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THE ROLE OF THE REHABILITATION COUNSELOR FOR THE DEAF IN A MENTAL HEALTH SETTING

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The early 1960's marked the development of a new frontier of service for the deaf: specialized mental health care. Soon after the New York pilot project opened its doors in April 1955 at the New York State Psychiatric Institute and in January 1963 at Rockland State Hospital, other rehabilitation centers, hospitals, and clinics instituted similar mental health care services. These services continue to increase in number and in the variety of professionals involved in mental health care. Most recently, the key goal in mental health care for deaf people has been comprehensiveness. Increasing knowledge leads to greater professional specialization in a variety of mental health fields.

This paper will examine the results of a survey of mental health facilities offering special programs for deaf people. The results should provide insight into how the services of an RCD are actually utilized, and whether or not the traditional domain, the Vocational Rehabilitation office, has altered. Secondly, the work of the RCD will be differentiated from the roles of other mental health professionals. This analysis should assist in delineating the unique nature and purpose of the Rehabilitation Counselor for the Deaf. Thirdly, the advantages of in-hospital RCD services will then be discussed. Finally, an existing comprehensive model of a mental health program for the deaf will be presented.

QUESTIONNAIRE SURVEY RESULTS

A questionnaire was distributed to mental health facilities to elicit opinions about the role and functions of a rehabilitation counselor and /or rehabilitation counselor for the deaf in mental health work. The 10-question form was sent only to those psychiatric facilities offering programs for deaf people. The 15 places selected represent a sampling from the listing in the April 1978 Directory Issue of the *American Annals of the Deaf.*

Results show that at the time of the survey, 8 of the 15 facilities did not have either an RC or RCD on staff. These respondents referred patients requiring rehabilitative assistance to counselors at the state Division of Vocational Rehabilitation (VR) office who regularly work with deaf people. Four facilities employed both an RC and RCD. Two facilities staffed an RC, but no RCD. One facility employed two RCD's but no RC. While RCD services were repeatedly helpful to overall mental health care planning, there was no agreement on whether these services should be based in-hospital or in a VR office.

Patient contact hours with RC/RCD averaged about 1½ hours per day, ranging from 4 hours daily to "whenever necessary." Team conferences involving the RC/RCD ranged from 3 hours per week to "when necessary." Except for one facility, all facilities offered at least the following departments: psychiatry/psychology, nursing, social work, physical and adjunctive therapy. Average deaf inpatient census per annum was 22, ranging from 3 to 43. Average deaf outpatient census was 39, ranging from 0 to 270.

Three of the 10 questions required subjective responses. The first of these questions asked for a brief description of the role of the RCD. The facility that employed two RCD's replied:

> Neither RCD does rehab counseling. One counselor coordinates the inpatient program for the hearing impaired, and does a variety of jobs usually done by the social worker and nurse-clinician. The other RCD is responsible for grant writing, some program development, public relations, and intake for our outpatient program.

Facilities which referred deaf patients to the local DVR usually described the RCD's role in more general terms.: "Evaluation training, job placement, follow-up," or simply "handled by our state Rehab Consultant." One facility considered the function of an RCD to be limited

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to job finding. Others regarded the role more broadly, such as: ". . . RCD sees inpatients and outpatients, works in aftercare, visits community facilities, and develops programs in communities; it is a multifaceted job." A few facilities mentioned personal and vocational counseling, and interpreting as duties within the role of the RCD.

The second question asked the respondent to differentiate between the functions of a rehabilitation counselor and a social worker. The third question solicited an opinion about the particular advantages a patient has when an RC or RCD is part of the staff. Opinions differed markedly. One response, written by a social worker, reflected the struggle for role identify that has been occurring between the fields of social work and rehabilitation counseling:

> I have yet to see a strong rehabilitation counselor with skills to compete with the breadth of a social worker's skills . . . I'll be damned if I've figured out what they offer except a particular set of contacts and knowledge of specific laws and policies - both of which could be learned by a social worker as well.

About half of the respondents viewed the functions of the rehabilitation counselor (RC) or RCD as being more specific than those of the social worker. The social worker was considered to be responsible for the "general welfare of the patient" and "all other needs, not only job related." The other half of the replies contrasted with this view by including functions other than job training and placement in the role of the RCD. Such functions were: personal and guidance counseling and preparing the patient for a job. Several participants failed to differentiate between the two professional groups, merely stating that the roles of the social worker and rehabilitation counselor "overlap."

Except for one facility that did not respond to the third subjective question, all facilities saw advantages in having an RCD on staff. One response read: "The (RCD) has knowledge of Sign Language, and knowledge about deafness; he/she knows about the possibilities, process, and procedure of rehabilitation." Another response read: "The RCD assists in the development of life and job skills, helps with increasing effective interpersonal relationships." Still another responded: "The RCD helps the patient toward the end goal of therapy — to live independently, with a measure of security."

Only two respondents mentioned a distinguishing contribution the RCD can make: the development of new human service programs in the community. The RCD can be the motivating force behind the establishment of necessary community support services.

Survey results suggest that the tasks of RCD's currently working in mental health facilities are most often vocationally-related. Secondly, the functions an RCD performs will be largely dependent upon the needs of the particular facility employing the RCD. Thirdly, as the availability of other mental health professionals in a facility increases (e.g., psychiatric social worker, psychiatric nurse, OT personnel), functions of the RCD become more tightly vocational in nature. A fourth observation concerns the apparent role confusion of the social worker and the RC/RCD. In some facilities, overlap in functions are expected, but survey results offered no general agreement on where the overlaps occurred.

DISCUSSION

Ambiguity seems to exist when the RCD is employed where a patient is given many different kinds of help. Since the scope of an RCD's position varies according to facility and composition of the mental health staff, it is helpful to consider what the other team members do.

The psychiatrist. The psychiatrist uses knowledge of medicine, psychiatry, and deafness to aid and modify chemotherapeutic regimens. Drugs are frequently necessary to render the patient more responsive to therapy (Robinson, 1978). The psychiatrist evaluates the readiness of the patient to begin other types of therapy, as well as rehabilitation, and provides psychotherapy as may be appropriate.

The psychologist. The psychologist engages in psychotherapy with the patient, and is responsible for diagnostic pscyhological testing (Rainer & Altshuler, 1966). These duties require the ability to communicate proficiently in

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the mode most comfortable to the patient or group. The psychologist needs to be aware of the psychology and adjustment problems of deafness so that behavior is not misinterpreted or mislabeled.

The psychiatric nurse. This professional has a continuous source of feedback from the patient, and is one professional member of the team who spends the most time with the patient. Therefore, information from the nursing staff is extremely valuable to the RCD assessing the patient's progress. The nurse maintains and promotes a therapeutic environment that allows and encourages the patient to gradually assume independence (Robinson, 1971). The success of the general treatment plan depends largely on how well that plan is implemented by the nurse.

The social worker. The social worker focuses on the patient's social functioning, and on the interaction of person with environment (Morales & Sheafor, 1977). The social worker undertakes family treatment, group therapy and individual counseling (Kahn, 1973) to help the patient arrive at a more satisfying and beneficial relationship with people and the world around him. Social work often involves changing living conditions and securing community resources.

The RCD. The RCD is concerned with a patient's abilities, preferences, skills (both vocational and personal) and life work that will foster a sense of well-being. These traits are examined during counseling. The patient is helped to learn more about himself, his handicap, and how these traits relate to the world of work (McGowan & Porter, 1977). The counseling relationship is product-oriented and cooperative. Both RCD and patient must be looking ahead, readying the patient for transition into the world outside the hospital. Goals themselves are vocationally-motivated and action-based. The RCD plans and facilities patient activity, enabling the patient to experience success along the way.

Although counseling is a function of both the social worker and RCD, the focus of the counseling relationship differs. The social worker is interested in the social adjustment of the individual. The RCD directs the counseling process to the person's vocational adjustment. Since both professionals offer a type of social service, their roles often overlap. However, there tends to be greater overlap in mental health programs for deaf people than in regular mental health programs. This tendency is most likely due to the paucity of mental health professionals able to work effectively with deaf people. Because the RCD is a specialist in deafness, the role will expand to provide services unavailable from other sources.

THE COMPREHENSIVE NEW YORK PROJECT

While several mental health programs for deaf people have published descriptions of their services (Ferguson, Gough, & Hester, 1976; Robinson, 1971), the New York mental health project for the deaf appears to have one of the most comprehensive programs (Rainer & Altshuler, 1978; 1970). The out-patient unit is run by New York State Psychiatric Institute; the 30-bed inpatient program is located at Rockland State Hospital, Orangeburg, N.Y. The RCD is employed by the hospital, and is part of the comprehensive plan: inpatient and outpatient services, partial hospitalization, community services, diagnostic services, and rehabilitation and transitional services. While many centers are busy expanding their services for the hearing population, the New York project has already adapted the required services to the special needs of the deaf.

Rehabilitation services were not an original part of the inservice program at Rockland State. They were instituted as a solution to a growing problem at the hospital. Patients had been referred to state DVR offices immediately following discharge. The lengthiness and complexity of the VR process seemed to cause problems for the discharged patients. As they waited, patients lost motivation, and many were readmitted. In response to this problem, DVR then assigned a counselor to the unit part-time, and patients became part of that counselor's caseload as soon as possible from the time of admission. The RCD was kept informed of each patient's progress in weekly conferences so that post-hospital training could be coordinated with time of discharge. Exploration of new skills began in-hospital.

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The RCD utilized occupational therapy to set up short-term, attainable goals and to motivate the patient to work in the pre-vocational period. Through OT, the patient started to develop better attention span and ability to concentrate. Patients were at different stages of the VR process upon discharge, but the usual time lag between discharge and VR placement was kept to a minimum. In the New York Project, the RCD heads the rehabilitation team, and is ultimately responsible for coordinating the rehabilitative progress of the patient. Contact is made at least once a month with both the staff social worker and DVR.

COMMUNITY ORGANIZATION

In areas without special programs for the deaf, the RCD has much opportunity for community organization. The RCD may be the only professional aware of the special needs of the deaf in that community, and as such, can be a powerful force in deaf community development (Schein, 1976). Suitable support systems should be prioritized and established gradually. Meeting with deaf professionals, and professional and civic organizations can provide input, motivation and support necessary to set up rudimentary services. The role of an RCD widens considerably in locales that do not offer mental health services for deaf people, or that offer fledgling programs. Here the RCD assumes more active inservice education of the mental health team, both professional and ancillary.

The present author suggests two standards by which the effectiveness of a mental health program for the deaf can be measured. One is simply the expressed approval of the deaf community, by organizational voting procedure, or informal correspondence. The second measure is an increase in the number of deaf people, or percentage population, using the new services. The RCD could play a major role in disseminating information about these services. Encouraging participation by the deaf community and stimulating feedback are other RCD functions in community organization.

ADVANTAGES OF RCD SERVICES IN THE MENTAL HEALTH SETTING

Efficiency. The period between a patient's discharge and the start of rehabilitative services can be frustrating and wasteful. In-hospital insutitution of these services minimizes this period. The time factor is very important with patients who have handicaps in addition to deafness, and who ordinarily require extended evaluations. As staff member in a hospital, clinic, or community mental health center, the RCD is the tie-in with Vocational Rehabilitation. Vocational preparation can begin in-hospital by planning and creating activities for the patient that are purposeful and realistic. The patient can start to experience the advantages and difficulties of autonomy at his own speed, dealing with problems as they arise. Also, the "live" evaluation could be more effective in choosing patient goals. Outpatient facilities could offer RCD services as a type of Vocational Rehabilitation outreach, minimizing the confusion a patient usually experiences in seeking various kinds of help from different agencies.

Service continuity. For any program, the RCD should know how the entire process of hospitalization, treatments, therapy and training affect the patient. Similarly, the patient should know there is someone who is coordinating his rehabilitation, and who will continue these services for a time following discharge. This provision of a continuity of services should be differentiated from purely administrative duties. Instead, it implies a caring relationship, as well as understanding of the intrapsychic, interpersonal, sociocultural and economic factors that may affect the person's behavior (Thoreson & Tully, 1971).

The main concern of the mental health team is the deaf person's returning to the community. Many job-adjustment problems will have causes related to mental health. The RCD has a key role in this final aspect of a deaf person's rehabilitation, and can oversee the case to its resolution. The ultimate goal of rehabilitation is reached when the patient assumes a practical and satisfying responsibility for his life. Patient motivation is a factor in achieving this goal. Success equally depends upon the dedication, skills and cooperation of all team members, as well as types of services available to the patient. Efforts to institute and maintain a rehabilitation team in mental health programs for the deaf will ensure quality in these programs, even as their numbers increase.

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