THERAPEUTIC
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Hope Realized
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Chair Fischer and Committee Members, my name is Lori Vigessa and I am a Clinical Supervisor of the Deaf/Hard of Hearing and Deaf Blind Program at Therapeutic Services Agency.

We received a referral from the family of a DeafBlind girl living in a small town that needed to see a counselor. The referral came from a concerned teacher for the deaf that this young lady seemed to be depressed, full of worries, and seemed to have given up on life. These things were negatively impacting her academic performance, and her relationships with her family members. The family had tried therapists before, but none of them continued working with her; citing it was not possible for her to communicate well enough to benefit from therapy. The issue was not only that this girl was profoundly deaf and legally blind, but she was also non-ambulatory, had multiple physical issues, and was losing sensation and movement in her hands. She also did not have intelligible speech and even one of the best ASL interpreters in the area admitted that they could only understand approximately 30% of what the young girl was trying to communicate.

After this teacher had received our brochure, she went to the family and convinced them to try one last time. Our Program came in with a very different approach as we knew the questions to ask about her communication style, what colors were best for her vision, and we were willing to do home-based sessions. We also talked to the doctors about the extent of her vision loss, hearing loss, and physical limitations to understand how we needed to modify our interventions and communication. We did all this to get the full picture of this young girl. Words pale when I tell you how much of an impact all of this made on this child once the therapist sat down in front of her after adjusting the lighting in the room, wearing the appropriate color, and got up close and personal to accommodate her field of vision and introduced themselves. A communication plan was set up between the client and the therapist for when things were not understood, and interventions needed to be heavily modified. Now, five years later, she is a strong, resilient, young woman who is ready to be discharged from therapy and face her future with coping skills that are allowing her to get out into the community that she once feared and flourish. This would not have been possible if it were not for our program's existence and the dedication of our mental health professionals to be thorough and intentional in their work.

Our Deaf and Hard of Hearing/DeafBlind (DHHDB) program was set up to fill a serious gap in culturally and linguistically affirmative services in Greater Minnesota for deaf, hard of hearing and deafblind children and adolescents. The rural nature and low incidence of this group poses its own challenges above and beyond what we consider the norm. Clinics and agencies everywhere are struggling with staffing shortages, and when the add in of needing someone who is bilingual, understands how hearing loss impacts mental health, and be willing to function as an itinerant therapist in a rural area; it becomes an insurmountable challenge. Couple that with the documentation and deadline expectations and the pressure to make sometimes four to five hours of clinical assessment, diagnosis, and summarization fit into one billable hour, one can understand why it has taken us over a year to fill a position and why we have had two of our uniquely qualified professionals leave to pursue private practice or work for places like the State of Minnesota's Adult Mental Health Program where documentation expectations are less and pay is more.

Our mental health professionals travel across three-fourths of the state to meet families where they are in their own communities to see more outcomes like that of the young girl mentioned earlier. We have more stories like that we can and would love to share. Happy endings that would not have been possible without the distinctive skill set and knowledge our staff use in their work. The widespread travel, however, means fewer clients we can see which means less productivity, or billable, hours as travel is disproportionate in reimbursement than what it cost us to cover that therapist's time. One may think that telehealth is the easy answer, but there are limitations to this as well. We have many families that do not have internet in their homes, or if they do, it is slow and the picture halts and pixelates. This does not pair well with the use of sign language and the need to read facial expressions. There are also modalities such as Play Therapy, Eye Movement Desensitization and Reprocessing (EMDR), and others that are best done in person and do not lend themselves well to telehealth. We are also seeing an increase in bilingual families where the family does not speak fluent English and the child uses sign language. In these instances, we need two interpreters. Reimbursement for that cost does not cover any travel that may be involved and is often not at the rate of what interpreters charge for their services. Our program could not even begin to run if it was not for the grant that partially sustains us due to these many inequities between service provision and reimbursement for those services. What we need is reimbursement that is in commensurate with other healthcare providers and services and rates that would come closer to covering the actual time and costs of completing the required documentation for our clients.

I will leave you with one more story of a young man that came to our services struggling with survivor's guilt over being an organ recipient and with his identity as a person with hearing loss. He was already struggling with knowing that a young child had to have their life cut short and that he benefitted from that loss when his parents, who had taught him to be proud of who he was just the way he was, had pressured him into another cochlear implant. He felt betrayed and lied to by his parents. They told him to be proud of who he was but appeared, to him, to not be able to accept it themselves. He stopped using sign language, he refused to look at his interpreters in school anymore and his grades were suffering, and his once close relationship with his parents was becoming increasingly more strained. This young man came to our program and with the support of our therapists, who completely understood what most of hearing society could not, was able to get to the point that when he took his senior pictures, he took one where he proudly displayed the scars of the surgery that saved his life wearing a graduation cap that read "proud donor recipient" on top. He rebuilt the relationship with his parents and is back to having a solid, more integrated identity and strong self-esteem. This is the work mental health professionals do and the promise of endings like these are why we do it.

Respectfully submitted,

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Clinical Supervisor