participants. Emma stated,

> I notice that our clients don't have assertive skills and are not sure how to communicate with people from other agencies. I always have to encourage them to be assertive to ask for whatever they need in order to receive appropriate services.

If social workers' efforts are not well recognized within the community, social workers may lose their motivation to work, which would impact the services available to of deaf and hard of hearing people with serious mental illness.

Theme 3: Professional Education

Challenges with professional education for social workers working with deaf and hard of hearing people with serious mental illness is the third theme that came out of the focus group. It is social workers' responsibility to continue professional education in order to retain and build skills necessary to provide culturally and linguistically competent services to deaf and hard of hearing people with serious mental illness. Barriers to professional education were discussed in the focus group and a common recognition and awareness of the necessity and importance of creating professional education opportunities for social workers working with deaf and hard of hearing people with serious mental illness was affirmed. The participants discussed their eagerness to see more training opportunities for them to increase their knowledge and enhance their skills to be able to work with deaf and hard of hearing people with serious mental illness.

Some participants shared their challenges working with deaf and hard of hearing people with serious mental illness. Their common challenge is to work with deaf people who have language dysfluency, and they expressed desire of a deeper understanding of appropriate and effective interventions for the population. Jacob stated, "There are unique challenges working with deaf people, especially those who don't have language. I have started working with deaf people with less function." Then, he explained the cause of the language dysfluency among deaf people and the result of the language deprivation, and said, "Deaf people are not exposed to language and are isolated in family. So, deaf people lack foundation and structure. I prefer clear communication but struggle to do that with deaf people." It was discussed why deaf and hard of hearing people with serious mental

illness have language dysfluency and someone from the focus group pointed out that it was because of a lack of exposure to language at home when they were grown up.

Jacob expressed a desire to see more professional training opportunities to better understand how to work with deaf people with language dysfluency. Other participants nodded their heads in agreement, expressing their interest in more professional education in this area. Mason pointed out that, "The most challenging part of my job is working with children with a language delay." Mason described the cause of the language dysfluency among his deaf children clients and stated, "Many parents don't sign to communicate with their deaf children so our children have a language delay." Mason described how challenging it was to work with deaf children with language dysfluency and stated, "When a member with a language delay has a temper tantrum, it is very difficult for me to understand why the member got mad because they cannot express themselves." A lack of communication between a child and his parents affects the development of deaf and hard of hearing people with serious mental illness and dealing. Deaf and hard of hearing people with language dysfluency require professional education to be able to work with them.

Participants arrived at another common perception that would bring a new perspective regarding professional education. Being able to use ASL does not mean one has the ability to work with deaf and hard of hearing people. Participants suggested that social workers need to not only learn ASL and deaf culture but also develop the ability to work with deaf and hard of hearing people with serious mental illness. The participants have fluency in ASL and have extensive knowledge about deaf culture. They also have

considerable professional experiences working with the population. Yet, they have desire to see more professional education opportunities provided to offer best practices. While it is evident from the focus group discussion that it is challenging for social workers working with deaf and hard of hearing people with serious mental illness, the participants also suggested more focus on the development of professional education opportunities for social workers working with deaf and hard of hearing people with serious mental illness to build professional experiences and enhance knowledge and skills in order to address the challenges of working with deaf and hard of hearing people with serious mental illness, especially those who have language dysfluency.

Participants shared examples of professional education they seek in order for them to address the challenges they face while working with deaf and hard of hearing people with serious mental illness. For example, Lily stated, "I would like to take training that helps me learn strategies to work with members, instead of just following the managers' instructions. I prefer we take training and apply new knowledge to work with members by ourselves." There was a shared understanding of today's challenges built from the focus group. Professional education opportunities for social workers working with deaf and hard of hearing people with serious mental illness need to be created and increased to provide effective and appropriate interventions for the population. Ava shared that, "I would like to see more training opportunities available for us to take. I would like to take intensive training to learn how to approach members more appropriately, especially with those who have serious mental illness." Participants shared their challenges and desire of subjects for professional education to address the challenges. Participants discussed how

many deaf and hard of hearing people with serious mental illness have language dysfluency. Participants shared their belief that social workers working with the population should be given more professional education opportunities to acquire sophisticated expertise and provide quality services, especially around language dysfluency.

The relationship between a deaf or hard of hearing child and his or her parents can impact the development of the deaf and hard of hearing child. Also, the relationship can create challenges for the social workers who work with the population. Social work participants expressed a desire to see more professional education opportunities to address the challenges. Their desire suggests that it is concerning for social workers working with deaf and hard of hearing people with serious mental illness not to be able to find professional education opportunities to address their challenges, especially professional education to learn technical expertise addressing the communication challenges. A lack of professional education opportunities for social workers working with deaf and hard of hearing people with serious mental illness was suggested by the participants of the focus group. A lack of professional education opportunities may prevent social workers from becoming more culturally and linguistically competent, which would affect the development of deaf and hard of hearing people with serious mental illness. Also, it is important to increase and develop professional education opportunities for social workers to not only enhance specialized knowledge and skills but also be able to provide better care for the population. The development of professional

education may enable social workers to increase specialized knowledge and skills related to the human development of the population.

The participants' comments suggest that addressing a lack of professional education opportunities is critical when working with deaf and hard of hearing people with serious mental illness. If social workers do not have professional education opportunities, they have difficulty providing culturally and linguistically competent services to deaf and hard of hearing people with serious mental illness. Without professional education opportunities, making a difference in the lives of deaf and hard of hearing people with serious mental illness becomes an even greater challenge.

Theme 4: Leadership to Advance Cultural Competence

The forth theme emerged from the focus group discussion was leadership to advance cultural competence. As participants spoke about the challenges and best practices, there were many different insightful quotes. Participants came to a common understanding on this theme after they shared their experiences about educating their clients' families, service providers, and communities about the language and the culture of deaf and hard of hearing people so that their clients would be able to receive services with appropriate accommodations. For the participants, leadership to advance cultural competence meant playing a strategic leadership role in the field of social work and being change agents who work effectively with agencies, organizations, and communities that lack of an understanding of deaf culture. Sophia emphasized the importance of continued education to service providers and stated, "We have to educate different providers about our needs so that we can work together better. That's something we have to do, which is

sad and very frustrating." It was evident from the focus group discussion that social

workers working with deaf and hard of hearing people with serious mental illness are

required to have the ability and skills to advance cultural competence within and beyond

their organization, helping to challenge institutional oppression, and shaping inclusive

institutions and communities. Sophia's quotes suggest that social workers working with

deaf and hard of hearing people with serious mental illness are required to be the change

agents to advance cultural competence within and beyond her organization because there

were few service providers that have specialized knowledge and understanding that is

inclusive of deaf and hard of hearing people.

It was clear from the focus group discussion that many deaf and hard of hearing

people with serious mental illness struggle to communicate with family and also family

need support to communicate with deaf and hard of hearing people. As a result, social

workers are required to have the ability to work with both deaf and hard of hearing

people and family. Social workers are required to educate family the importance of

learning ASL to be able to communicate with deaf and hard of hearing people and also

services and resources for both groups. Emma explained that a lack of an understanding

of resources for deaf people among parents can delay their child's mental health

recovery. She stated, "For example, my child client seemed to have motivation to work

but the mother was reluctant about it because she was afraid if the child would be cut off

the social security disability." Also, Lily described her work with her deaf children

clients and their families, and stated, "My experience working with children involves

education to their parents at the same time." She shared her observation of how parents

communicated with their deaf child and stated, "Many parents don't know how to approach our children in a way that is "friendly" to deaf culture. Parents often don't explain to children in a way how they can understand." Lily pointed out about the importance of parents' learning ASL to communicate with their deaf child and stated, "While our deaf children communicate by ASL, their parents don't use ASL fluently. So, our deaf children often struggle to understand what was said in English, which can be too abstract to them to understand." Emma explained that the mother thought it would be hard for the child to get back the social security disability. Emma stated she had to educate the mother how to reapply for the social security disability for the child. Emma continued to state, "The mother was worried about the child's social security disability and if they were going to be homeless if the child was fired. And, the child is already 30 years old and the mother is still worried about her son."

The quotes of Lily and Emma suggest that social workers working with deaf and hard of hearing people with serious mental illness are required to have the ability to work with not only their clients but also their families by educating the families about effective communication with deaf and hard of hearing people, including people of limited English proficiency or low literacy skills. Without education to families, deaf and hard of hearing people with serious mental illness have difficulty living in dignity and security. Social workers are the change agents to impact families of deaf and hard of hearing people with serious mental illness by teaching ASL and deaf culture. Teaching families how to communicate with deaf and hard of hearing people, what their rights are, and what resources they can use in their communities is an important part of the leadership skills

that can impact the development of deaf and hard of hearing people with serious mental illness.

Advancing cultural competence within and beyond in the service provider for deaf and hard of hearing people with serious mental illness requires effort. It is critical to recognize their effort and provide support to the change agents who demonstrate the leadership skills to work effectively with deaf and hard of hearing people with serious mental illness. Participants shared their challenges that supported the common perception that a lack of understanding of deaf culture is a big barrier for social workers working with deaf and hard of hearing people with serious mental illness, and continued education to families, providers, schools, and communities about deaf culture is needed to increase public awareness of deaf issues and people.

In order to address the issues around a lack of an understanding of deaf culture among families, providers, and communities, it is necessary for social workers to demonstrate leadership to advance cultural competence by educating others about deaf culture and spread deaf awareness with the potential to create an inclusive culture and provide services to deaf and hard of hearing people with serious mental illness without any barriers. As it was apparent from the focus group discussion, it is imperative for social workers to have the leadership skills to influence within and beyond the organization, and agencies, organizational settings, and communities to increase expert knowledge and enhance cross-cultural skills to work with deaf and hard of hearing people with serious mental illness. Mason provided an example of using his cross-cultural skills and stated, "Hearing people feel sorry about us for not being able to hear. But, I want to

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teach to help them understand about deaf culture and realize that they are happy for who they are." Also, Mason demonstrated his leadership to enhance cultural competence within and beyond the organization with a positive attitude by suggesting the rest participants in the focus group an appropriate way to educate hearing people about deaf culture. He encouraged deaf people to continue teaching hearing people about deaf culture, instead of criticizing them for their lack of an understanding of deaf culture.

Participants arrived at a common perception of leadership to advance cultural competence within and beyond the organization after they shared their own suggestions and ideas to help agencies, organizational settings, and communities develop specialized knowledge and understanding that is inclusive of deaf and hard of hearing people. Ava stated it is important to have to continue educating hearing people about deaf culture and empathy. Ava also described her perception of the importance of patience with hearing people and supporting them through their learning process. Empathy and patience are critical parts of leadership to demonstrate cross-cultural skills working with people who have various cultural backgrounds. Furthermore, Sophia shared three key words to summarize what she wanted to point out "Exposure, education, and inclusion." Sophia shared her experience working with various service providers such as insurance companies and referring organizations that had never met deaf people and stated, "We need to expose unique needs of our deaf members to them so that they become more familiar with the needs and can help other deaf people more appropriately." All the participants provided insightful quotes that emphasized the importance of having

leadership responsibility and using their skills to work effectively with agencies, organizations, and communities that lack an understanding of deaf culture.

The participants' comments suggest that leadership to advance cultural competence is critical when working with deaf and hard of hearing people with serious mental illness and service providers. Without recognizing and promoting leadership to advance cultural competence, social workers would be further challenged as change agents through their efforts to educate families, service providers, and communities about deaf culture and make a difference in the lives of deaf and hard of hearing people with serious mental illness.

Summary

The research questions in this action research focused on the experiences of social workers working with deaf and hard of hearing people with serious mental illness. The findings suggest that experiences working with this population included developing personal cultural competence, having to advocate with others outside of the deaf community, and empowering client and families to advocate for themselves. The findings further suggest challenges such as lack of knowledge about deaf culture from other service providers and family members, a lack of professional education opportunities related to appropriate and effective interventions for deaf and hard of hearing people with serious mental illness, especially those who experience language dysfluency, and a lack of specialized knowledge in deaf culture and cross-cultural skills required for working with deaf and hard of hearing people in families, service providers, and communities. Findings also suggest best practices that include developing cultural

competence and developing leadership skills in order to be able to appropriately advocate at the organizational and policy levels.

The findings of this action research study offer an understanding of the experiences of social workers working with deaf and hard of hearing people with serious mental illness and the importance of appropriate services for the population. Section 4 will include the implications for social change raised by these findings and a discussion of the application of these findings to the social work profession.

Section 4: Application to Professional Practice and Implications for Social Change

The primary purpose of this capstone project was to gain an understanding of the experiences of social workers working with deaf and hard of hearing people with serious mental illness. I conducted this action research project to engage nine social workers in a focus group setting. I sought to address the lack of evidence about experiences of social workers working with deaf and hard of hearing people with serious mental illness. Nine social workers participated in a focus group to discuss their experiences working with deaf and hard of hearing people with serious mental illness at a healthcare provider that offered culturally and linguistically appropriate therapeutic services; they also discussed the challenges, best practices, and cultural competence required to work with the population. The themes that emerged from the focus group discussion were (a) cultural competence, (b) empowerment and advocacy, (c) professional education, and (d) leadership to advance cultural competence. The key findings from the focus group included the importance of understanding cultural competence when working with deaf and hard of hearing people with serious mental illness. The findings suggest that social workers must be able to exercise cultural competence in order to work effectively with deaf and hard of hearing people with serious mental illness and with families, service providers, and communities around the service population.

The key findings highlighted that social workers working with deaf and hard of hearing people with serious mental illness need to offer empowerment and advocacy to help members of the population obtain appropriate accommodations and have full access to the services provided. The findings suggest that even today, deaf and hard of hearing

people with serious mental illness have continued to be diminished in practice. There are still social justice issues that are unresolved, which continue to make deaf and hard of hearing people with serious mental illness disadvantaged, vulnerable, and underprivileged. Additionally, participants urged recognition of the necessity and importance of generating more professional education opportunities for social workers to develop clinical social work skills and enhance their knowledge about social practice with deaf and hard of hearing people with serious mental illness, especially appropriate and effective interventions for those who have language dysfluency. The findings suggest that a lack of professional education opportunities for social workers working with the population remains an issue. Last, the key findings included how it is imperative for social workers to continue to make people aware of deaf culture in order to advocate for deaf and hard of hearing people with serious mental illness and to work effectively with families, schools, and service providers without exclusion or discrimination. The findings suggest that social workers working with the population need to be change agents who demonstrate the leadership skills required to work effectively with families, schools, service providers, and communities that lack specialized knowledge about deaf and hard of hearing people. In other words, in order to address the lack of understanding of deaf culture in a society that harms the dignity and rights of deaf and hard of hearing people with serious mental illness, social workers need to demonstrate leadership to advance cultural competence within and beyond their organizations, helping to challenge institutional oppression as well as to build and sustain inclusive institutions and communities.

Application for Professional Ethics in Social Work Practice

There are seven core areas of ethics in the NASW Code of Ethics (2017): self-determination, informed consent, professional competence, conflicts of interest, privacy and confidentiality, nondiscrimination, and professionalism. Social workers who work with deaf and hard of hearing people with mental illness are required to have fluency in ASL and have specialized knowledge about deaf culture. If social workers cannot communicate with their clients in ASL fluently and do not have appropriate knowledge of deaf culture, they could be violating articles promoting professional competence in the Code of Ethics. The Code of Ethics states, "In instances when clients are not literate or have difficulty understanding the primary language used in the practice setting, social workers should take steps to ensure clients' comprehension" (NASW, 2017, 1.03b). As evidenced by the findings from the focus group, social workers working with deaf and hard of hearing people with serious mental illness are required to demonstrate a high level of proficiency in ASL and extensive knowledge of deaf culture. Unfortunately, the findings suggest that there is a lack of professional education opportunities for social workers working with deaf and hard of hearing people with serious mental illness to enhance knowledge and skills to be able to address challenges in working with the population, especially with those with language dysfluency. Therefore, it is critical for social workers to call attention to academic institutions and professional organizations to create professional education opportunities for them to participate in professional education and training programs that advance cultural competence for more effective and appropriate interventions for the population.

Social workers should adjust services to meet the needs of all of their clients. Unfortunately, the findings suggest that deaf and hard of hearing clients still experience exclusion or discrimination, where social workers are needed to advocate for their clients to receive services from other service providers. Additionally, the findings suggest that social workers are called on to educate people about deaf culture in an effort to guide views about deaf people away from a medical perspective (Padden & Humphries, 1988). A lack of understanding of deaf culture in families, service providers, schools, and communities remains an issue that impacts social work practice. Even today, deaf and hard of hearing people with serious mental illness encounter service providers that have little knowledge about appropriate accommodations. Research shows that there are still not enough practitioners who have a strong command of ASL and seasoned knowledge of deaf culture (Anderson et al., 2017; Schild & Wilson, 2014; Thomas, 2014). Therefore, social workers need to continue to advocate for deaf and hard of hearing people with serious mental illness to receive necessary and appropriate services provided by service providers, schools, or communities, thereby creating opportunities to increase knowledge about deaf culture and to exercise cultural competence.

According to the NASW (2015), "Social workers shall be change agents who demonstrate the leadership skills to work effectively with multicultural groups in agencies, organizational settings, and communities" (p. 5). A lack of understanding of deaf culture overwhelms and challenges social workers to be change agents who educate society about deaf culture. A lack of support for social workers who try to be such change agents can negatively impact the support that social workers are able to offer deaf and

hard of hearing people with serious mental illness. It is important to recognize the challenges that social workers experience when advocating for deaf and hard of hearing people with serious mental illness. Moreover, it is critical to provide them with as much support as possible. Doing this may enable social workers to continue providing best practices for the population and make a positive impact on the development of deaf and hard of hearing people with serious mental illness.

Recommendations for Social Work Practice

My first recommendation for clinical social work practitioners who work in the field of mental health for deaf and hard of hearing people is to learn about the experiences of social workers working with deaf and hard of hearing people with serious mental illness and exhibit a better understanding of their efforts to provide culturally and linguistically competent services for the population. This represents potential changes at the micro and macro levels. At the micro level, knowledge related to the experiences of individual social work practitioners, including challenges and best practices that they identify, may encourage other social workers to seek out professional education in order to offer appropriate and effective interventions for the population. At the macro level, the development of future culturally and linguistically competent services will be influenced by social workers understanding the cultural realities and the social context of the deaf and hard of hearing individual.

My second recommendation is to recognize the challenges of working with the population and provide support for professional educational opportunities for social workers to enhance their knowledge and skills to be able to work with the population

more effectively, especially with those who have language dysfluency. Social workers could advocate for, develop, and participate in professional education and training programs that advance cultural competence within the field of mental health for deaf and hard of hearing people. In order to address a lack of professional education opportunities, social workers could work with academic institutions to develop academic programs and with professional organizations to create professional education opportunities to develop their skills and increase their knowledge to provide effective communication with deaf and hard of hearing people with serious mental illness, especially people of limited English proficiency or low literacy skills. At the mezzo level, increasing professional education opportunities for social workers working with the population to address challenges could also strengthen interconnections between social workers, the service population, and families.

My last recommendation focuses on lack of understanding of deaf culture among families, providers, and communities. It is necessary for social workers to demonstrate leadership that advances cultural competence by educating families, providers, and communities about deaf culture and social context in an effort to increase deaf awareness. Through their leadership, social workers may encourage other healthcare providers to identify key components of program design and service delivery that support culturally and linguistically competent mental health services for the population, which could have a beneficial influence on the well-being of deaf and hard of hearing people with serious mental illness.

These findings from this capstone project will impact my own social work practice as an advanced practitioner by suggesting that I need to identify stakeholders and work with them to develop an academic program to train students and professionals to advance cultural competence for deaf and hard of hearing people with serious mental illness. Further, these findings remind me of my need to continue to provide empowerment and advocacy for deaf and hard of hearing people with serious mental illness by conducting a needs assessment in my local community to identify the problems that the population experiences and exploring advanced practice opportunities.

I believe that the findings from this capstone project may be transferable to other contexts or settings in the field of clinical social work practice. However, transferability is ultimately determined by the reader. The findings were produced by nine participants who had experience working directly with deaf and hard of hearing people with serious mental illness. The participants provided insight that helped to answer the research questions. Additionally, the nine participants held varied positions such as residential advisor, partial therapist, case manager, care manager, training coordinator, and clinical coordinator. The findings from participants with diverse positions may enable the reader to hear different perspectives on the experiences of social workers working with deaf and hard of hearing people with serious mental illness and to integrate different aspects of information into their setting to heighten transferability.

The findings from this capstone project are useful to the broader field of social work practice because they suggest a need for academic programs that train students and/or professionals who have a desire to acquire advanced skills and knowledge to

provide culturally and linguistically competent services to deaf and hard of hearing people with serious mental illness. According to the NASW (2015), "Social workers shall assume personal responsibility for continuing professional education" (p. 4). It is critical for social workers to remain competent and continue to build competency. Continuing professional education is an ongoing process throughout a professional's career. As mentioned in the literature review, social workers who are themselves deaf and hard of hearing are often the best providers of culturally sensitive and accessible services for deaf and hard of hearing people because they use sign language fluently and have communication skills (Glickman, 2013; Sheridan et al., 2010). However, because this is not always the case, the availability of professional education is important. It is my hope that there will be academic institutions whose leaders consider developing a program to offer professional education opportunities for social workers or prospective students who have a desire to gain specialized knowledge and extensive skills to work with deaf and hard of hearing populations like the ones that University of Maryland, Ohio State University, and Boston College used to have (Sheridan et al., 2010). As evident from the findings, a lack of professional education opportunities makes working with this population more challenging, I believe that an academic program specialized in deaf and hard of hearing people may remain in high demand among professionals working with the population.

Further, the findings may be useful to the broader field of social work practice because they suggest that there is a need for further empowerment and advocacy for deaf and hard of hearing people with serious mental illness to have full access to the services

that they need. According to the NASW (2015), "Social workers shall be aware of the impact of social systems, policies, practices, and programs on multicultural client populations, advocating for, with, and on behalf of multicultural clients and client populations whenever appropriate" (p. 5). Advocacy is defined as all efforts to ensure that people who are most vulnerable in society are able to have their voices heard on issues that are important to them and to protect their rights (Barker, 2003). On other hand, Hegar and Hunzeker (1988) and McDermott (1989) described empowerment as an active intervention with marginalized populations. Empowerment refers to strengthening a client's ability to do for himself or herself, and it is closely related to advocacy (NASW, 2017). It is my hope that more stakeholders will be willing to conduct needs assessments to identify exactly what clinical issues deaf and hard of hearing people with serious mental illness have with all involved entities such as social workers, families, service providers, and communities. Needs assessments can suggest where shortages of services exist and can suggest how to make such services accessible to the population in different locales. Without needs assessments, implementation of services that are accessible for deaf and hard of hearing people with serious mental illness and realization of social justice equality would be challenging.

One limitation that may impact the usefulness of this capstone project is the possibility of limited transferability and usefulness to other social workers working with deaf and hard of hearing people with serious mental illness. Although I was able to recruit nine participants who worked for a healthcare provider that provided culturally and linguistically competent services on the East Coast, the sample for this capstone

project may not represent all the social workers working with the population because there are different types of healthcare providers on the East Coast. Social workers who work for other healthcare providers may have different experiences, challenges, and ideas for best practices based on their providers' organizational cultures and systems. In addition, transferability may be limited because other states have different governmental systems, deaf communities, climates, regional features, and cultures. Another limitation that may impact the study's usefulness is that the healthcare provider where I conducted the focus group was one where I had worked for 8 years. While I stayed in my role as a facilitator and did not have any participants whom I had supervised during my time at the healthcare provider, I may have impacted the outcome of the focus group. Because there were some participants with whom I was familiar, my presence may have had both positive and negative effects. Additionally, there was only one participant who had a social work degree, who was a master's-level social worker. Because I welcomed participants who functioned in a social work capacity, the sample for this capstone project may not represent those who actually hold a social work degree.

My recommendation for further research is to continue studying the experiences of social workers working with deaf and hard of hearing people with serious mental illness by recruiting participants from other healthcare providers that offer mental health services to deaf and hard of hearing people in locations nationwide. Further studies specific to those who hold a social work degree could enhance the credibility of data and may be needed.

One way I will disseminate the information in this capstone project is to identify conferences that have audience who may be interested in learning about the experiences of social workers working with deaf and hard of hearing people with serious mental illness. For example, I would like to present this capstone project at an Annual Conference that NASW hosts on both state and national levels. Also, another way to disseminate the information is to identify professional organizations that are related to social work or deaf and present the information produced in this capstone project at their professional conferences. For example, the American Deafness and Rehabilitation Association (ADARA) and the National Association of the Deaf (NAD) host a conference biannually. As both organizations represent the deaf community, it would be beneficial for me to gain further legitimacy and credibility for this capstone project by presenting the information from the capstone project and obtaining feedback from the organizations.

Implications for Social Change

The potential impact of this action research study for positive social change at a practice level is for clinical social work practitioners to become interested in working with deaf and hard of hearing people with serious mental illness and start learning ASL and the deaf culture so that they will be able to provide culturally and linguistically competent mental health services for the population. As Greco et al. (2009) stated, it is important to train staff to become specialized in the population and increase the number of professionals who are trained in ASL and the deaf culture. I hope this action research

study would help to address a lack of clinical social work practitioners who can use ASL fluently and understand the deaf culture.

The potential impact for positive social change at an organizational level is for healthcare providers to understand and implement strategies to address known challenges to the delivery of culturally and linguistically competent mental health services for the population. Ultimately, the increasing number of culturally and linguistically competent healthcare providers may help to reduce deaf and hard of hearing people's experiences of communication disparities in the healthcare system. This action research study may also help to call attention to the lack of opportunities for professional education for clinical social work practitioners to be culturally and linguistically competent working with deaf and hard of hearing people. I hope more clinical social work practitioners will work with academic institutions and professional organizations to train students and professionals to be able to provide culturally and linguistically competent services for deaf and hard of hearing people by learning about experiences, challenges, and best practices with the population.

The potential impact for positive social change at a policy level relates to social work leaders with competence in culturally and linguistically appropriate services for the deaf and hard of hearing community collaborating with mental healthcare providers and the deaf community to identify key components of program design and service delivery that can be incorporated in behavioral healthcare policies to make it more likely that the needs of this population are met effectively. As policies that include culturally and

linguistically appropriate strategies are implemented, the deaf and hard of hearing community may find easier access to quality mental health care.

Summary

Nine social workers who have various experiences working with deaf and hard of hearing people with serious mental illness at a healthcare provider that offer culturally and linguistically competent mental health services participated in a focus group and provided valuable and thought provoking discussion. Four themes emerged: cultural competence, empowerment and advocacy, professional education, and leadership to advance cultural competence. The use of action research afforded the participants the opportunity to add to the current body of social work knowledge. Important areas of insight about the experiences of social workers working with deaf and hard of hearing people with serious mental illness has become evident through this action research study. This action research study has been completed within the deaf community to advance the social work knowledge base related to experiences working with the population. It is critical to disseminate the findings to the deaf community and continue working with the deaf community to achieve social justice equality in the right to have full access to services for deaf and hard of hearing people with serious mental illness. Also, it is important for clinical social work practitioners to understand the experiences working with deaf and hard of hearing people with serious mental illness at the three different levels of environmental factors so that they can have a significantly positive effect on the human development of deaf and hard of hearing people with serious mental illness. It is my dream that a day when there is the society where social justice is achieved by

removing communication disparities in larger systems for deaf and hard of hearing

people with serious mental illness will come at some point not far in the future.

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Appendix A: Demographic Questionnaire

Please complete this questionnaire by selecting the responses that best address your current status. Information reported on this survey will remain confidential and any reports published will not contain identifying information.

- Hearing Status: _____Deaf ____Hard of Hearing _____Hearing

- Gender: ____Female _____Male

- Age: _____18 to 24 ____25 to 34 _____35 to 44 _____45 to 54 _____55 to 64 _____65 to 74

- Ethnicity (Please check all that apply): _____Black/African American ____Caucasian/White _____Native American _____American Indian or Alaskan Native _____Asian Indian _____Hispanic/Latino _____ Other Asian ____ Other _____

- Degree (Please select highest degree held – Check only one): _____High School Diploma _____Bachelor's _____Master's _____Doctoral

- Social Work Degree (Please check all that apply): _____Bachelor of Social Work (BSW) _____Master of Social Work (MSW) _____Doctor of Social Work (DSW) or PhD in Social Work

- Years of Employment at Current Employment Setting – Please specify: _____

- Total Years of Experience Working with Deaf and Hard of Hearing Population – Please Specify _____

- What is your position at the organization?

Briefly describe your responsibilities as they apply working with deaf and hard of hearing

people with serious mental illness.

Appendix B: Group Interview Protocol

1. What experiences do you have working with deaf and hard of hearing people?

    i. How would you describe cultural competence for deaf and hard of hearing people with serious mental illness?

    ii. How would you describe your experiences working for a healthcare provider that provides culturally and linguistically competent services for the population?

        1. Working directly with the clients?

        2. Working with schools or other community organizations?

        3. Working on a larger level for system or policy change?

    iii. How would you describe your academic preparation or professional development for working with the population?

2. What challenges do you have working with deaf and hard of hearing people with serious mental illness?

        1. Working directly with the clients?

        2. Working with schools or other community organizations?

        3. Working on a larger level for system or policy change?

ii.   How do these challenges impact your work?

iii.   How did your academic studies prepare you to address these challenges?

iv.   What strategies or solutions could be implemented to help you address these challenges?

    1. For working directly with the clients?

    2. For working with schools or other community organizations?

    3. For working on a larger level for system or policy change?

3. What would you identify as best practices for providing culturally competent services for deaf and hard of hearing people with serious mental illness?

    1. For working directly with the clients?

    2. For working with schools or other community organizations?

    3. For working on a larger level for system or policy change?

4. Is there anything else you would like to share with us before closing focus group?