**Assessment of the Needs of Virginians who are Deaf, Hard of Hearing, Late Deafened, and DeafBlind**

**A note of THANKS from the Statewide InterAgency Team:**

**Thank you to all who participated in this most important survey. The results of the needs assessment are compiled on the following pages. Please review the information and share it with your colleagues.**

**We have managed to apply some of the information and suggestions, such as the revised Visor Alert Cards and hiring the DeafBlind Coordinator. Other needs are still awaiting action, and this is where YOU can help. Contact your state representative and / or State Senator to learn how he or she can help to close these gaps in service.**

**Again, THANKS to all who participated.**

**Your Statewide InterAgency Team**

**Assessment of the Needs of Virginians who are Deaf, Hard of Hearing, Late Deafened, and DeafBlind**

**Lanier, R.L., Nunnally, M., Talley, G.W., Baker, K., Reid, C, & Spiers, E. (2012) Assessment of the needs of Virginians who are Deaf, Hard of Hearing, Late Deafened, and DeafBlind. Richmond, VA: Statewide Interagency Team Serving Virginians who are Deaf, Hard of Hearing, Late Deafened and DeafBlind.**

**Assessment of the Needs of Virginians who are Deaf, Hard of Hearing, Late Deafened, and DeafBlind**

**FOREWARD**

The Statewide InterAgency Team (SIT) is a workgroup of four state agencies providing services to Virginians who are deaf, hard of hearing, late deafened, and deafblind. These agencies are: The Virginia Department for the Deaf and Hard of Hearing (VDDHH), The Department for Aging and Rehabilitative Services (DARS), Valley Community Services Boards (VCBSs), and the Department for the Blind and Vision Impaired (DBVI). Each of these agencies provides and/or coordinates services based on eligibility for program services, meaning these are not “entitlement programs”, but consumers must be eligible for services.

It is important to note is that when this survey was conducted, the Department of Rehabilitative Services and the Department of Aging were two separate agencies and are now the Department for the Aging and Rehabilitative Services. We do not make this distinction when quoting actual responses from participating consumers. When individuals are quoted in this document, their exact words are used. Although the comments must be considered anecdotal, they are the comments from the individuals.

Also, while the Executive Summary was written just prior to the release of the results, the actual survey was begun in 2007. The lack of resources to quickly and appropriately conduct, evaluate, and interpret the results is due to the lack of funds for such as purpose. No staff was available to provide support, so the members of the SIT were tasked with every step of the process. With an ever-increasing workload filled with higher priority demands, it has taken a great deal of time to appropriately evaluate the results into this report.

Statewide InterAgency Team Members

Ronald L. Lanier, Virginia Department for the Deaf and Hard of Hearing   
Mary Nunnally, Virginia Department of Aging and Rehabilitative Services   
Gary W. Talley, Virginia Department for the Deaf and Hard of Hearing   
Kathy Baker, Valley Community Services Board   
Christine Reid, Virginia Commonwealth University   
Elizabeth Spiers, Virginia Department for the Blind and Vision Impaired

The 8 Priorities

(as identified from the Needs Assessment)

1. Expanding access to qualified interpreters, communication providers, and C.A.R.T. services
2. Building the support services providers program
3. Ensuring emergency preparedness and training with police, EMTs, and medical personnel
4. Boosting employer training
5. Enhancing advocacy and deaf self-advocacy training
6. Raising public awareness through training
7. Providing information, communication and support groups for families and children
8. Growing qualified staff to increase accessibility of services

**EXECUTIVE SUMMARY**

The attached document is a report of the gaps in services for Virginians who are deaf, hard of hearing, late deafened, or deafblind.

The State-wide InterAgency Team recognized that a comprehensive plan to provide services to deaf, hard of hearing, late deafened, and deafblind Virginians must be based on identified needs. The individual members of the SIT took the questions to consumers in communities all across the Commonwealth, attending established meetings of consumer groups, beginning with the annual conference for the Virginia Association of the Deaf (VAD). Visits to other VAD chapter’s meetings, chapter meetings of the Hearing Loss Association of America, the annual meeting of the Virginia Deafblind Association and other events held during from the Summer of 2007 into the late Spring of 2008 gave us access to hundreds of Virginias who experience hearing loss, from mild to moderate to total deafness.

One very important aspect to keep in mind is that although this is not a “scientific” assessment, the comments reported here are directly from the consumers in Virginia who experience the issues being discussed. They are presented as told to us. The questionnaires were designed for individuals with hearing loss, their caregivers, and / or family members to respond.

The questions asked were:

1. What kinds of communication problems do you have? (Or what kind of communication problems does the person you know have?):

2. What other BARRIERS have you (or the person you know) experienced because of hearing loss?

3. What services do you feel are needed for deaf, hard of hearing, and deafblind residents that are not now being provided?

4. What other problems have you (or the person you know) had related to hearing loss? What else would you like to tell us?

From the answers to these questions, we identified five major themes:

1) Functioning in a hearing environment and culture,

2) Communication access,

3) Agency-specific issues,

4) Perception about how people who are deaf or hard of hearing are treated by the general population, and

5) Enhancing productivity and quality of life.

These are the concerns of the deaf, late deafened, hard of hearing, and deafblind consumers, summarized from the responses to the questions posed.

Responses about functioning in a hearing environment and communication access (themes one and two) address the lack of communication access in business, medical and other public settings. Too often, medical services and other providers (law offices, banks, etc.) refuse to provide interpreters for appointments. Announcements at Virginia’s airports and train and bus stations are not visually available. Television captioning is often still missing or garbled. Weather information on local news channels is often not captioned or visually presented, even when the other portions of the news broadcast are captioned. Movie theaters are not fully accessible, as generally, only one local theater shows one movie with captions, and that movie is shown captioned at odd times during the day. While we are making strides toward more inclusion, so much more needs to be accomplished.

Communication access is an everyday barrier to deaf, hard of hearing, deafblind, and speech impaired Virginians. Many state programs are not accessible to walk-in consumers, as no one can clearly communicate with them. Writing back and forth can be helpful – though cumbersome – but is only effective with those who are English proficient. Many hard of hearing individuals without hearing aids struggle without access to an assistive listening system or devices. For those hearing Virginians who want to learn ASL, sign language classes need to be less expensive and more widely available.

Some agency-specific issues have been addressed, while others are budget related, meaning the SIT agencies do not have the funds to resolve the need. For example, DBVI hired a Program Director for DeafBlind Services (who functions as the State Coordinator for Deaf-Blind Services) at their central office in Richmond in 2010, a position that was vacant for over three years. Changes to the VDDHH Visor Alert Card, with the pictures on the back, recommended by the deaf community, were completed and are well-received. Training is presented at various Criminal Justice Academies throughout the Commonwealth, so police officers will recognize and utilize the card.

Feedback from the needs assessment identified the importance of “marketing” available services more effectively. Many Virginians who can benefit from available services and programs do not know of the programs and services; however, better marketing may lead to waiting lists for services, as budgets and personnel of the involved agencies are already strained. Marketing means advertising in publications that target our populations. Print media (magazines) are often not read by culturally Deaf individuals, as English is a challenge to understand. Television is too expensive, and radio is ineffective with both deaf and many who are hard of hearing.

The availability of interpreters and captioning is also of concern. Sometimes no qualified interpreters are available or the office/business simply refused to obtain an interpreter. CART (Communication Access Real-Time Captioning) is very expensive ($150 - $175 per hour) and again, businesses refuse to obtain and pay for the service. Many community events are inaccessible to deaf and hard of hearing, late deafened and deafblind individuals because the events are neither signed nor captioned, as the cost of accommodations are prohibitive, especially for free admission events. This is true across the Commonwealth, but it more prevalent in rural areas and smaller cities and towns.

The perception of the lack of respect for individuals who are deaf, late deafened, hard of hearing, or deafblind is reflected in the lack of accommodations in public programs and services. Counseling programs are often inaccessible due to the lack of direct communication. Interpreters, even when available, often are not the best means of communication access between a counselor and a client. Subtle nuances (true meaning versus what is signed) expressed directly between the client and counselor could be missed. Direct communication between counselor and client is preferred and more effective, but few mental health counselors are fluent in ASL or Signed English.

Many deaf and hard of hearing consumers also face barriers when attempting to access state and local government services. If a deaf individual walks-in to a county clerk’s office, a local health department or Area Agency on Aging office or any other department, the individual is almost always unable to communicate his or her needs. No one there signs, there is no access to a Video Remote Interpreter, and if the individual is not English proficient, then writing is all but useless. The lack of assistive technology devices for the hard of hearing makes communication difficult for these Virginians.

The simple addition of a personal amplification device (i.e, Comfort Duett) could make communication with a hard of hearing individual more effective. Easy access to a Video Remote Interpreter could easily allow the signing deaf consumer to express their needs such as a request for a birth certificate, marriage license, or to pay their property tax. Currently, only the Department of Motor Vehicles (DMV) will allow a deaf consumer to contact VDDHH directly to request an interpreter for a specific date. At that point, VDDHH will contact the DMV office to coordinate the service. This allows the individual to access the service on his or her schedule. Other agencies, at all levels of government, require the consumer to make an appointment, request the accommodation, and then, hopefully, the agency will be able to obtain an interpreter at the consumer’s requested day and time. If an interpreter cannot be obtained for that specific appointment request, then the individual must take whatever time and day is available. Many times, repeated calls are required for just one appointment. This is not “equal access” and is both time-consuming and frustrating for all involved.

Often, state agencies serving deaf and hard of hearing Virginians cannot fill vacancies due to budget shortages. Since 2007, VDDHH Outreach Contracts have been cut more than 30%, and most contractors work only part-time and must cover multiple counties and cities. Money appropriated for Mental Health Counselors is not enough to hire qualified personnel who also can communicate fluently in ASL, so there remains a great shortage of services. Individuals who are deaf, hard of hearing, late deafened and deafblind who reside in group homes, nursing homes and assisted living facilities often live in isolation from those around them, due to the lack of clear communication. Effective communication between the caregivers and the residents who are deaf or with severe hearing loss is virtually non-existent. Because of this lack of communication, these residents are at risk of inappropriate care and are often unable to effectively express their needs and wishes. In many cases, this isolation and lack of communication could be eliminated with appropriate assistive technology and/or access to Video Remote Interpreting.

All of the identified issues are closely linked, either directly or indirectly, to communication access. It is difficult to recruit qualified personnel with the necessary expertise and appropriate communication skills because of budget constraints. It is difficult and frustrating for all involved when communication barriers are present in almost every aspect of daily life. Full access to interpreters, captioning services and assistive technology can break down many of these barriers and greatly increase the quality of life for many Virginians.

**Background Information about Services/Programs/Assistive Technology**

ASL versus English

American Sign Language (ASL) is not a manual form of English. It is a very real and living language, but has little connection to spoken or written English. ASL was never intended to be a written language. Although the now wide-spread use of TTY’s and text messaging requires more written English, teaching English remains a challenge.

One of the challenges is that in ASL, different forms of the same word use the same sign. For example, the words participate, participation, and participating use the same sign. Another example is performance, acting, and show (as in a play).

Another difference/challenge is sentence structure. English uses subject-verb-object structure, while ASL uses topic-comment structure. In ASL, time is signed first, and there are no articles (a, an, or the). Interrogatives (what, when, where, how, why) appear at the end of the sentence, rather than the beginning. For example:

1. English: Where are you going?

ASL signed: You go where?

1. English: I want to go shopping this afternoon at 2:00.

ASL signed: Today, afternoon, 2:00, shopping want go.

Assistive Technology

“Assistive Technology” generally refers to the equipment or devices used to facilitate communication or to provide alerts. This equipment can be an amplified telephone, a teletypewriter (TTY), a VideoPhone, or a personal amplification device. It includes alarm clocks with bed-shakers and flashing lamps to awaken someone who cannot hear sounds a regular clock generates. Individuals who are deaf, late-deafened and very hard of hearing must rely on this type of tactile / visual alert. Special smoke detectors that use flashing lights and bed-shakers are another example. This is another area where funding limitations impact the availability of equipment.

“Regular”- meaning sound generated - smoke detectors are often distributed free of charge through local fire departments. This type of detector can be purchased for less than $20.00 each. The cost of smoke/fire alarms specifically for those who cannot hear generally begins at nearly $200 each. A good-quality telephone can be purchased at discount store for $25.00 and can be used by someone with no hearing loss. The retail price of a TTY is over $450 each. An effective amplified telephone with amplification up to 55+ decibels and tone control can easily cost $150 each. VideoPhones – distributed for free by at least one Video Relay Provider, but sold by many other providers – require high speed internet access, and that is often either not available or cost prohibitive for someone with limited income. The cost of the device itself begins at $150.00 and can exceed $300.00 each.

The report also mentions Regional InterAgency Teams. These regional teams are comprised of the SIT’s regional and local counterparts, such as Regional Counselors for the Deaf, VDDHH Outreach Contractors, mental health Counselors working with deaf and hard of hearing clients, and other service providers.

**Assessment of the Needs of Virginians who are Deaf, Hard of Hearing, Late Deafened, and DeafBlind**

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**Assessment of the Needs of Virginians who are Deaf, Hard of Hearing, Late Deafened, and DeafBlind**

**Introduction**

Consumers who are deaf, hard of hearing, late deafened and deafblind often “fall through the cracks” when trying to access public services. The four agencies of the Statewide InterAgency Team are accessible; other state agencies are not able to communicate with this population. There are a limited number of accessible public services and there are unmet needs with this population. Although there are specialized programs for individuals who are deaf, hard of hearing, late deafened and deafblind in four adult service agencies, there are challenges in meeting the needs of all these individuals and in addressing gaps in service coordination with other agencies where there are no specialized programs or communication access. To identify the specific unmet needs of this population and develop a plan for addressing those needs, the Statewide InterAgency Team conducted a needs assessment.

**Defining the population**

“Even though this target population shares hearing loss as a disability, it is not a homogeneous population. Persons with hearing loss vary on degree and type of loss, age at onset of loss, preferred communication mode, and race or ethnic background. Examples of the diversity of this population are evident in the variety of terms used to describe its various subgroups such as: deaf, deafblind, hard of hearing, late deafened, minority deaf, and traditionally underserved or "low functioning" deaf. These differences impact upon the nature of.… [human services] needs and the resulting service delivery models and programs designed to meet these needs” (Anderson, Boone, Jennings, Tomlinson, Watson, 2008).

**Statistical information**

According to the National Institute on Deafness and Other Communication Disorders, approximately 17% of adults in the United States report that they have a hearing loss (NIDCD, 2010).  The Centers for Disease Control and Prevention's most recent national health interview survey similarly concluded that "16% of adults aged 18 years and over experienced some hearing difficulty without a hearing aid"  (Schiller, Lucas, Ward, & Peregoy, 2011, p. 23).  These figures include people who are hard of hearing as well as those who are deaf.   A conservative estimate of the percentage of adults who are deaf in the United States is provided by the National Center for Health Statistics. In 2009, 2.1% of civilian, non-institutionalized adults 18 years of age and over reported that they had "a lot of trouble hearing" or were deaf; that number increased to 11.4% for people 75 years and over (National Center for Health Statistics, 2011, p. 223).  These estimates of prevalence rates among adults are expected to be low, because they exclude people living in institutions (who frequently have disabilities, including hearing impairments) and military personnel (who are at higher risk of noise-induced hearing loss).  One estimate of the prevalence of some degree of hearing loss among children is provided by Niskar, Kieszak, Holmes, Esteban, Rubin, & Brody (1998):  Among children 6 to 19 years of age, a "total of 14.9% of children had low-frequency or high-frequency hearing loss of at least 16-dB hearing level" in one or both ears (p. 1071).   Clearly, hearing loss affects the lives of many individuals in the United States.  Applying these conservative estimates to Virginians (based on population count from the 2010 census), over 1,360,000 Virginians are likely to have hearing impairments, and over 168,000 are likely to be deaf or have "a lot of trouble hearing."  

**Statewide Interagency Team**

To enhance and strengthen a comprehensive service delivery system, an interagency training initiative was developed statewide in May 2005 called “Agencies Working Together: A Collaborative Model for Services to Persons who are Deaf, Hard of Hearing, Late Deafened or DeafBlind.” The Collaborative created a formal mechanism and low-cost method to support each agency’s efforts to improve services; to identify service gaps and to further develop or improve access to services within or outside of the collaborative agencies. This led to the development of a statewide interagency team, as well as six regional teams. The Regional teams are comprised of local offices of State Agencies providing services to this population.

The Statewide Interagency Team: Serving Virginians who are Deaf, Hard of Hearing, Late Deafened and DeafBlind, SIT consists of the four agencies within the Health and Human Resources Secretariat that have specialized programs for individuals who are deaf, hard of hearing, late deafened or deafblind. These agencies are: the Department for the Deaf and Hard of Hearing, Department of Aging and Rehabilitative Services, Department for the Blind and Vision Impaired and Valley Community Services Board.

The SIT members had one goal. They wanted to have access to detailed demographic information, as well as current service environment and needs data through a formal, valid statewide needs assessment.

The first obstacle to a state-wide needs assessment was budget. It was estimated that $250,000 would be needed for a formal assessment, and as SIT members discussed this, another complication was identified: most formal assessments do not address the language needs of the targeted consumer groups. Many formal assessments rely on telephone interviews, written questionnaires, and electronic questionnaires; these methods are not effective with people who use American Sign Language.

Historically, when these types of surveys were attempted, the response rates have been very low. The conduct of standardized individual interviews - i.e., face to face with the people, one at a time – was determined to be too time intensive and cost prohibitive. Another concern was that there is no physical concentration of a Deaf community or Hard of Hearing community; members do not live in one physical place (such as “Chinatown,” “Little Italy,” or “Little Havana”). Additionally, the deaf and hard of hearing communities do not tend to inter-mix with each other. In general, Virginians who are hard of hearing are not members of the Virginia Association of the Deaf, and people who are culturally Deaf do not generally belong to the Hearing Loss Association of America chapters.

After outlining a tentative plan and researching what it would take for it to happen, members of the SIT struggled with how to locate appropriate funding for this effort. Knowing state funds were limited, they created another avenue to collect the information.

Members of the SIT recognized the need to attend individual meetings of various diverse consumer groups throughout the Commonwealth, providing the communication access methods appropriate to each group. Through a series of Town Hall Forums across the state with various local, regional, and state consumer organizations and community events, the team was able to gather significant public comments to capture service needs. Computer-Assisted Real-Time captioning (CART) and wireless amplification “loop” systems were provided for meetings with consumers who were hard of hearing or late deafened, and sign language interpreters were provided for meetings with signers who were deaf or deafblind. For some groups, all of these communication facilitation methods were necessary, to ensure culturally and linguistically appropriate communication with all participants.

The Town Hall approach was determined to be the most effective means of gathering the information and questions presented to the various consumer groups to elicit their feedback. The SIT began with the Virginia Association of the Deaf Convention in July of 2007. The group continued to attend meetings of various consumer groups: Hearing Loss Association of American (HLAA) meetings, Community Picnic at Camp Roanoke, the final celebration at the Virginia School for the Deaf and Blind in Hampton, and the Southwest Club of the Deaf were just some of the places we traveled and gathered information and feedback from members who were deaf, hard of hearing, late deafened and deafblind.

In each of these meetings, comments were made from citizens/stakeholders, family members and/or service providers of individuals who are deaf, hard of hearing, late deafened and deafblind. Public comments were collected in the least expensive method, but in a way that was found to be most effective.

People representing diverse geographic, demographic, disability, racial, and cultural cross-sections of the communities were included. In response to consumer requests, some paper copies of the survey questions were provided for those people who do not use American Sign Language (ASL). As a final effort to reach as many people as possible, an electronic version of the survey questions was posted via Survey Monkey.

The Town Hall meetings were conducted in one of two ways: All or most of the SIT members attended and asked questions, or one member of the SIT would attend to lead the discussion and bring notes about the responses to the questions back to the SIT group. The whole group approach worked very well, especially in areas where the individuals may not have known all of the SIT members. Open-ended questions about three main topics were asked:

* + Types of communication problems
  + Barriers to communication due to hearing loss, and
  + Services needed/desired that are not currently provided.

Copious notes were taken on the responses. As expected, many other topics were raised, and the SIT members took each in turn, documenting all responses and concerns.

**Data Collection/Analysis**

To capture public comments, team members took notes during each event. All notes were compiled into an event summary document and reviewed at the next team meeting to ensure all information was recorded correctly. Next, the team reviewed methods to analyze the data. Demographic areas were identified that would be useful in categorizing the information. Service categories and coding scheme were established by modifying an existing tool used by the Virginia Disability Services Boards for local needs assessments.

As a group, the team reviewed and categorized each comment for coding purposes. A spreadsheet was utilized as the team analyzed and identified needs and implications. The following areas were used in the initial analysis:

* 1. Service Category (Assistive Technology, Case Management, Counseling, Education, Employment Services, Family Support Services, Housing, Independent Living, Medical & Therapeutic, Personal Assistance Services, Transportation, Communication Access, Emergency Preparedness, and Training, including Self-Advocacy Training)
  2. Comment Made by (consumer, service provider, family member)
  3. Geographic Region in Virginia (Tidewater, Central, Northern, Southwest)
  4. Disability Group (Deaf, Hard of Hearing, Late Deafened, DeafBlind)
  5. Age Issue Addressed (school age, adult, elderly)
  6. Responsible Agency to Address Issue (specific, several, all, none)
  7. Quotes (identified comments to quote in final document)
  8. Implications
  9. Positive Comments

During the process of categorizing these comments, team members identified some areas needing immediate attention. Some changes in service delivery have already been made based on this feedback, and consumers’ responses to the team’s collaboration have been very positive.

**Use of the data to date**

Following the collection of the data, the SIT was able to review the information and begin to work on some of the items listed as needs or gaps in service. Among the results is the revision of the Visor Alert Card, a large, orange card identifying the individual/ driver as someone with a hearing loss. This Visor Alert Card was initially developed through collaboration between the Department of Motor Vehicles (DMV), the Virginia Association of Chiefs of Police (VCOP) and VDDHH. In its updated revision, it includes signs and symbols to be used with people unable to communicate using voice or signs. It was distributed as a way to assist Virginia Police Officers who are interacting with citizens who are deaf, hard of hearing or late deafened. The members of the Regional InterAgency Teams (RIT) also conducted trainings for hospital staff members to address interpreting needs. They also advocated and worked with local television /cable stations to improve closed captioning issues, especially as it related to emergency notices and information presented in airports and subway systems. Many of these Regional Teams have created their own websites to share information with one another and to publicize their services in their communities. Another addressed issue was the advocacy that occurred with the Disability Services Boards. With this advocacy, “communication access” was included as a service category in their statewide disability needs assessment. The Department for the Blind and Vision Impaired was able to address one of the gaps in services as identified in the survey by hiring a statewide Coordinator of DeafBlind Services. This position was filled in December of 2010.

Assessment results identified needs and their implications for each respective agency, different regions of the state, different consumer groups, etc. Changes in service delivery were modified based on this feedback, and consumer response to the SIT collaboration has been very positive.

**Overall Findings**

After the survey results were coded into categories, Mabel Fleming, Senior Analyst Research and Evaluation of Virginia’s Department of Rehabilitative Services conducted a qualitative analysis of the public comments. The purpose of this analysis was to identify themes among the needs and issues identified (Fleming, 2010).

Five major areas of themes were identified: 1) Functioning in a hearing environment and culture, 2) Communication access, 3) Agency-specific issues, 4) Perception about how people who are deaf or hard of hearing are treated, and 5) Enhancing productivity and quality of life.

**Needs necessary to function - Education/Training at various levels**

* + 1. Professionals/state agencies
    2. People who are DHH, on advocacy
    3. People who are DHH, on available resources/services/technology
    4. General public
    5. People who are DHH, on operating with hearing loss
    6. Parents of children who are DHH, on available support

groups/resources/advocacy

* + 1. People who are DHH/DB, on emergency preparedness

The first theme included five categories: education and training at various levels, interpreters, technology, services, and housing and camps. The need for education and training of professionals and employees of state agencies was a very common problem identified. One deaf individual who had requested an interpreter at a hospital said, “*When I ask for [an] interpreter, they tell me no. Where is respect for me?*” Another described a problem when waiting in court for a case to be called; a court officer told the interpreter to stop signing what was happening in court. The deaf person asked, “*Why do hearing people get to hear what is being said while waiting but deaf can’t?*”

Another educational need identified was advocacy training for people who are deaf, hard of hearing, late deafened, or deafblind. One person said, “*There needs to be a way to get the services that are supposed to be provided without having to pay for a lawyer to get involved.*” Another asked, “*Why not set up [a] workshop in [the] Deaf community to help educate the public? Deaf [people] need to get involved with agencies in training police and hospitals.*”

The need to educate people who are deaf, hard of hearing, or deafblind about available technology was also identified. One person asked, “*How do I make calls if I am somewhere else (not at home) and they do not have TTYs or any accommodations?*” Another said that “*We are constantly contacted for information about this [technology], education about how hearing loss is nothing to be ashamed of any more than wearing glasses – in fact you are hurting others by turning up the volume on TV so loud and hurting their hearing and yours more*.” The need for locally accessible places throughout the state for learning about and trying out assistive devices was emphasized.

Many examples of the need to educate the general public were provided. One individual said that “*Statistics about hearing loss should be ‘front page news’*.” Another recommended developing a list of “Ten Things to Do If You Are Hearing Impaired,” and another of “Ten Things to Do If You Are Trying to Talk to a Hearing Impaired Person.” One person clarified that “hearing people are not all insensitive. Some are not informed and consider Deaf like Mentally Ill to be ‘dumb or handicapped’.” The need for “free or cheap” American Sign Language classes was also emphasized.

Education of parents focused on two areas: general training about deafness, and advocacy training. One parent noted, “*When my son was born there was no support or educational groups available for me to attend. Nobody was willing to teach me sign language, my local early intervention [program] closed down.*” Discussing the need for advocacy training, one parent said, “*Teach me how; tell me what to do*.”

A need was identified for educating people who are deaf, hard of hearing, late deafened, or deafblind about emergency preparedness. Discussing weather-related emergencies, one person asked, “*how are they going to hear the information if the captions don’t work…….how are you going to get the information out to the Deaf Community? How are they going to know if there’s, for example, a traffic jam? There’s no way of getting that information to them. So how do we help them, encourage them to be prepared for such situations?*”

**Needs necessary to function – Interpreters**

1. Shortage or lack of interpreters in various settings
2. General need, program service, criminal justice, medical, employment/community, school
3. Need for qualified interpreters
4. Ability to access interpreters when needed
5. Issue with denial of interpreters in medical setting
6. Issue with use of family members as interpreters in medical settings

The second major theme identified in the public comments was the need for qualified interpreters. Discussing the general lack of interpreters, one individual noted that the “*number of freelance interpreters is dwindling*.” Another commented about challenges in different parts of the state, saying that “*good interpreters develop skills and then leave the Southwest Virginia area.*” Other comments about interpreting focused on the need for interpreters in specific settings. The need for interpreters (and somebody to pay for interpreting services) in Alcoholics Anonymous and Narcotics Anonymous meetings was commonly identified, as well as need for qualified interpreters in mental health and residential settings, criminal justice settings, medical settings, employment and community activities, and in schools. The need for court interpreters and medical interpreters was exemplified by the situation of a deaf person who was in a car accident. The passenger was taken to the emergency room with no interpreter, and the driver went to court without an interpreter. The driver “*Pleaded guilty because I did not know what was going on and was charged with DUI and suspended license for 90 days. But there was no alcohol involved.*”

Ways to effectively access interpreter services statewide are needed. Some individuals noted that this is especially challenging in rural areas. One said that it would be helpful to have “*other ways to access interpreting services that might be alternatives to live interpreting, [such as] remote interpreting or video interpreting or even captioning where a number of people can view it on a projection screen*.”

Employers not being willing to pay for interpreters was a problem identified, as well as the denial of requests for interpreters in medical settings. The common practice of inappropriately relying on family members as interpreters in medical settings was mentioned repeatedly. One individual said that doctors “*Tell us to bring a friend or family or write notes.*” However, there are serious problems with that approach. First, the friends or family members may not be qualified to accurately interpret, especially in a medical situation. Writing back and forth in English may not be sufficiently understandable for an individual who uses English as a second language. Introducing a friend or family member into the interaction with a medical professional also interferes with the confidentiality of the doctor-patient relationship; professional interpreters must follow a Code of Ethics that mandates confidentiality.

Another comment exemplified the importance of accurate interpreting, and problems with interpreting errors. One person noted that in court, a deaf individual said “bull” but the interpreter voiced the word “screw.” The deaf person was put in jail for five days for contempt of court. This person was pulled out of the courtroom screaming, “*What did I do?*”

**Needs necessary to function – Technology**

1. Better technology in various settings
2. Visual alert systems
3. Video relays or phones
4. Availability and quality of closed captioning
5. Funding for hearing aids or other systems
6. Access to better technology
7. Technology center

A number of comments made in the Town Hall Meetings related to need for access to appropriate technology. For the benefit of readers of this document who are not familiar with communications technologies needed to enhance accessibility for people who are deaf, hard of hearing, late deafened, or deafblind, examples of those technologies are discussed here. These examples are organized in the categories of needs identified by people participating in the needs assessment.

Not too long ago, wired loop systems were the best technology available in classrooms and public buildings, such as museums, libraries, and churches. The older wired systems are still beneficial, especially in large public meeting rooms where they are often permanently installed and only require the user to have a Telecoil (T-coil) in the hearing aid. However, with the advent of new systems such as Comfort Contego and the Comfort Duett, users can use a variety of hearing aids, and give the user control over the volume. Unfortunately, relatively few classrooms and public buildings are equipped with wireless systems in Virginia.

Small projectors that connect to a laptop computer enable CART and other captioning services to be more readily accessible than they were in the past. However, provision of these services is relatively expensive, and availability is limited in some areas of Virginia.

Visual Alert Systems are now being installed in many public buildings. Most fire alarms are both auditory and visual – with a very loud siren coupled with a strobe light. These dual systems can ensure that those with vision or hearing loss are alerted to fire and smoke dangers. However, many public buildings do not have such alert systems available.

Home alarm clocks, coupled with a doorbell, allow more individuals with hearing and/or vision loss to remain in their own homes far longer than before, as this technology helps to ensure their safety. In addition to the alarm clock and doorbell, The AL-10 from Clarity works with motion detectors, baby criers and smoke alarms also, so that even when asleep, the individual will be warned. However, many Virginians who could benefit from using such technology do not even know that it exists, or cannot afford to purchase it.

Videophones are the newest and highly desired telephones for people who are deaf. These allow the user access to a video relay service interpreter who signs to the deaf caller and voices to the hearing person. Although the relay functions much like a traditional relay which utilizes a TTY, deaf callers don’t have to type in English, a language that is often not their native language; instead they can directly sign to communicate. Videophones also allow two deaf users to sign directly to each other, resulting in a faster and smoother conversation. However, some Virginians who could benefit from using Videophones do not have access to this technology. One of the barriers to effective use of this technology is insufficient internet bandwidth in some geographic areas.

Captioned telephones have improved greatly from the original models, with one model providing captions much faster over the internet. Many people who could benefit from captioned telephones are not aware of this technology, and some who are aware of it run into barriers with insufficient internet bandwidth.

The VDDHH Technology Assistance Program (TAP) provides great access to consumers, as many with limited income (currently based on 250% of the Federal Poverty Level) can obtain a phone (telecommunications device) and an alerting device (e.g. AL 10) at no cost. VDDHH Outreach Specialists assist consumers who do not qualify for the TAP program to find appropriate devices on the various vendors’ websites. CapTel telephones, normally a $500 phone, can currently be purchased directly from the manufacturer, for $99.00. Many Virginians who could benefit from TAP do not know that it is available to them.

All of the devices available through the TAP program are on display and can be tested at the VDDHH office in Richmond, and at the Contractor’s offices in Roanoke, Fairfax, Fredericksburg, Norfolk, Lynchburg, Norton, Fishersville, and Abingdon. For consumers with serious transportation or mobility issues, the devices can be demonstrated and tested in their homes. Many people who could benefit from testing out these devices do not know how or where they could do so.

**Needs necessary to function – Service**

1. Better access to services for people who are D/HH/DB
2. State Coordinators for people who are DB
3. Regional centers in various areas
4. Support staff in various services

Results of this needs assessment show that many deaf, hard of hearing and deafblind Virginians have trouble accessing services across the board, from early intervention programs to driver’s education classes for high school graduates to accessible group homes for seniors who are deaf or hard of hearing. They experience barriers with existing agencies, as well as limited services and programs in rural areas. Many agencies providing services to people who are deaf, hard of hearing, or deafblind need more specially trained personnel, such as teachers, independent living staff, interpreters and speech language pathologists. Agencies in the Northern Virginia area report a high need for independent living teachers, and most agencies across the state need more support staff. In addition, more regional service centers are needed statewide to serve this population.

Some early intervention programs do provide services to deaf and hard of hearing infants and young children, but doctors don’t always provide enough follow up and information to parents and children. Also, there are not enough mental health services for children with hearing loss.

Virginia needs more services and experts in the area of deafblindness. Staff working with people who are deafblind should consider the diverse needs of people with all types and degrees of combined vision and hearing losses.

A State Coordinator for Deafblind Services has now been hired, but people who are deafblind still experience difficulty getting services. One gap is the lack of Support Service Provider (SSP) services. SSPs are specially trained individuals who serve as the “eyes and ears” of people who are deafblind. SSPs assist these individuals with traveling, shopping, reading mail and providing environmental information that help people who are deafblind access their communities and connect with other people. The Virginia Association of the DeafBlind provides volunteer SSPs for their meetings, but people who are deafblind need SSPs for work, errands and community access.

The following quotes from participants in the needs assessment illustrate some of these points:   
  
“*One woman graduated from VSDB [Virginia School for the Deaf and Blind] last year and didn’t get her driver’s education and now it has been so difficult to arrange any programs to get her that class.”*

“*Don’t focus on just hearing with vision loss/blind, hard of hearing with vision loss and ignore the needs of deafblind. The State Coordinator for the DeafBlind needs to have knowledge of all needs with the variety of hearing and vision losses—hard of hearing and ASL Deaf.”*

Another person narrated her experience staying in a hotel overnight. “*I was in a hotel and asked for a wake-up call to catch a cab the next morning. Hotel Security came in and shook me to wake me up. I then went to the bathroom. Someone kept trying to open the bathroom door and I kept saying, “Wait, I’m not ready.” He handed me some things and moved me out into the hallway. In the hallway the fire alarm was going off and I asked if there was a fire. He said, “Maybe, not know.” I then realized this was not my “wake-up” call. The hotel room had no flashing alarms*.”

Another need noted is the Red Cross’s lack of awareness and training to work with deafblind people. The survey participants noted that staff need to know more about equipment and loaner programs so they could assist deafblind people more effectively.

**Needs necessary to function – Housing and Camps**

1. Group homes to meet special needs of people who are D/HH/DB
2. Camps that meet special needs of people who are D/HH/DB
3. Transitional housing

A huge need exists for group homes designed for people who are deaf, hard of hearing or deafblind who have other special needs, such as intellectual challenges, autism or developmental delays. Current group homes for people with intellectual challenges are not designed for sign language users.

Senior adults who are deaf, hard of hearing, or deafblind need group homes and living situations where they can communicate easily with each other and with staff members. Some transition-aged young adults also need accessible group homes so they can receive the training and assistance needed to become independent.

People who are deaf, hard of hearing or deafblind also lack accessible recreational activities. Few camps are designed to meet theirspecial needs. One person emphasized the need for a camp for people who are deafblind

Selected quotes that illustrate some of these points:

”*We are the parents of a 16 year old young man who is deaf with special needs along the autism spectrum. We are seeing a deficiency in camps and group homes for children with deafness and other disabilities. Many camps and group homes are for children/young adults who are just deaf or just have special needs, not both.”*

“*I have a daughter with MR (intellectual disability) and cognitive delays. What happens when she graduates? Teach me how/tell me what to do—how to advocate!”*

“*We need a VADB (Virginia Association of the Deafblind) camp. I went to camp in Western Maryland for one week and had two SSPs [support service providers]. I participated in boating, swimming, etc. What a wonderful time for deafblind people.”*

**Communication Issues Encountered**

1. Limited methods of communication
2. Hearing in public settings
3. General communication problems
4. Lack of understanding in group settings
5. Difficulty with mutual understanding
6. Communication access
7. Communication with family
8. Communication with doctors

People who are deaf, hard of hearing, late deafened or deafblind repeatedly face communication access problems. Town Hall Meeting participants identified this as a major issue in many everyday life situations. They frequently commented that there is limited access to effective communication methods. A person who is deaf and uses sign language must depend on others who know sign language. A person who is hard of hearing but without amplification, such as in an emergency or when ill, is not able to follow the communication as well as with amplification. If the service provider is unaware of this problem, the results could be catastrophic for the individual who is hard of hearing. Likewise, a person who is deafblind depends on tactile sign language, a slower paced means of communication requiring others who are able and willing to use this form of communication. So people who are deaf, hard of hearing, late deafened, or deafblind are not able to interact easily with other people in everyday situations that promote effective interpersonal relationships and healthy lifestyles. One frustrating situation mentioned in the needs assessment process was the difficulty of hearing in public settings. The current use of glass windows and vents to allow sound to “flow through” (e.g., theater box office), makes it difficult for people who depend on auditory communication to hear, and for people who depend on visual means of communication to see clearly. The glass distorts the sound and movements, creating frustrating and sometimes embarrassing misunderstandings. The lack of amplification and/or visual alerting in public places was another problem identified in the survey. Public places such as airports, subways and even department stores are using public address systems to alert customers to dangers or potential dangers, as well as to discounts or in-store events. Virginians who are deaf, hard of hearing, late deafened, or deafblind are missing this information.

Group meetings create a unique set of communication difficulties. The language variance of the speakers, the language comprehension of the group members and the pace at which group meetings occur make it very difficult for people who are deaf or hard of hearing to follow the communication, much less participate. One such example is “twelve step” meetings where the pace is fast and the vocabulary may or may not be familiar to the member who is deaf or hard of hearing. Because of the different speakers, the person who is deaf or hard of hearing must try to swivel from place to place to determine who is speaking, and then sometimes lose the content of the message.

Sometimes people who are deaf or hard of hearing are embarrassed to ask for repeated communication and just nod or smile, hoping to end the communication exchange without making too many mistakes. This lack of effective communication is less than satisfactory for either the person who is hearing or the person who is deaf or hard of hearing, and doesn’t promote healthy interpersonal relationships.

The lack of communication access for people who are deaf or hard of hearing was identified as a major issue by many participants in the needs assessment; there were a number of specific issues identified. The most often reported was the lack of communication access with physicians and the lack of communication with family. Several individuals reported going to physicians and being told to bring their own interpreter or receiving services without an interpreter. One individual indicated that the lack of interpreters results in people not receiving needed services: “*It is often hard to get people to provide interpreting services for my son who is deaf. Especially, counseling and mentoring services. He has gone without because of this.*” Some expressed frustration with feeling disrespected; for example, “*When I ask for [an] interpreter, they tell me no. Where is respect for me? They think deaf people are nothing. Hospitals need more education on getting interpreters and deaf/hard of hearing needs*.”

The most frequent comment related to communication access was that interpreters cost money, and service providers and community agencies are not willing to provide that financial support to ensure effective communication. These comments summarize the theme of many of the comments received: “*Provide interpreter services statewide that can be requested & utilized within rural workplaces. This would include a list or contact number that a business could call to request assistance easily without any pressure or negativity toward the deaf employee;* [the] *state should pay for services of interpreters too!*” “[There is] *Limited amount of interpreters so community functions are usually not interpreted or they use unqualified people that ‘know some’ sign language because* [they’re] *cheaper to use*!” One individual shared “*concerns about interpreter services, particularly for AA and NA meetings and who's going to pay for the interpreters for those meetings on a monthly basis*.”

**Agency Specific Issues**

1. **DRS (Department of Rehabilitative Services)**
   1. Improvement in providing jobs
   2. Interpreter/Communication issues
   3. More marketing including closed captioned DVDs
   4. Positive service comments

Comments on employment issues indicated that community services were needed. One participant expressed a concern that DRS focuses on *“low-paying jobs so some deaf don’t like to go to DRS”.* Others provided positive comments like, *“DRS helped me to get a job, now also working with my daughter”.*

An ongoing theme throughout our public comments was communication accessibility and interpreting, especially at DRS. *“DRS got me a job and then closed my case. But I have problems communicating with my boss. There is no communication with my employer. DRS needs to help me.”*  This comment had numerous attendees indicating agreement by “nodding heads”. Participants also mentioned the uncertainty of who is responsible for obtaining and paying for interpreting services. “*DRS won’t provide interpreters. DRS needs to give us a list of interpreters.”*  Another participant explained that DRS is for employment and does provide interpreting related to job seeking, job training and initial support on the job. “*DRS wonderful services provided interpreting services at vocational program.”*

Marketing was an issue that was discussed in several areas. Participants commented that many people are unaware of DRS and its services. One high school senior commented that many of her friends in mainstreamed schools do not know about DRS services and suggested that we need more public awareness of DRS. Another individual asked, *“What is DRS and can older people use DRS for jobs?”* Another recommendation was to provide captioning of DVDs *“for clients to learn about DRS services or any essential job duties”.*

1. **VDDHH (Virginia Department for the Deaf and Hard of Hearing)**
2. Interpreter services
3. Advocacy and awareness

The issues relating to interpreter services, or lack thereof, were repeated in every corner of the Commonwealth. There was a general lack of interpreters commonly expressed by participants, whether the interpreter was qualified or not. We heard that the “number of freelance interpreters is dwindling”, and that “good interpreters develop skills and then leave the SWVA area”. There seems to be no incentive to encourage interpreters to remain in certain areas. There seems to be a tendency to move on to where the jobs are. This shortage or lack of interpreters was exacerbated by the growth of video relay call centers. Such developments contributed to “taking away from the community services”.

Participants also expressed the lack of interpreters in program services. Mental health services are not easily accessible because in most cases, the provider does not sign. We also heard, “*It is often hard to get people to provide interpreting services for my son who is deaf, especially counseling and mentoring services. He has gone without because of this.”* Even participants in group homes do not have full access because staff does not sign, but they also feel this lack of interpreters because of its negative impact on employment efforts. Some participants felt that disclosing their need for interpreters impacts their job search in a negative way as many employers do not want to pay for interpreters or use interpreters even when an agency like DRS pays for them during a job interview. Participants also expressed concern about access to twelve-step programs and similar services not covered by the ADA with the looming question of *“…who’s going to pay for the interpreters for those meetings…?”*

Even in criminal justice situations, there is concern for appropriate communications access. When one person told some lawyers he needed an interpreter, the lawyers told him to “*bring a friend to interpret*”. There are reports of the inability to exercise one’s civic duty to serve as a juror because of being told they did “not have an interpreter”. There is also the age-old misunderstanding regarding preferred modes of communication. For many cultural deaf individuals, English is a second language, yet they are constantly bombarded with the English mode and expected to understand it. “*One court used CART instead of interpreters. Could not follow English*.” There needs to be a no-one-size-fits-all approach when it comes to communications access. We also heard that VA needs more court interpreters.

The medical setting probably has more instances where communications access is lacking, than any other setting. There were numerous reports of interpreters not being provided for doctor and other medical appointments. “*Sometimes doctors call staff to sign (but not as interpreter). Someone who has had 1-2 classes in signing. This is not good; can misunderstand what doctor or patient is saying.”* Some are “*poor at interpreting and not qualified for deaf adults/deaf community*”. Also, “*sometimes it is hard to find qualified interpreters and to get medical and service providers to understand the importance of providing an interpreter to a teen with a hearing loss*”. There is the constant experience of hospitals not providing interpreter services; emergency rooms not providing interpreters; hospitals not providing interpreter services in preparation for surgeries, etc. “*We have a big need for interpreters at the hospital. They tell us ‘NO’*”. The following reported experience speaks poorly of communication access in the medical and court settings: “*Had a car accident. Provided no interpreter. Passenger was injured and taken to ER and provided with no interpreters. Went to court and was without an interpreter. Pleaded guilty because I did not know what was going on and was charged with DUI and suspended license for 90 days. But there was no alcohol involved*.” One person was told by her doctor that she did not need an interpreter but she did because she could not understand the doctor’s notes. She went on to say that, “*She had an operation and they wouldn’t provide an interpreter.*” Another reported, “*When I ask for interpreter, they tell me no. Where is respect for me? They think deaf people are nothing. Hospitals need more education on getting interpreters and deaf/hh needs*.” There is also the well-known expectation that a family member or friend, whether adult or child, can interpret for the deaf individual.

There were reports of similar scenarios in areas of employment, school and community activities. *“…community functions are usually not interpreted or they use unqualified people that ‘know some’ sign language because cheaper to use*!” There are those who give up on applying for jobs because employers are not providing interpreters, which also prevents one from even getting an interview. Some public schools lack qualified interpreters. There was this report that, *“…at my high school…some interpreters not properly certified/trained (i.e. ASL vs. English and inaccurate concept of signs). I told Principal about this and he said that the ‘Central Office’ doesn’t care*.” Overall, there is simply a lack of qualified interpreters, coupled with an unwillingness to provide accommodations.

1. **DBVI (Department for the Blind and Vision Impaired)**

Deafblind people who contacted DBVI for services were informed that DBVI does not have funds or services for senior citizens unless there was a goal for employment. Also, deafblind people applying or reapplying for services from DBVI have to go through the application and certification process each time, and potential applicants want a faster, easier way to get services.   
  
One person expressed a desire to get services closer to home, similar to the ones offered at the Helen Keller National Center.

Many families, educators and professionals are unaware of services available in Virginia to deafblind people. A deafblind student said, “*My parents and I never knew about any of the services I could have used while growing up. Actually we never found out until I started college. I guess perhaps all school counselors should be required to take training in the state services available to deafblind students.*”

**4. Valley Community Service Board (CSB)**

No “agency specific” comments related to services they provide or need to provide.

**5. Other Agencies: Department of Aging (DOA); Virginia Office for Protection and Advocacy (VOPA), Department of Education (DOE)**

Comments related to services they provide or need to provide

The SIT is comprised of DBVI, DRS, VDDHH and VCSB. These four agencies were represented at each town hall meeting and were listed on the original Town Hall Flyer and on the surveys that were distributed. While the presence of staff members from these agencies prompted comments related to these specific agencies, there were a few comments made about other agencies and their provision of services for people who are deaf, hard of hearing, late deafened, or Deafblind. The comments were related to the Department of Aging (now part of DARS), Virginia Office of Protection and Advocacy, and several comments for the entire body of SIT.

There was a comment about the potential for the Department of Aging to be involved in residential services. “*Need for Dept of Aging* [to be] *involved. Could they help with setting up Assisted Living for the population that would have communication access as key services?*” As well, there was a comment about Virginia Office of Protection and Advocacy being involved in supporting the lack of housing and accessible employment for people who are deaf, hard of hearing, late deafened, or deafblind. “VOPA [is] not focusing on housing or employment issues.”

The SIT was addressed as a whole and encouraged to act together to improve services. It was suggested that adding team members such as the Departments of Education and Emergency Preparedness would benefit the constituency served by the current SIT. *“[It is] important to have DOE as part of SIT.*” “*SIT needs to add emergency preparedness personnel to [the] team for checks and balances. Make sure everyone is doing what they are supposed to do.*”

A final comment about the SIT as a whole body was that perhaps this team would be able to offer education and serve as an advocate for the constituency with other agencies not familiar with Deaf services and needs. “*Doctor offices do not feel it a necessity to provide interpreters. SIT and state level needs to apply pressure and give information to local health departments. There is not enough pressure on doctors*.”

**Perception of how people who are DHH are treated**

1. Sense of being treated inferior
2. Having difficulty in getting jobs or opportunity to do more within current job
3. On-going racial bias
4. Additional
   1. General call for help
   2. Suggestions for brainstorming opportunities

There were many comments related to the perception of how individuals who are deaf, hard of hearing, late deafened and deafblind are treated. There was a general sense of being treated as inferior, having difficulty in getting jobs or opportunity to do more within the job due to their disability, and on-going racial bias. Additionally, there was a general call for help and suggestions related to the need to brainstorm opportunities for individuals who are deaf, hard of hearing, late deafened and deafblind.

The lack of respect for individuals was a recurring theme with various comments supporting the perception. One individual stated that he contacted the police from his Blackberry device. *“They arrived but wouldn't talk to me. Talked to everyone else, but me. I know I look different but should talk to me.”* Another comment stated that there was a *“Total lack of respect, not getting help for anything that is needed.”* There were two comments made that had many attendees signing “yes” in agreement at separate public meetings. Both related to the “wait a minute” concept, “*Want to ask something, put on hold then forget”* and *“Hearing ignore to the deaf when need help or advise.”* The lack of patience of “hearing persons” also was identified. This is also recognized by service providers as one stated, “*Client appears to be isolated at times during the day from others, particularly during meeting times.”*

Another perception related to employment. One individual stated, “*Not able to get hired by a company. Most companies required to pass a hearing test. I'm not able to pass, even know I pass the interview process.”* Comments acknowledged discrimination issues by saying, “*Some discrimination in workplaces, especially if they involve machinery or production work. Employers are concerned about safety.”* One person expressed concern about being discriminated even though the person was qualified for the position. Another person wrote in a comment, “*Jobs private company better understanding when come to interview, saw deaf then come back later waster time.”*

Racial issues were another area that was identified. One person stated that, “*Virginia favors one group over other.”* Another comment discussed inferior education being related to "racial/deaf" and that the perception that race bias leads to low expectation of achievement. One suggestion to address the racial discrimination in services was to form a “task force” to look at issues and problems. This also was expressed with another suggestion, “*Why don’t we black deaf people from different city in state of VA to have meeting once a year and form panel to express their problem, frustrating.”*

Overall, the comments of perception mirrored similarities that "*it is very must important they are still keeping help the people Deaf*". Several suggestions offered were to work with businesses and services to brainstorm opportunities for “*freedom, education, jobs, etc.”*

**Things to help with life and productivity**

Many respondents stated that an identification card or some identifying documentation would be helpful. Several comments suggested a visor card for the police or an identification card with the name of an interpreter on it so it could be used in emergency situations. One example of how this might help was reported by the son of a hard of hearing mother who said that his mother had surgery and the doctor thought she was learning disabled because she didn’t respond appropriately. The issue was that the mother didn’t have her hearing aids. The son said, “*Doctors should have this information in the chart!*”

Respondents indicated a lack of professionals and educational opportunities for individuals who are deaf, hard of hearing, late deafened, or deafblind. For example: “*My friends, students who are hard of hearing, need increased speech-language therapy, but due to the lack of speech-language pathologists in our area, there are not enough for adequate services. Also, the lack of qualified interpreters [and] teachers of the deaf and hard of hearing hold our area behind in needed services.*”

Respondents indicated that they wanted more “*employment opportunities*” and “*better support from the related agencies*.” There was also concern stated about “reduction in funds and [order of selection] effect on people who are hard of hearing that need hearing aids to obtain employment.”

**Conclusion**

All of the issues identified in the needs assessment are tied in some way to communication access. It is difficult and sometimes impossible to recruit qualified personnel with the necessary expertise and appropriate communication skills because of budget constraints – meaning the jobs do not pay enough. It is difficult and frustrating for all involved, and potentially dangerous, when communication barriers are encountered in almost every aspect of daily life. Effective communication with qualified personnel and access to interpreters, captioning services and assistive technology can break down many of these barriers.

Now that the data are compiled and analyzed, members of SIT seek to place the information into the hands of those who will be able to promote its use. The process of gathering the material was in itself a useful endeavor to allow the consumers opportunity to have input into the services they wish to receive. It is now important to use the material in some productive way to meet the unmet needs or address the gaps in services. Toward that end, members of SIT will use this report to educate others in the Commonwealth about the unmet needs and gaps in services provided. The final report is being distributed to the Secretary of Health and Human Resources and to the agency heads of each of the SIT’s representative agencies. The report will be available to all legislators and will be distributed specifically to those who hold key positions in Health and Human Resources Sub Committees, to legislators on the Disability Commission, as well as those representatives who have expressed an interest in disability issues.

It is important that agencies in the Commonwealth of Virginia develop goals and objectives within agency strategic plans to address the unmet needs and gaps identified in this report. The report will be a public document that can be linked to all agency and consumer group websites and posted on the Regional Interagency Teams’ websites that currently exist. The report will be shared with each consumer group participating in the needs assessment process, for their review and use for promoting and advocating about issues specific to them.

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