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REMOVING BARRIERS TO MENTAL HEALTH SERVICE UTILIZATION FOR INDIVIDUALS WITH SENSORY IMPAIRMENTS

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REMOVING BARRIERS TO MENTAL HEALTH SERVICE UTILIZATION
FOR INDIVIDUALS WITH SENSORY IMPAIRMENTS

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Kery Silva
June 2020

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ABSTRACT

The present study explored common themes and barriers associated with mental health service utilization among people with sensory impairments. The ultimate goal is to promote social workers' preparedness to serve individuals with sensory disabilities. This study is significant considering that (1) a large proportion of people with sensory disabilities do not receive mental health services and (2) there is a paucity of studies within the field of social work that examine barriers to mental health services for the aforementioned population. In this qualitative study, the researcher conducted semi-structured interviews with 14 professional social workers (N =14) who have direct experience with sensory challenged individuals. Among the major themes that emerged for the data, there was (a) lack of interest in the studied population, (b) communication difficulties, (c) stigma, (d) social construction of disability, and (e) social workers' lack of preparedness/readiness to serve sensory challenged individuals. These findings hold major implications for theory, research, social work practice, and social work education.

Keywords: sensory impairment, social construction of mental health services, critical disability theory, social work practitioner, qualitative research

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CHAPTER ONE

INTRODUCTION

Problem Formulation

Sensory impairment is a term that encompasses disabilities such as deafness, blindness, visual impairment, hearing impairment, and deaf-blindness. There is a wide array of disabilities that may affect or relate to the sensory output; however, the sensory impairments mentioned above were the focus of research for this project. The majority of information an individual acquires about the world comes from hearing and seeing; therefore, a sensory disability can affect how a person gathers information from the world around them (Guthrie et al., 2016).

Sensory impairment research is often based on the medical model approach, as opposed to using a person-centered framework. With respect to seeking mental health services, people who are deaf and blind communicate differently than those who are sighted or hearing-abled individuals. This highlights the need for suitable communication methods during mental health assessment and treatment. Individuals who are either deaf, blind, or both and have a mental illness or emotional disturbance face many barriers in their effort to receive effective, comprehensive mental health services (Critchfield, 2002).

The latest American Community Survey (ACS), which measures the prevalence of disability in the United States, found that the occurrence of disability in the United States was 12.8% for both children and adults in 2016. Of

those measured, 2.4% reported a visual disability ranging from blindness to partial blindness, and 3.6% reported a hearing disability ranging from complete hearing loss to partial hearing loss (Erickson & Von Schrader, 2018). From a global perspective, an estimated 1.3 billion people worldwide live with vision impairment. Among them, 285 million reported moderate to severe visual impairments (Aa et al., 2015). With the majority of people who experience vision impairment being 50 years or older (Aa et al., 2015), the incidence and prevalence of sensory disabilities will tend to increase due to the aging trend worldwide.

The disparity of mental health services for blind and deaf individuals is concerning. One-third of visually impaired older adults experience clinically significant symptoms of anxiety and depression. This figure is twice as high compared to the prevalence in the older adult general population (Aa et al., 2015). Furthermore, Cabral et al. (2012) found that 90% of deaf and hard of hearing (D/HH) adults reported difficult mental health access and a lack of services. The study also found that 80-90% of D/HH people with severe and persistent mental illness did not seek mental health services for their mental health diagnosis due to outside factors such as communication barriers.

Social work professionals must be trained in multi-sensory impairments to have the ability to provide specialist assessments and treatment plans that meet the needs of the identified clients. Social work encompasses micro practice, direct contact with clients to address individual problems, and extends to macro

policy level advocacy. Ultimately, both micro and macro social work falls within a spectrum which intersects with one another. In terms of social work macro practice, the United States does not have a national framework or streamlined procedure to address the needs of those living with sensory impairments (McDonnall et al., 2017).

Purpose of the Study

The purpose of this study was to explore how social work professionals understand and perceive the mental health needs of consumers with sensory disabilities. More specifically, this research sought to extend the literature on sensory impairments and service delivery by answering the following set of questions: How can the social work profession remove barriers to mental health service utilization among sensory disabled individuals? What is the perceived preparedness of social workers when servicing sensory impaired individuals?

Significance of the Project for Social Work

Social workers, regardless of specialization, need to understand and acknowledge the prevalence and impact of sensory loss to work effectively with consumers or advocate for policy change. People who are blind, visually impaired, deaf, or hard of hearing are consumers who do not actively seek social services. The disparity between those receiving services and those who qualify for services was an area of needed research within social work practice due to the lack of existing literature. It is of utmost importance to reduce the burden of

individuals with sensory impairments experience and decrease the disparity in mental health services.

The findings of this study will inform social work practice on both a micro and macro level. On a micro level, these findings will contribute to the profession of social work practice by offering awareness on the barriers faced by consumers who are visually impaired or deaf/hard of hearing when seeking social services. Specifically, the findings are of paramount significance to social workers who have direct contact with consumers who are diagnosed with a co-morbid sensory disability and mental illness. On a macro level, this study brings awareness to existing social work programs within universities concerning the importance of incorporating curriculum that increases social work preparedness. For instance, this study can be used to determine an existing program's competency-based education standards. Moreover, this research study can be of considerable significance to the general intervention process, especially when assessing consumers and formulating appropriate treatment plans. The field of social work may utilize the findings of this study to recommend the implementation of standardized services that meet the needs of individuals with disabilities to decrease barriers to services.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter consists of an examination of the research relevant to social work practice involving individuals who are diagnosed with sensory disabilities who utilize mental health services. The subsections will include literature encompassing sensory disabilities within mental health practice, substance abuse dual-diagnosis, sensory disabilities within healthcare practice, the role of culture, and disparity in service delivery. The final subsection will examine Critical Disability Theory and Andersen's Behavioral Model, which were the guiding conceptualizing theories for this research.

Social Work Practice Involving Sensory Disabilities

Worldwide, nearly 466 million people have disabling hearing loss, and roughly 1.3 billion people are diagnosed with a form of visual impairment (World Health Organization, 2019). In the United States, the occurrence of medically diagnosed disabilities for children and adults is 12.8%; of those, 2.4% are diagnosed with a visual disability, and 3.6% are diagnosed with a hearing disability (Erickson & Von Schrader, 2018). The existing research demonstrated a correlation between sensory disabilities and mental health problems, specifically those who are deaf, blind, visually impaired, deaf-blindness. To meet the demands of people with a co-occurring sensory disability, the following

review of the literature confirms that social workers need to understand and address the limitations within social work practice by specifically understanding mental health within disabled populations to bridge the disparity in mental health services.

Mental Health and Sensory Disabilities

People with sensory disabilities are afflicted with mental health disorders and, consequently, the symptoms of the disorder at a higher rate than the general population. As previously mentioned, visually impaired individuals are two times more likely to suffer from clinically significant symptoms associated with anxiety or depression (Aa et al., 2012). Cabral et al. (2012) found that in the deaf and hard of hearing population, 90% of adults indicated a deficit in mental health services due to a lack of accommodations, as standard care does not meet the needs of those who are hearing impaired. Moreover, in hearing-impaired individuals with severe and persistent mental illness, 80-90% do not receive nor utilize mental health services. Outcomes from this study show a multigenerational consistency in need of services, as the need for services remained constant throughout the age brackets. Yet, found that as people aged, their knowledge of services and trust towards mental health professionals declined, and younger participants had more accessible access to research information by the use of technology. As the United States continues to age, the need for person-centered competent services continues to grow.

Substance Use and Sensory Disabilities

Substance abuse disorders also compound mental health concerns among disabled individuals. People with disabilities face barriers when diagnosed with a co-occurring substance use disorder (SUD). Particularly concerning treatment and availability of fully accessible treatment facilities. In 2009, the Substance Abuse and Mental Health Services Administration (SAMHSA) reported that in terms of SUD treatment centers, only five providers in the United States met the criteria to treat deaf patients (2011). Formidable barriers were also identified when SAMHSA (2011) reported findings related to health service provider's perceptions regarding disabled patients. It was found that vocational rehabilitation counselors and SUD treatment providers revealed negative attitudes and prejudices regarding treatment for disabled patients. Particularly, asserting a belief system that disabled patients who seek SUD treatment are "not worthy" of substance use treatment, and providers had preconceived notions that the outcome of treatment would be poor when patients had both co-occurring conditions.

The survey also found that staff lacked specified training and the materials used for treatment were inaccessible to blind or deaf patients (SAMHSA, 2011). Living with a co-occurring untreated substance use disorder and a sensory disability leaves people at risk for further consequence. According to SAMHSA (2011), females with co-occurring disabilities such as blindness or deafness and substance use are at a higher risk for physical and domestic violence, with 47%

of disabled females reporting at least one incident of physical, sexual, or emotional. As much as 20% of disabled males also report at least one incident of domestic violence. Lack of treatment facilities and trained personnel is exposing this already vulnerable population to further risk, such as domestic violence.

Sensory Disabilities in the Health Care Practice

Research findings (Iezzoni et al., 2004; Steinberg et al., 2006) pointed to a deficiency of qualified health care professionals as the most significant challenge when providing health care services to individuals with sensory disabilities. Both Steinberg et al. (2006) and Iezzoni et al. (2004) identified a disconnect between D/HH patients and their mental health providers. Patients seeking mental health services reported that clinicians lacked appropriate communication skills when providing psychotropic medication dosage and instructions for consumption. Similarly, another study found that D/HH individuals commonly misunderstood clinical terms such as depression and psychosis, due to either limited knowledge of English language or lack of understanding in American Sign Language (ASL) during intake assessments or routine visits (Cabral et al., 2012). For individuals who are not fluent in English or ASL, navigating health care systems can be overwhelming and result in barriers to treatment, as shown in the disparity in individuals received much needed mental health services.

Due to communication barriers when treating individuals with sensory disabilities, many health care agencies depend on interpreters or family members for translation purposes. The lack of understanding regarding impairment,

compounded by a difference in communication delivery, leads to a disparity in treatment. Bean and Krcek (2012) indicated that in the United States, 29% of families have at least one member diagnosed with a disability; however, individuals may not divulge personal information due to the stigma surrounding mental health, especially in families where culture influences mental health beliefs. The utilization of a family member leads to a further disconnect between the individual and their mental health provider.

Sensory Disabilities and Culture

Culture plays a large role in the way people think of disabilities and mental health. Children and adults with congenital or acquired impairments are part of a larger community, with disability being only one factor within the culture. When working with people who have a sensory disability, social workers, and other health care professionals cannot assume that one treatment approach will fit every disabled client. Daley (2002) discussed how health care professionals commonly and erroneously generalize treatment approaches across all disabilities worldwide. The culture within disabled individuals, such as the general population, influences how one perceives, experiences, and manages health care, specifically mental health. Ravindran and Myers (2011) found that culture shapes a person's worldview, and professionals must be able to deliver culturally competent treatment, with the understanding that disability varies greatly across cultures and time.

Disparity in Services

Significant disparities in mental health services are evident among those with sensory disabilities. People who have a visual or hearing impairment and experience symptoms of mental health disorders such as depression or anxiety are often undiagnosed or misdiagnosed due to their sensory disability. Aa et al. (2012) found that health care providers focus on physical symptoms more so than psychological symptoms, with a systematic review showing only 20% of adults needing psychological services such as individual or group therapy are receiving services. Similarly, Cabral et al. (2012) reported that barriers in communication within health care providers are the main cause of disparity related to mental health services. Indeed, providers rely on peer support services to meet the demands of patients, leading to disabled individuals living with undetected mental illness and consequently experiencing feelings of isolation and stigma (Cabral et al., 2012).

Theories Guiding Conceptualization

As mentioned in the research, significant inequalities in mental health services are evident among those with sensory disabilities. Moreover, individuals with sensory impairments are afflicted with mental health disorders and, consequently, the symptoms of the disorder at a higher rate than the general population (Aa et al., 2012). Therefore, the two major theories guiding the study are Critical Disability Theory and the Andersen's Behavioral Model.

Critical Disability Theory, expanded from Critical Theory, is a framework that addresses the needs of people with disabilities and impairments.

Sociologists developed critical Theory at the University of Frankfurt in Germany, specifically, the Frankfurt School (Brincat, 2016). Critical Social Theory, first outlined by Max Horkheimer, has become a diverse family of theories, including Critical Disability Theory (Horkheimer, 1972). Critical theories aim to incorporate insights from all social sciences to explain social problems that exist and offer practical solutions on how to respond to domination and oppression (Brincat, 2016).

Critical Disability Theory serves to challenge the discrimination against people with disabilities as it asserts that discrimination against people with disabilities is so ordinary, that it is invisible within society (Rocco, 2005). Critical Disability Theory addresses the invisibility experienced by the identified population, using the core criteria of Critical Theory, stating that a theory must be explanatory, practical, and normative, all at the same time (Brincat, 2016). Critical Disability Theory explains what is wrong with the current social reality of disability by arguing that “disability is not a fundamentally a question of medicine or health, nor is it just an issue of sensitivity and compassion; rather, it is a question of politics and power(lessness), power over, and power to” (Devlin & Pothier, 2006, p.2)—asserting the notion that people with disabilities inhabit a system of structural, social, political, and cultural inequality as the conventional

belief is that disabilities and impairments are not the norms within a society, ultimately asserting the idea that disability is a social construct.

When attempting to assess the mental health needs of people with sensory disabilities, Critical Disability Theory can be used as a constructive framework as it encompasses the role of society in respect to disability within a socio-cultural context. The theory reveals an interrelated system as it examines power and privilege in terms of which groups of individuals are valued and which groups are marginalized within a culture (Rocco, 2005). Disabilities are prevalent worldwide, yet, the implications and perceptions vary within culture and time. Applying a socio-cultural lens within social work practice can be useful when addressing perception and understanding surrounding services for the identified population.

Critical Disability Theory's central theme is that disabilities and impairments are socially constructed; thus, the individual who is impaired is hindered due to society's inability to respond adequately to diversity outside of socially constructed norms. Although Critical Disability Theory has made advancements concerning disability awareness, a limitation is that the theory has marginalized the experiences of those living with profound disabilities (Scambler, 2005). Regardless of the social construct of disabilities, profound disabilities such as visual impairments exist independent of socio-cultural contexts.

Due to the disparity between prevalence and utilization of mental health services for people with sensory disabilities, Andersen's Behavioral Model is a

valuable tool to measure health care usage. The Behavioral Model is one of the most widely acknowledged models in health services, which was developed in 1968 by US medical sociologist and researcher Ronald M. Andersen (Andersen, 1995). Andersen's Behavioral Model, as outlined by Aa et al. (2012), provides a framework for establishing and validating the influences that steered an individual to seek the use of health care services determined by three dynamics from the client's perspective. First, predisposing factors such as biological imperatives for health care needs, for example, age or gender; secondly, enabling factors such as the person's income or medical coverage; lastly, clinical need factors representing chronic conditions (Aa et al., 2012). Deafness, blindness, visual impairment, hearing impairment, and deaf-blindness would fall under chronic conditions, along with any mental health diagnosis.

The model is a multilevel framework that allows for both individual and contextual causes of health care usage, and it will enable health care professionals to gauge why services are underutilized and serve as a tool to identify the needs of vulnerable populations. According to Aa et al. (2012), studies using the Andersen Behavioral Model have found a correlation between predisposing factors and mental health services; yet, further research is warranted to diminish barriers and gain insight into the health care needs of individuals with sensory disabilities.

Critical Disability Theory has an overall quality-based score of 38 and Andersen's Behavioral Theory, a score of 32 based on Joseph and Macgowan's

(2019) Theory Evaluation Scale. Social work theorists Rigaud Joseph and Mark J. Macgowan developed the Theory Evaluation Scale (TES) in 2018 to critically appraise social work theories (Joseph & Macgowan, 2019). The TES uses scores of 1 as the lowest possible point and 5 being the highest point to evaluate the overall quality of theories on nine different criteria: coherence, conceptual clarity, philosophical assumptions, connection with research, contextual testability, empirical evidence, theory limitations, client context, and human agency (Joseph & Macgowan, 2019). The range of scores on Joseph & Macgowan's (2019) score is as follows: 1 to 9= Poor, 10 to 19= Fair, 20 to 29= Good, and 30-45 Excellent.

Under the prism of the TES, the Critical Disability Theory and The Andersen's Behavioral Model generated a score of 38 and 32, respectively (please refer to Table 1 below). As seen in Table 1, the TES deemed both theories strong in terms of coherence, conceptual clarity, historical roots, philosophical assumptions, and human agency. Nonetheless, there was some room for improvement, namely with respect to testability and boundaries. The excellent scores on the TES depict the quality and relevance of the two aforementioned theories for the social work profession.

Table 1. Critical Analysis of Study Theoretical Perspectives with Joseph and Macgowan's (2019) Theory Evaluation Scale (TES)

<i>Item</i>	<i>Criteria</i>	<i>Score</i>	
		CDT*	ABM**
1	The theory has coherence.	5	5
2	The theory has conceptual clarity.	5	5
3	The theory clearly outlines and explains its philosophical assumptions.	5	4
4	The theory describes its historical roots in connection with previous research.	5	3
5	The theory can be tested and proven false via observational and experimental methods.	3	3
6	The theory has been critically tested and validated through empirical evidence.	4	2
7	The theory explains its boundaries or limitations.	2	2
8	The theory accounts for the systems within which individuals interact with people around them.	4	3
9	The theory recognizes humans as active agents within their environment.	5	5
Overall score		38	32
<i>Theory quality based on overall TES score:</i> Excellent for both theoretical perspectives			
*Critical Disability Theory **Andersen's Behavioral Model			

Summary

As the United States population continues to age, the prevalence of people living with disabilities will also increase. Literature indicates a direct demand for mental health services for those living with a sensory disability, yet, there is limited research that targets the identified population directly. Existing literature focuses on the medical healthcare perspective, and the research did

not provide results within the lens of social work practice. Therefore, this study seeks to enhance the literature by researching the barriers faced by consumers and to analyze the understanding and perception of social workers concerning the needs of consumers with sensory disabilities to obtain solutions for improved service utilization.

CHAPTER THREE

METHODS

Introduction

This study sought to identify and describe the barriers to mental health service utilization amongst sensory disabled individuals, specifically blind, visually impaired, deaf, or hard of hearing. This chapter presents the research methods and data collection instruments used for this study. The sections discussed in this chapter are the study design, sampling, data collection, procedures, protection of human subjects, and data analysis.

Study Design

The purpose of this study was to identify, examine, and assess common themes and barriers to mental health service utilization among blind, visually impaired, deaf, or hard of hearing individuals and explore methods to improve access to services. This study measured the perceived preparedness of social workers regarding accessibility and service delivery for the identified population, specifically concerning mental health services. The present research is an exploratory research project due to the limited amount of research on the mental health needs of the identified population, particularly from a social worker's perspective. The research that was conducted will increase the understanding of social workers serving individuals within the identified population; therefore, it will

be a qualitative study. The researcher utilized individual face-to-face interviews with open-ended questions to collect data from participants.

In terms of benefit, utilizing an exploratory, qualitative approach with individual face-to-face interviews allowed the participant to deliver a more in-depth expression of their professional perspectives. Facilitating interviews allowed the researcher to make clarifying questions or follow-up questions based on responses, creating more in-depth data. Furthermore, it also allowed the researcher to capture verbal and observe non-verbal cues. Due to the limited research currently available in terms of social work perception with the identified population, a qualitative study provided a more extensive picture of each worker's perception as opposed to quantitative research.

In terms of limitation, when conducting individual face-to-face interviews, the researcher had to ensure the interview questions were free from bias. Another limitation of conducting interviews was that due to allowed timespan, the researcher could only conduct a smaller sample size, which will not be representative of all social workers. Lastly, the qualitative data gathered cannot be used to determine causality. The findings from this study were not intended to define the causal relationship between specific sensory disabilities and mental illness.

Sampling

This study utilized a non-random snowball sample of social work professionals, as well as advanced year graduate social work students

completing field practicum hours. The study consisted of one sampling group conducted through individual confidential interviews. The social workers interviewed were gathered through the researcher's professional network. With a snowball sample, participants referred other social workers in the field who were willing to take part in the study. Their respective agencies were not contacted or included as part of the research. Participants were contacted through personal contact information, and their agency contact information was not utilized as a form of communication. There was a total of 14 subjects participating in individual interviews with the researcher (N = 14). Specifically, ten social workers who are actively practicing in the field and four advanced year graduate social work students who are completing practicum hours.

Data Collection and Instruments

Qualitative data was collected via live, audio-recorded interviews with social workers and advanced year Master of Social Work candidates. The individual interview began with an introduction of the researcher and a brief description of the purpose of the study following by informed consent. The researcher proceeded to gather demographic information using a survey, which will be previously provided to participants for review. The demographic information collected consisted of age bracket, gender, ethnicity, achieved educational degree, the status of licensing, number of years in current practice/field, and social work specialization.

The researcher conducted each face-to-face interview using an interview guide created by the researcher outlined in Appendix D. The interview questions were developed to be open-ended, and the researcher encouraged participants to elaborate on answers to gather the most comprehensive information available from each participant. The data collected during each face-to-face interview served as qualitative data to gain insight into the social worker's perception and preparedness to serve the identified population.

Procedures

A handout was created describing the purpose of the study, as well as a description of the research being conducted, the terms of confidentiality, and the goals of the study. The handout was sent to potential participants via email to inform them of the study. Upon agreement to participate in the study, the researcher dispersed a packet to each contributor before the interview, the package included the informed consent which described the study's purpose, significance to social work practice and the interview instructions, demographic questionnaire, and a copy of the interview guide so the participants could view the questions during the interview. The location, as well as the date and time of the interview, were determined by the participant to ensure suitability for the participant as the study was voluntary. Qualitative data was collected via audio recording and was later transcribed and entered onto a Word document. Before recording, the interviewees signed the informed consent form that provided consent to take part in the study and consented to audio record the interview.

The researcher explained to each participant that the recording would only be used for the present study, and recordings would be coded without identifiable information.

The participants were asked to complete the demographic questionnaire once informed consent was completed. Upon completion of all forms and instructions, the interview was conducted (forms are located in appendices B-D). The qualitative one on one face-to-face interview ran approximately 15 minutes to 45 minutes. After the interviews, the participants were thanked for participating in the study.

Protection of Human Subjects

This study was approved by the Institutional Review Board at California State University San Bernardino. The study involved 14 adult human subjects in relatively good physical health, and that posed little, if any, a risk to participants. The study was entirely voluntary, and the identity of the participants during the study was entirely confidential. All interviews were conducted in a private location. Participants were given pseudonyms during the recorded interview.

Furthermore, participants were required to sign an informed consent form with an "X" before participating in the study, allowing the researcher to audio record and conduct the interview. The researcher utilized a dedicated digital voice recorder for safeguarding accuracy and privacy. The audio recordings were transcribed, and upon transcription, the audio recordings will be stored on a USB stick with password encryption and kept in a locked desk within the researcher's

home office. The pseudonym assigned to each subject was given a randomized number for transcription, to assure the confidentiality of the subject. One year after completion of the study, the audio recordings will be deleted from the USB stick, and informed consent will be disposed of properly through the use of a shredder meeting appropriate security clearance. There was no potential benefit of the study to any of the participants involved in the research.

Data Analysis

The data collected from the individual interviews were transcribed and analyzed with qualitative themes by the researcher. The researcher utilized a qualitative research study, employing grounded theory to analyze the data. Each participant was assigned a unique code to separate each participant's responses. The researcher used thematic analysis, where recurring themes in the data were categorized. A complete explanation of the analysis will be provided in chapter four.

Summary

The purpose of this study is to identify, examine, and assess common themes and barriers of mental health services among blind, visually impaired, deaf, or hard of hearing individuals and explore methods to overcome barriers and expand social workers' preparedness. Participants in this study provided demographic information and answered open-ended interview questions. Once

qualitative data was collected, the research was transcribed and analyzed to measure recurring themes.

CHAPTER FOUR

RESULTS

Introduction

This chapter illustrates the results of the data that was analyzed through fourteen semi-structured qualitative interviews. The author examined the data by utilizing a thematic content analysis to explore the data. The study aimed to explore limitations to mental health services amongst blind, visually impaired, and deaf or hard of hearing individuals and examine social workers' preparedness to service individuals with sensory disabilities.

This chapter also discusses the demographic characteristics of the sample interviewed and the recurrent themes that emerged throughout this exploratory research study. This chapter provides a statistical description of the social work participants who participated in the study. Furthermore, the chapter provides an explanation of the results and a summary of findings.

Demographic Information of Study Participants

Table 2 below presents the demographic characteristics of the social work participants pertaining to age, race/ethnicity, gender, years of field experience, prior experience with identified population, specialization, and licensure status.

As seen in Table 2, the sample consisted of fourteen participants; the vast majority of the participants were over the age of thirty-three, and slightly over two-thirds of the sample was female. Half of the participants were

White/Caucasian, and slightly over one third were Hispanic/Latino, while less than 15% were Black or African American. In terms of years of field experience, marginally less than two-thirds of participants had under eight years of field experience, while one third had eight or more years of experience. Prior experience with the identified population varied, with the vast majority reporting previous experience in one or categories and slightly less than half reporting prior experience with every impaired sensory disability listed. In terms of the participant's self-reported specialization, the sample was mostly evenly divided between the seven specializations, with the majority reporting a specialization in substance use and mental health. The sample's licensure status was equally divided, with half of the participants licensed and the other half either not licensed or pre-licensed and accruing hours towards licensure.

Table 2. Participant Demographic Characteristics (N=14)

Variable	N	%	Variable	N	%
Age		100	Prior Exp w/ Population		100
20-26	2	14.3	Hard of Hearing	1	7.1
27-32	1	7.1	Hard of Hearing and Deaf	4	28.6
33-39	3	21.4	Visually Impaired (VI)	1	7.1
40-46	3	21.4	VI and Hard of Hearing	1	7.1
47-53	1	7.1	All of the Above	6	42.9
54 and above	4	28.6	None	1	7.1
Race/Ethnicity		100	Specialization		100
White/Caucasian	7	50	School-Based SW	2	14.3
Hispanic/Latino	5	35.7	Macro SW	1	7.1
Black or African American	2	14.3	Substance Use/Mental Health	4	28.6
Gender		100	Forensic SW	2	14.3
Male	3	21.4	Military SW	2	14.3
Female	11	78.6	Medical SW	2	14.3
Years of Experience		100	Child Welfare	1	7.1
Under 8 years of practice	9	64.3	Licensure Status		100
8 years of practice or more	5	35.7	Not Licensed	4	28.6
			Pre-License	3	21.4
			Licensed	7	50

Presentation of the Findings

Five major themes emerged from the thematic analysis of the interview data. First, a correlation between social construction and the view on sensory impairments appeared. Second, social work practitioners have perceived awareness of stereotypes concerning the identified population. Third, the analysis pointed to common challenges concerning service utilization. Fourth, there is a lack of preparedness within social work practice; lastly, recommendations to bridge services were detected. The themes that emerged from the data are presented in Table 3 below:

Table 3. Major Study Themes

-
- 1) Social Construction of Sensory Impairments
 - 2) Awareness of Stereotypes
 - 3) Common Challenges
 - a) Lack of Interest in the Population
 - b) Readiness Concerns
 - c) Communication Concern
 - d) Stigma
 - 4) Social Workers Lack of Preparedness
 - 5) Recommendations
 - a) Training and Consultation
 - b) Client-Centered Approach
 - c) Advocacy
-

Social Construction of Sensory Impairments

To assess for preparedness when servicing the identified population, the participants were asked what their initial thoughts or insight were, along with any relevant personal and professional experience. The participants offered differing perspectives concerning the capabilities and limitations of those living with sensory impairments. The views differed based on the participant's self-reported experiences with the identified population, with some reporting that they had a sensory impairment. In contrast, other participants reported they had extensive experiences before entering the field of social work, and the minority of participants said they only had professional experience with the identified population. The multiple views of social work professionals appear to be dependent on personal and professional skills concerning the abilities of those living with sensory impairments, leading to a finding that views on sensory impairments are socially constructed, based on the experiences of each participant. Two participants reported:

I've been blind all my life since birth due to retinopathy of prematurity. This is a very fast paced, visual, oral, graphics-based society, and people simply have not been trained to consider accommodations or working for people with sensory deficits. As an example, I went into Denny's, and I asked for a braille menu, and the waitress didn't even know what that was. I bring that up because we have professionals working with people with hearing deficits and vision deficits and psychological deficits. Yet, they

don't have the appropriate training to access information and to make assessments of these individuals because they are so based on their own biases (Participant 7, Personal Communication, February 2020).

I am blind, I've been blind my whole life, very low vision until age 14 and then totally blind since then. I believe it is the same dynamics for them as the people I used to work with cancer or multiple sclerosis or a major stroke or some other disability that came on them at a later stage of life and totally altered their life as does vision loss for most people. People think a blind person can't do this or they don't think they can learn for any number of reasons, of course then that's suggesting that most people come in as helpless, fear written people (Participant 12, Personal Communication, February 2020).

Additionally, participants who had personal experience with the identified population before entering the field of social work reported that individuals with impairments of vision or hearing needed accommodations, yet, they were fully capable of having autonomy and society required to adapt to said accommodations. Two participants reported:

It's important to learn to communicate, like sign language, maybe like how somebody grows up not knowing Spanish, but if they're put into a Spanish family or in a different country, automatically you're going to start to

become accustomed to what's going on around you. I had a friend when I was younger, and his nephew was deaf. I noticed the whole family knew sign language, so they had to adapt to that culture; it's just another culture (Participant 4, Personal Communication, February 2020).

I've learned about the blind, visually impaired population, or deaf population from a young age. Even though they may have these difficulties or these impairments, they always still have their rights of self-determination. Meeting them where they are at is always the avenue or approach to any type of patient regardless of their disability (Participant 14, Personal Communication, February 2020).

Whereas, social work practitioners who only had professional exposure to those with sensory impairments reported lack of exposure and the need for specialized services and accommodations, yet, they also reported the identified population lacked autonomy and professionals required assistance in terms of communication such as translators to engage with the identified population. One participant reported:

I don't have much experience in that population, just work, for about two years. They need specialized services; we don't have them. We have limited experience or zero knowledge of even signing basic things to understand or for us to communicate. Even those like that are blind, we

are not allowed to guide them anywhere, they're supposed to be able to move on their own. So, it'd be great to be able to give them social cues so we can communicate with them. Yet, I can't connect the same way in terms of communication, so we can't service them (Participant 9, Personal Communication, February 2020)

Awareness of Stereotypes

Participants in the study conveyed common misconceptions and expressed that visually impaired, blind, deaf, or hard of hearing individuals have a history of being misinterpreted in society. Due to misconceptions, people's views regarding the population may erroneously lead to stereotyping. Participants who self-reported visual impairments, blindness, and hearing impairments shared their awareness of stereotypes commonly shared regarding sensory impairments as well as their insight:

The most common stereotypes of blind people are they all see or don't see the same, that they need a dog, or the dog tells them when to cross the street. If someone has not been exposed to someone with a vision loss or they were exposed to someone who wasn't a good example, we often get to be the last blind person anyone ever met, because they think we're all going to be like that, this is true of social workers (Participant 12, Personal Communication, February 2020).

For people who are low vision, we don't have boundaries. For us, whatever's in hearing range is like for sighted people; whatever you see in your line of vision, that's what you communicate with or who you communicate with. We don't really understand non-verbal's because we can't see when people are rolling their eyes. We don't know that someone isn't necessarily wanting to include us in on a conversation just because we heard it. And so, we enter into the conversation, and that's being rude or nosy. At work, the staff have told some of the patients that I've worked with that their ear hustling (Participant 7, Personal Communication, February 2020).

That we talk loudly, can't do stuff. Then there's people talking loudly and slowly when you're talking to someone, and the weirdest thing is that once you put a hearing aid in, you can hear better than the people standing next to you. And people talking loudly can be quite painful (Participant 13, Personal Communication, February 2020).

Whereas participants who had solely professional experiences shared similar thoughts regarding stereotypes:

Maybe people think that people with those kinds of impairments aren't capable of making decisions for themselves, do they always have to have somebody there to be like the interpreter. So maybe the assumption is

that they don't have a lot of autonomy. Maybe that they would have to have someone there to be like sort of like a guardian, which isn't the case, and people can communicate effectively (Participant 5, Personal Communication, February 2020).

I have heard individuals who say they're really challenging, or they always will need a translator or they're always going to need extra assistance, it's even in the media, it's portrayed different than what they might be capable of doing. So, I think there's a lot of stereotypes out there for people with disabilities (Participant 11, Personal Communication, February 2020).

They can't do anything, and they're not independent. They can't do activities of daily living, which I feel is incorrect (Participant 2, Personal Communication, January 2020).

Common Challenges

Another major theme was the common challenges faced when servicing sensory impaired individuals. This theme has four sub-themes: lack of interest in the population, readiness concerns, communications concerns, and the effect on stigma on mental health and sensory impairments. Many participants expressed these common challenges through the detailed responses in the open-ended interview conducted.

Lack of Interest in the Population. A sub-theme that emerged from the data was that participants expressed that servicing individuals with sensory impairments required a specialization within social work practice. The obligation to meet the needs of the population was minimized as other populations were more commonly serviced. Participants shared their thoughts as follows:

My first thought is that they're (sensory impaired) not mainstream, like the homeless population, they do have a lot of services, and that's because there's so many of them and they're louder and then they interfere.

(Participant 1, Personal Communication, January 2020).

We have cultural competence, and it basically talks about gender identity, religion, cultural identity, but again, for people with disabilities, no matter what kind of disability, it is lacking (Participant 7, Personal Communication, February 2020).

We cannot accept blind or visually impaired, because we're not allowed to guide them anywhere. They need specialized services (Participant 9, Personal Communication, February 2020).

The impression I get is that it's not my responsibility because everything that we've learned thus far within social work, it's more tailored to different levels of case management. We don't see that there's a real need

because there are specialists for that, like behavioral specialists that are kind of more tailored to their needs (Participant 2, Personal Communication, January 2020).

Readiness Concerns. Another sub-theme was how social work participants expressed concerns over readiness concerns regarding resources and programs to meet the needs of the identified situation. Participants reported:

There's not a lot of resources for them, and I know they also suffer from mental illnesses as well. There's not a lot for services for that population (Participant 8, Personal Communication, February 2020).

Whereas, participants who have been in a supervisory role reported the importance of agency awareness and advocacy for the population:

A needs assessment needs to be done, I know we have transportation resources, but just further resources in the community to care for them, I don't know of too many that can assist them (Participant 14, Personal Communication, February 2020).

Communication Concerns. A sub-theme that emerged from the data when asked about the most effective strategies was communication concerns and needed to introduce a third-party service outside the scope of social work to engage with the client. Participants shared their most effective strategy below:

I would say talk to them because everybody is an individual; interestingly enough, though, I feel like there is still sort of this taboo about talking to disabled people about their disability (Participant 8, Personal Communication, February 2020).

I haven't had much exposure working with those populations in the schools; parents have been hearing impaired, used a translator (Participant 5, Personal Communication, February 2020)

Work in the hospital with different patients, incorporating translator services, having them do it (Participant 6, Personal Communication, February 2020).

Working with deaf/hard of hearing, I use interpreters to help with the interview assessment process. There's no connection between me and the resident (Participant 9, Personal Communication, February 2020).

Stigma. Another sub-theme was the intersection of mental health and sensory impairment and the role of the stigma that is associated with both, and the compounded stigma effect when individuals are faced with both diagnoses. Participants reported:

Our disability is noticeable enough and disturbing enough and, and I'm not suggesting that everyone is against us or giving us a hard time or stereotyping us. I don't look at the world as my enemy. And sometimes, people are amenable to education, and we all have things to learn, but it leads to barriers to services (Participant 12, Personal Communication, February 2020).

I think there's a barrier to mental health services in general. I think we still deal with a lot of stigmas. So, I think you're dealing with two issues that are both highly stigmatized, and people still have issues talking about, which is one mental health. It's still sorts of this weird like taboo topic where everybody's like, yeah, we need to talk about that. We need to come up with solutions. But no one's coming to the table to have that conversation unless something horrific happens. And then you're also dealing with people with disabilities, which no one wants to talk about either (Participant 8, Personal Communication, February 2020).

Social Workers Lack of Preparedness

All fourteen participants expressed there is a lack of preparedness and agreed that there are limited knowledge and training about the identified population. All participants reported that their MSW curriculum did not cover social work service delivery for individuals with sensory impairments.

Furthermore, all reported they did not receive specialized training in their respective internships or current place of employment. As a result, participants said they do not feel prepared to serve individuals with sensory impairments. Participants who are social work practitioners and have either their sensory impairment or personal experience with sensory impairments reported:

My comment is that as a social worker colleague, it's a very lonely place to be. People don't know how to treat colleagues with disabilities, and they really don't know how to treat people that they serve. Due to lack of education and training, they don't know to approach the populations, and they haven't dealt with their fears and biases. So those biases get placed on people with sensory deficits, whether they are coworkers or clients
(Participant 7, Personal Communication, February 2020)

We are sending people out in the field, ready to work with communities, but the communities are a wide range of individuals with all sorts of things going on. So, we need to be prepared for that. The only way to do that is to let people know and educate them and make them knowledgeable. If school did not offer that exposure, then maybe during our internships, or having something like training or someone come speak to have a broader range of knowledge (Participant 11, Personal Communication, February 2020)

Additionally, participants with narrow personal and professional experience reported:

Just addressing it at all. Like in my MSW program, that was never addressed at all. Because in my undergraduate and my graduate program, that was never even brought up at all. We had substance use, death and dying elective, child welfare, school social work, things like that. But never anything with people with those specific impairments. The vast majority of us aren't trained, there's no protocol, so there's nothing to follow. One of the biggest barriers is that, even if you go to trainings and stuff or how to do your job, those populations are rarely ever addressed. I would think it's like a trial and error kind of thing, which probably doesn't serve them very well (Participant 5, Personal Communication, February 2020).

Recommendations

Another major theme was the recommendations provided by participants. This theme has three sub-themes: training and consultation, utilizing the client-centered approach, and advocacy. Many participants expressed recommendations through the detailed responses in the open-ended interview conducted.

Training and Consultation. A sub-theme that emerged from the data was that existing MSW programs need a more comprehensive curriculum that

incorporates disabilities and impairments, as well as wanting the ability to consult knowledgeable sources to ensure ethical practice. Participants shared their thoughts as follows:

I think it would be beneficial to have an MSW program that was more comprehensive in terms of teaching about different populations, as this is like a completely unaddressed area of our education (Participant 5, Personal Communication, February 2020).

I'm sure they have different needs than someone who's not blind or deaf, or you know disabled in that way. So just like cultural sensitivity training, like we do for ethnicities or culture, that would be good to do (Participant 3, Personal Communication, February 2020).

Information, education, consultation, because I think there is sort of that taboo. Like don't talk about it, don't stare at it, but we're going to be working with these people in really vulnerable ways, and I think it would have been nice to know what the best approaches are. We cover best practices in so many other areas (Participant 8, Personal Communication, February 2020).

Client-Centered Approach. Another sub-theme that emerged was the concept of focusing on the client, not the impairment. It is the role of

professionals to work from a person-centered approach and focus on the individuals' needs and goals. Several participants reported that the client is the expert, and one must meet the client where they are. Participants expounded on this sub-theme as follows:

Clients were dealing with a lot of emotional things that needed my skills and my support. But to provide that, I had to understand their experience. I needed to understand medically what they had, what the treatment implications were, or lack thereof. So, because of that, I made it my business to learn the culture, the language, the dynamics, the psychosocial implications of having that particular type of illness. And it's the same, that is a parallel, to vision loss in that sense, even though everyone's an individual (Participant 12, Personal Communication, February 2020).

I think that I think that we're primed to work with them. We meet the patient where they're at, I think sets us up to be a great advocate for people with different disabilities. There's a lot of this world that is not designed to be conducive of their daily life. And I think we are in a better position to not just look at the individual and what's going on with them but look at the individual in their environment and what's going on there (Participant 8, Personal Communication, February 2020).

Advocacy. Another sub-theme that emerged was the need for advocacy as social work professionals. Participants who self-reported visual impairments and blindness shared the importance of advocacy and the barriers that are not being addressed for sensory impaired individuals:

We probably need to do a better job of education and insight; I don't expect a sighted person to get that, but it should be pointed out to them. Not all of us are perfect role models in the group, of the blind group. Not all of us have it all together. Not everyone gets it all together, like everyone else (Participant 12, Personal Communication, February 2020).

Where I work, first of all, there is no assessment being done. There is no data concerning the number of people with legal blindness or low vision and seeing all of the people that are, I read the hospital reports every day, and I see people going to ophthalmology and having cataract surgery and I know some of the patients that are legally blind or visually impaired. I'm not called on. I have approached units and said, here I am, how can I help, or may I please assess this patient so that I can help you figure out what is needed (Participant 7 Personal Communication, February 2020).

Summary

This chapter provides the demographics and significant theme findings that emerged concerning barriers to mental health service utilization among sensory impaired individuals, as well as the perceived preparedness of social

work professionals. The study utilized a qualitative approach using one on one and face-to-face semi-structured interviews, with the researcher utilizing open-ended questions to gain a better understanding of the participants' perceived preparedness. By applying thematic analysis and employing grounded theory, the researcher was able to identify the five themes that were discussed in this chapter.

CHAPTER FIVE

DISCUSSION

Introduction

The present study sought to examine the barriers of mental health service utilization among the blind, visually impaired, deaf, or hard of hearing individuals and sought to assess and further explore social workers' preparedness to service individuals with sensory disabilities. This study was of paramount importance, considering that the vast majority of people with sensory impairments reported difficulties accessing social services. Qualitative interviews gathered from 14 social work professionals who work directly with recipients of mental health services revealed five major themes: social construction of sensory impairments, awareness of stereotypes, common challenges, social workers' lack of preparedness, and recommendations.

Consistency with Prior Research

The findings in this study are consistent with other research conducted on people with disability (Aa et al., 2012; Cabral et al., 2012; Bean & Krcek, 2012; Daley, 2002; Iezzoni et al., 2004; McDonnall et al., 2017; Ravindran and Myers, 2011; SAMHSA, 2011; Steinberg et al., 2006). In fact, previous research revealed that there is a disparity in services regarding the sensory impaired population (Aa et al., 2012; Cabral et al., 2012). However, the findings in this study depart from previous work by focusing on the field of social work. In other

words, this study not only aligns with previous research in other professions—particularly occupational therapy, exceptional education, ophthalmology, and otolaryngology—but also represents a qualitative template within the field of social work. By assessing the preparedness and perceptions of social work professionals who have experience working directly with sensory impaired individuals, this research makes a significant contribution to the field.

Implications for Theory, Research, Practice, and Social Work Education

Implications for Theory

This study holds major implications for theory, especially for Horkheimer's Critical Disability Theory (1972). The literature asserts that impairments and disabilities are socially constructed (Rocco, 2005). The theory addresses the invisibility experienced by people with disabilities, stating that people with disabilities inhabit a system of inequality, leading to the marginalization of—and inadequacy of services for—the population (Brincat, 2016). The current study aligned with Critical Disability Theory, as one of the main themes that emerged within this research, was the social construction of sensory impairments. Participants offered differing perspectives concerning the capabilities and limitations of those living with sensory impairments. The multiple views differed based on the participant's self-reported experiences with the identified population, either personal, professional, or both.

Implications for Social Work Research

This study also holds implications for social work research. As previously mentioned, the results from this study mirror previous studies that showed a significant disparity in services for those living with sensory impairments due to a lack of knowledge and training, communication barriers, and an overall lack of preparedness. Yet, previous research on sensory impairments, specifically visual and hearing impairments, have been limited to the medical model. The existing literature reports barriers in communication within health care providers as the leading cause of disparity related mental health services, leading to disabled individuals living with undetected mental illnesses (Cabral et al., 2012).

Although the existing scholarship coincides with this study's findings, there is a lack of research in the field of social work. More specifically, there is a lack of research concerning the perceived preparedness of social workers in terms of servicing individuals with sensory impairments. The current study, therefore, makes a significant contribution to the literature by expanding the research of sensory impairments and applying the research directly to the field of social work.

Implication for Social Work Practice

The findings in this study hold major implications for micro social work practice. A major theme that emerged from the study within common challenges was the sub-theme of there being a lack of interest in the population. The participants in the study denoted a duty to help other marginalized groups, yet the identified population was seen to be more of a specialty group. For some

participants, the population was considered outside the scope of social work practice. The findings suggested that persons with sensory impairments were not a high-risk community in need of services. Yet, the literature states otherwise. In fact, one-third of visually impaired older adults experience clinically significant symptoms of anxiety and depression. This figure is twice as high compared to the prevalence in the older adult general population (Aa et al., 2015). Hence, social work practitioners can rely on this study to better serve the sensory impaired population on a micro level.

The National Association of Social Workers (NASW) established a Code of Ethics that serves as a guide for the professional conduct of social workers; the NASW promotes the ethical principles that help to address social problems and further build relationships (NASW, 2008). Furthermore, the NASW maintains its commitment to alleviate any existing barriers that exist within the field of social work for those who persons with disabilities (NASW, 2008). The current study suggests that social workers should provide culturally competent, comprehensive, and socially diverse services to all members of society per the guidelines set forth by the NASW.

The United States does not have a national framework or streamlined procedure to address the needs of those living with sensory impairments. The majority of participants from this study pointed to a lack of protocol and a deficiency in agency policies to meet the needs of the identified population, noting that the gap in services stems from a shortage in programs and

streamlined services. To illustrate this point, McDonnall et al. (2017) published a survey of state mental health agencies that revealed that a majority of state agencies do not have the proper policies and procedures in place to meet the demands of people with sensory impairments.

The NASW states that social workers must follow a set of values, principles, and standards, including the ethical principle, to challenge injustice and to engage in competent practice (NASW, 2008). The current study, along with existing literature suggests that social workers are breaking these ethical standards by not advocating for adequate policies and procedures to meet the needs of sensory impaired individuals.

Implications for Social Work Education

Finally, this study has implications in the field of social work education. All participants of this study reported there is a lack of knowledge and training provided in graduate social work programs. The Council on Social Work Education (CSWE) mandate social work programs to meet accreditation guidelines by offering a curriculum that meets core social work competencies. Two of those CSWE competencies being the ability to engage diversity and difference in practice as well as advance human rights and social, economic, and environmental justice (CSWE, 2020). Findings by Laws et al. (2010), found that only 37% of the 50 examined CSWE accredited social work programs provided at least one course tailored to the study of disability (Laws et al., 2020).

Those findings align with the present study, inferring that social work programs do not offer a curriculum that meets the core competencies aforementioned. Researchers, professors, and students have an ethical responsibility to their clients to engage in informed practice. Accredited social work programs can utilize the findings of this study to incorporate a curriculum that includes best practices and interventions that will prepare social work graduates to service clients with sensory impairments.

Limitations

As with any human work, the current research project was not exempt from shortcomings. The first limitation was that the design was qualitative. Qualitative designs have reduced generalizability compared to research studies that use quantitative designs. That is, although 14 participants seem to be an impressive number for the hard-to-reach population, such sample size, unfortunately, does not produce generalizable knowledge.

Furthermore, the sample lacked diversity, primarily pertaining to race and ethnicity. In fact, half the participants were White/Caucasian and key racial groups such as Asian/Pacific Islander, Middle Eastern, and Native American participants were not included in the study. Another limitation pertains to geographical location. Indeed, the study was conducted on participants who resided in Southern California. Hence, the findings in this research may not reflect the perceptions of all social workers across the State of California, let alone the United States and beyond.

Recommendations for Social Work

Future research can build on these findings to further explore the barriers to mental health service utilization for individuals with disabilities, specifically those with sensory impairments. Researchers who wish to replicate this study would be wise to increase the sample size of social work professionals. A larger sample could have added more weight to the findings. Furthermore, future research would benefit by performing a mixed-methods study where sensory impaired individuals who are recipients of mental health services be surveyed using a quantitative study design. Future research would also benefit from a more diverse group of social work practitioners with a broader range of specializations to further assess the preparedness of social work professionals concerning the service delivery of the identified population.

APPENDIX A
INSTITUTIONAL REVIEW BOARD APPROVAL LETTER



December 20, 2019

CSUSB INSTITUTIONAL REVIEW BOARD
Administrative/Exempt Review Determination
Status: Determined Exempt
IRB-FY2020-150

Kery Silva Rigaud Joseph
CSBS - Social Work
California State University, San Bernardino
5500 University Parkway
San Bernardino, California 92407

Dear Kery Silva Rigaud Joseph

Your application to use human subjects, titled "Overcoming Barriers To Mental Health Service Utilization Among Sensory Disabled Individuals" has been reviewed and approved by the Chair of the Institutional Review Board (IRB) of California State University, San Bernardino. The IRB has determined that your application meets the requirements for exemption from IRB review. Federal requirements under 45 CFR 46. As the researcher under the exempt category you do not have to follow the requirements under 45 CFR 46 which require annual renewal and documentation of written informed consent which are not required for the exempt category. However, exempt status still requires you to attain consent from participants before conducting your research as needed. Please ensure your CITI Human Subjects Training is kept up-to-date and current throughout the study.

The CSUSB IRB has not evaluated your proposal for scientific merit, except to weigh the risk to the human participants and the aspects of the proposal related to potential risk and benefit. This approval notice does not replace any departmental or additional approvals which may be required.

Your responsibilities as the researcher/investigator reporting to the IRB Committee the following three requirements highlighted below. Please note failure of the investigator to notify the IRB of the below requirements may result in disciplinary action.

- Submit a protocol modification (change) form if any changes (no matter how minor) are proposed in your study for review and approval by the IRB before implemented in your study to ensure the risk level to participants has not increased,
- If any unanticipated/adverse events are experienced by subjects during your research, and
- Submit a study closure through the Cayuse IRB submission system when your study has ended.

The protocol modification, adverse/unanticipated event, and closure forms are located in the Cayuse IRB System. If you have any questions regarding the IRB decision, please contact Michael Gillespie, the Research Compliance Officer. Mr. Michael Gillespie can be reached by phone at (909) 537-7588, by fax at (909) 537-7028, or by email at mgillesp@csusb.edu. Please include your application approval identification number (listed at the top) in all correspondence.

If you have any questions regarding the IRB decision, please contact Michael Gillespie, the Research Compliance Officer. Mr. Michael Gillespie can be reached by phone at (909) 537-7588, by fax at (909) 537-7028, or by email at mgillesp@csusb.edu. Please include your application approval identification number (listed at the top) in all correspondence.

Best of luck with your research.

Sincerely,

Donna Garcia

Donna Garcia, Ph.D., IRB Chair
CSUSB Institutional Review Board
DG/MG

APPENDIX B
INFORMED CONSENT

INFORMED CONSENT

The study in which you are asked to participate is designed to assess social workers perceived preparedness in servicing the mental health needs of individuals who are blind/visually impaired and/or deaf/hard of hearing and to further assess the barriers to services within social work practice. The study is being conducted by Kery Silva, a graduate student, under the supervision of Dr. Rigaud Joseph, Assistant Professor in the School of Social Work at California State University, San Bernardino (CSUSB). The study has been approved by the Institutional Review Board at CSUSB.

PURPOSE: The purpose of the study is to examine advance year Master of Social Work candidates and graduated social workers perceived preparedness to serve individuals with sensory disabilities, specifically individuals who are blind/visually impaired and/or deaf/hard of hearing.

DESCRIPTION: Participants will be asked questions regarding their preparedness, competency, and willingness toward serving individuals with sensory disabilities, and some demographic information will also be collected.

PARTICIPATION: Your participation in the study is completely voluntary. You can refuse to participate in the study or withdraw your participation at any time without having to give any reason.

CONFIDENTIALITY: Your confidentiality is ensured with all data collected within this research project. No personal information will be disclosed to individuals outside of the project's research team. Your information will only be published in pseudonyms form, that is, all personal information will be removed so that you and others cannot be identified.

DURATION: It will take up to 1 hour to complete the face-to-face interview.

RISKS: There is no foreseeable risks to participants.

BENEFITS: There will not be any direct benefits to the participants, but your participation is likely to help researchers find out more about how to understand the perceived preparedness of social workers to serve individuals who are blind/visually impaired and/or deaf/hard of hearing.

CONTACT: If you have any questions about this study, please feel free to contact Dr. Joseph at (909) 537-3501.

RESULTS: Results of the study can be obtained from the Pfau Library ScholarWorks database (<http://scholarworks.lib.csusb.edu/>) at California State University, San Bernardino after July 2020.

I agree to have this interview be audio recorded: _____ YES _____ NO

I understand that I must be 18 years of age or older to participate in your study, have read and understand the consent document and agree to participate in your study.

Place an X mark here

Date

APPENDIX C
DEMOGRAPHICS

DEMOGRAPHICS

1. Gender

Male Female Other

2. Age

20-26 27-32 33-39
 40-46 47-53 54 and above

3. Ethnicity

African American Native American
 Hispanic/Latino White/Caucasian
 Asian/Pacific Islander Middle Eastern
 Other _____

4. Field Experience _____ years.

5. Licensure Status

Not Licensed Pre-License Licensed

6. Do you have prior experience working with individuals who are:

Blind Visually Impaired Deaf Hard of Hearing Both

7. What is your social work specialization?

Child Welfare Mental Health
 School based Social Work Substance Use
 Medical Social Work Macro Social Work/Advocacy
 Forensic Social Work Public Administration
 Other _____

Developed by Kery Silva

APPENDIX D
INTERVIEW GUIDE

Interview Guide

Opening Statement before starting the interview: “Thank you for participating in this study. This study seeks to identify and describe the barriers to mental health service utilization among sensory disabled individuals, specifically blind/visually impaired and/or deaf/hard of hearing. The following questions are aimed to identify the barriers of the identified population by measuring the perceived preparedness of social workers.

1. Can you explain what you know about either the blind/visually impaired or deaf/hard of hearing population? Or Both? And where did you learn about the identified population?
2. Do you have any personal or professional experience with the identified population?
3. Do you have any initial thoughts or insight regarding the identified population?
4. Can you explain what you know about the identified population?
5. Can you talk about your personal experience with the identified population before entering the field of social work?
6. Can you talk about your professional experience with the identified population within your scope of practice?
7. Can you share your thoughts about the social work profession regarding serving individuals within the identified population?
8. Can you share your thoughts about why there is an existing barrier of services for the identified population?
9. Can you share your thoughts on stereotypes regarding the identified population?
10. Have you received training within your organization/agency to increase your preparedness to meet the needs of the identified population?
11. If any, can you share your thoughts on training you would like to have received regarding the identified population to bridge services?
12. In your opinion, what do you believe are the most effective strategies when serving the identified population?
13. What kind of training would you have found beneficial when completing your MSW program to improve your service delivery concerning the identified population?
14. What do you feel you lack in terms of service delivery for the identified population?
15. Any final thoughts, comments, and/or questions?

The researcher plans to ask probing questions as needed.

Developed by: Kery Silva, Advanced Year MSW Candidate

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