Culturally Affirmative & Mobile Psychological Assessment Program for Children with Hearing Loss or Combined Hearing and Vision Loss in Rural Areas

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The problems of misdiagnosis and mislabeling of children with hearing loss have been well-documented in general literature since the 1970s (e.g., Glickman, 2003; Paul & Jackson, 1993; Orr, DeMatteo, Heller, Lee, & Nguyen, 1987; Schlesinger & Meadow, 1972; Vernon & Andrews, 1990). Even with a correct diagnosis, recommendations provided in psychological assessment reports may not adequately address the specific needs of children with hearing loss. The purpose of a psychological assessment is to obtain crucial information such as intelligence, language aptitude, behavioral functioning, emotional functioning, and personality. Parents and professionals often rely on this information to make significant decisions such as educational placement, place of residence, and the child/family’s primary language. All of these decisions impact the child’s developmental progress, future opportunities, and emotional well-being. Due to the potential impact of the results of a psychological assessment, it is vital that the assessment be culturally affirmative.

The main focus of this article is to discuss a culturally affirmative program model of assessing children with hearing loss in rural areas. More specifically, sections of this article will cover the following:

1. The description of a particular state-funded mobile psychological assessment program in Minnesota and its model, including its programmatic approaches to conducting psychological assessments of children with hearing loss,

2. The advantages of the program as well as its common issues faced, challenges, and special considerations,

3. The program’s clinical outcomes, and

4. Discussion of best practices and recommendations for similar program(s) for other states to adopt.

**What is Culturally Affirmative Mental Health Care?**

Glickman (2003; 2009; 2013) has described a model of culturally affirmative mental health care for individuals who are deaf. Culturally affirmative means that consumers who are deaf obtain services from clinicians who are fluent in American Sign Language (ASL), are trained to work with this client base, know how to tailor services to their consumers’ particular strengths. Clinicians also adapt their communication with auxiliary aids, such as gestures, props, drawings and role playing, and enhance communication when needed. In expanding this definition, a culturally affirmative psychological assessment of children with hearing loss can be described as being administered by a qualified psychologist who is culturally and linguistically effective in

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1 The term “hearing loss” includes children who are deaf, hard of hearing, deaf-blind, hearing aid users and cochlear implant users.

2 It is beyond the scope of this article to critically review the theories and methods related to psychological assessments for children with hearing loss. In addition, this article does not attempt to provide a comprehensive listing of reviews of tests used with this unique population. Finally, this article does not cover characteristics of tests relative to norm and criterion reference, validity, and reliability, as well as reviewing appropriate procedures of administering, scoring, and interpreting the results of children with hearing loss.
working with this group through an array of assessment tools, both standard and non-standard, to measure their cognitive functioning and other abilities as accurately as possible.

Clark (2003) elaborated further that a culturally affirmative psychologist has a greater understanding of the implications of hearing loss upon child development and discerns the unique factors in the child’s history, communication skills and aptitude that may influence the child’s development. Clark (2003) also stressed that the culturally affirmative psychologist who embraces important considerations and perspectives in assessing a child with hearing loss is much more likely to advocate for the child and the family, gently challenge preconceived ideas or philosophies that the interdisciplinary team may have for the child, and offer valuable input or options for consideration that reflect important linguistic and cultural affiliations among children with hearing loss.

Unfortunately, many existing batteries are not carefully reviewed to ensure adequate reliability and validity as assessment measures for children with hearing loss (Marschark, 1997; Orr et al., 1987; Paul & Jackson, 1993). A culturally affirmative psychologist must make an informed selection from available evaluation tools and exercise careful clinical judgment during the evaluation and interpretation process when working with children with hearing loss. Clark (2003) warned that even if the psychologist can sign fluently, the child may not understand the task directions sufficiently to ensure the accuracy of the test results. A culturally affirmative psychologist has a keen understanding of the translation of the test instructions from spoken English to ASL and is aware this can produce a different test result, and act accordingly by modifying the test instructions and interpreting the test data. Brauer, Braden, Pollard and Hardy-Braz (1998) wrote, “As is the case for all culturally diverse groups, the interpretation of test scores is the most important consideration in the testing of the deaf population. Interpretation is the process of assigning meaning to the assessment results.” (p. 310).

**WHAT DOES A CULTURALLY AFFIRMATIVE PSYCHOLOGICAL ASSESSMENT PROGRAM LOOK LIKE?**

In short, a culturally affirmative psychological assessment program employs trained and experienced psychologists who are qualified to conduct evaluations for children with hearing loss and strives to perform psychological assessments within the child’s educational environment due to the enormous impact of educational factors on the development of a child with hearing loss. This program carefully selects psychologists who are well-versed in child development, child psychology and Deaf culture, as well as in various communication methods, including ASL. When assessments are conducted, they are not limited to theory, and also keep best practices in mind. Pollard (1996) emphasized that culturally affirmative psychologists hold in-depth knowledge of audiological, developmental, educational, vocational, legal, social, and cultural implications that may affect children with hearing loss. Another vital component of a culturally affirmative program is selecting psychologists who use a wide range of psychological test batteries, taking linguistics and culture into consideration.

With this breadth of experience and training, these psychologists can bring valuable skills to a program that aims to be culturally affirmative. By doing this, these psychologists strive to meet each child’s communicative needs and preferred mode(s) of communication in a flexible manner.
More specifically, psychologists adapt their communication style(s) when interacting with a child in a testing situation. There are wide ranges of communication modes used by children with hearing loss including ASL, Signing Exact English, Simultaneous Communication, Sign Supported Speech, Cued Speech, Simultaneous Communication, and a wide variety of spoken languages. Some children use a combination of communication modes while others use rich visual descriptions through pantomime or gestures interlaced with ASL. Many children with hearing loss use one communication mode when interacting with hearing people and “switch” to another mode when talking with others who are deaf. In addition, many children with hearing loss do not master any one language. The psychologists from a culturally affirmative program working with this truly heterogeneous population must be respectful and competent in working through all these communication modalities.

A culturally affirmative program hires a psychologist to communicate with the child with hearing loss without bringing in an interpreter. It has been documented that the introduction of an interpreter into the testing situation or into any mental health setting has significant impact to the results in many ways (DeMatteo, Veltri, & Lee, 1985; Glickman & Crump, 2013; Gold-Brunson, & Lawrence, 2002; Harvey, 1982; Marschark, 1997; Orr et al., 1987; Straub, 1976; Stansfield, 1981;). Working with an interpreter does not solve the communication barriers in a testing situation, nor does it guarantee that interpretations from the test scores or data will be accurate. If a culturally affirmative psychological assessment program hires an interpreter, the psychologist is mindful of how the interpreter is used in certain testing situations.

Finally, a culturally affirmative program utilizes psychologists who strive to empower as well as advocate for children with hearing loss and their families to make informed decisions about their future opportunities and to tap into existing resources on local, state, and national levels to maximize the children’s potential.

**WHY A GRANT FOR CHILDREN IN RURAL AREAS?**

The state of Minnesota spans over 86,000 square miles. According to the Minnesota Department of Education’s July 2014 report to the state legislature, Minnesota has 2,464 children with hearing loss receiving special education services in the state. More specifically, there are 1,072 children with hearing loss living in rural or “Greater Minnesota,” the portion of the state outside the seven-county metropolitan area surrounding Minneapolis/St. Paul (Twin Cities). Within the Twin Cities area, children with hearing loss have access to schools and clinical psychologists who are fluent in ASL and have training/experience working with them. Even within the Twin Cities, access to culturally affirmative psychologists is generally available, but limited. There are four to five specialized psychologists serving over 1,350 children within the metropolitan area. Given these numbers, these psychologists are in high demand trying to meet the needs of the children living in the Twin Cities, leaving neither time nor resources to serve children living in rural Minnesota; thus this state grant through Minnesota Department of Human Services, Deaf and Hard of Hearing Services Division (DHHSD) was created to meet this unique demand.

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3 For further description of various communication modes, please see [http://www.gallaudet.edu/clerc_center/information_and_resources/info_to_go/educate_children_(3_to_21)/resources_for_mainstream_programs/language_and_communication.html](http://www.gallaudet.edu/clerc_center/information_and_resources/info_to_go/educate_children_(3_to_21)/resources_for_mainstream_programs/language_and_communication.html)
**HISTORY OF PREVIOUS MODELS**

The first Psychological Assessment Services Program was officially established in 1997 by Regions Hospital in St. Paul, Minnesota. Its deaf and hard of hearing mental health clinic responded to a request for proposals issued by DHHSD. At that time, the grant award was for $150,000 each fiscal year. Regions Hospital was the sole provider of this program from 1998 through 1999. From 2000 to 2002, Regions Hospital partnered with Alliant University to run the program. In 2003, Regions Hospital was again the sole provider before Lifetrack Resources, Inc. took over from 2004 to 2010. Lifetrack Resources renamed the program to Greater Minnesota Assessment Services (GMAS), and the state grant amount increased to $152,250 in 2009 and 2010 due to a cost of living adjustment.

The GMAS program model (2004-2010) included a program coordinator handling all referrals and assigning a psychologist to the cases identified as the best match for each child with hearing loss. This position did not require the staff person be a trained mental health professional or a licensed psychologist; rather, the staff person coordinated between the referral parties and the contracted psychologists. GMAS had the main responsibility of providing psychological, psychoeducational, neurological, diagnostic and any other kind of specialized, psychological evaluation, depending on the referral question. Most assessments were provided directly by contracted licensed psychologists using ASL (the population of children with hearing loss has changed greatly due to the increase in non-ASL children receiving cochlear implants, discussed later in this article). All children with hearing loss living outside the Twin Cities metro area were eligible to receive services through the grant. Children who were deafblind living within the metro area were also allowed to receive services through the grant due to the severe shortage of psychologists qualified to work with this population. The GMAS coordinator hired ASL-fluent psychologists from other states on a part-time basis and handled all of their travel arrangements. The psychologists flew to Minnesota and drove to the remote areas for psychological assessments. In the late 1990s and early 2000s, Minnesota did not have enough local ASL-fluent psychologists specializing in working with children with hearing loss. When the budget permitted, the out-of-state psychologist was also paid to give a presentation or training to teachers of the deaf and hard of hearing children as well as to community members in the area on topics such as hearing loss, psychiatric diagnoses, raising a child with special needs, attachment, and coping skills. The psychologists also provided follow-up services when needed after an assessment was conducted, including checking in with the child’s progress, regularly communicating with the referral party and the child’s parents, and providing resources.

The GMAS agreement expired in mid-2010 due to statewide financial constraints influenced by the national recession. The State of Minnesota and the DHHS budget was hit particularly hard during 2008 to 2011. The state discontinued this grant funding and Lifetrack Resources was unable to maintain this program. Furthermore, GMAS did not bill health insurance companies for assessment services rendered, and was fully reliant on this state grant. With this program closed, Minnesota did not have a stand-alone assessment program for two years, until 2012. As the state’s economy improved and no further budget cuts were made, DHHS decided to re-purpose grant dollars from another other grants not mental health-related to meet the high demand for the revival of this program. DHHS provided $105,000 each fiscal year, much lower than previous years. Re-designing this program model was absolutely essential to ensure its survival and to maintain this unique service in the most cost-effective way.
THE CURRENT PROGRAM MODEL

Psychological Advantages, LLC’s GM-Launch PAD\(^4\) program located in Minnesota was founded by Dr. Nanette McDevitt (first author) in responding specifically to a request for proposals during Fiscal Year 2012, as issued by Dr. John Gournaris (second author) through DHHSD. This company is solely owned by Dr. McDevitt, a Minnesota-licensed clinical psychologist who is also a licensed teacher of the Deaf and Hard of Hearing and a child of a deaf adult (CODA). Like the previous grant providers in Regions Hospital, Alliant University and Lifetrack Resources, GM-Launch PAD is dedicated to working with children ages 0 to 21 who are identified with hearing loss and living in Greater Minnesota outside of the seven-county area of the Twin Cities, and who receive services from a school funded by the Minnesota Department of Education. This program is also staffed by contracted part-time deaf and hearing psychologists who have both specific training and clinical experience in working directly with children with hearing loss and their families. Referrals to this program primarily come from mental health professionals, school administrators and teachers, social service agencies, and parents. More often, referrals to GM-Launch PAD are made to obtain one or more of the following:

- Mental health diagnosis based on the Diagnostic and Statistical Manual of Mental Health Disorders, Fifth Edition (DSM-IV)
- Routine triennial assessment in compliance with federal and state guidelines for special education services
- The child’s level of intellectual functioning
- Documentation of current functioning in reference to educational aptitudes and interests,
- Documentation of behavioral and social-emotional functioning of the child
- Recommendations for effective and evidence based psychological and educational interventions

The formulation and recommendations developed by psychologists at GM-Launch PAD are then shared with the referral party, as well as the child’s parents during a meeting immediately following the evaluation (same day). The results and recommendations are also documented in a comprehensive written report.

The program model of GM-Launch PAD was redesigned from a previous model in a more cost-effective way by requiring the program coordinator to be also a licensed psychologist, in order to eliminate the middle person. It is expected that Dr. McDevitt both coordinate the program and conduct the majority of psychological assessments. Hiring an in-state or an out-of-state psychologist is allowed but only on a limited basis. Workshops for teachers of deaf and hard of hearing children were eliminated due to financial constraints and the availability of workshops through other programs. The grant dollars of $105,000 is allocated exclusively for the programming operations at GM-Launch PAD and to pay for psychological assessments. In

\(^4\) Greater Minnesota Launch Psychological Assessments for Deaf, Hard of Hearing, and DeafBlind Students (GM-Launch PAD): Launching Deaf, Hard of Hearing, and DeafBlind children and adolescents to success by uncovering their unique talents and supporting families and schools in using those unique skills to their full advantage.
addition, to bring in additional income for the program, Dr. McDevitt is also required to bill health insurance companies for assessment services rendered whenever possible.

The current program is considered “mobile” as opposed to the traditional model of service by requiring a child to come to the psychologist’s office for a psychological assessment. To ensure that a child with hearing loss receives the most culturally affirmative psychological assessment possible, GM-Launch PAD sends a psychologist directly to the child in Greater Minnesota. The GM-Launch PAD program is also required to evaluate its programmatic outcomes, unlike its predecessors, to evaluate its clinical effectiveness and its program success. Figure A illustrates the steps of the referral and evaluation process utilized by GM-Launch PAD.

### Figure A

<table>
<thead>
<tr>
<th>Steps</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. REFFERIAL</strong></td>
<td>Parent, teacher, therapist, or social worker contacts GM-Launch PAD to refer a child for an evaluation.</td>
</tr>
<tr>
<td><strong>2. DETERMINE ELIGIBILITY</strong></td>
<td>The program coordinator determines if the child needs a psychological evaluation and meets the program criteria.</td>
</tr>
<tr>
<td><strong>3. COMPLETE APPLICATION</strong></td>
<td>The child’s family and/or the referral person completes an application packet and gives permission for testing.</td>
</tr>
<tr>
<td><strong>4. DETERMINE EVALUATOR</strong></td>
<td>The coordinator identifies a psychologist matching the child’s communication and clinical needs (such as medical and/or mental health diagnoses and referral questions).</td>
</tr>
<tr>
<td><strong>5. SCHEDULE EVALUATION</strong></td>
<td>Evaluations are scheduled 6 to 18 in advance, due to a waiting list for services.</td>
</tr>
<tr>
<td><strong>6. EVALUATION DAY</strong></td>
<td>The psychologist completes the evaluation at the child’s school, and interviews family, staff, and the student. Observation also takes place.</td>
</tr>
<tr>
<td></td>
<td>At the end of the day, preliminary results and recommendations are shared with the team.</td>
</tr>
<tr>
<td><strong>7. REPORT</strong></td>
<td>The psychologist sends a written report to the parents and other agencies per the parents’ request.</td>
</tr>
<tr>
<td><strong>8. BILLING</strong></td>
<td>The health insurance company is billed, from claim submittal to answering the insurer’s questions.</td>
</tr>
<tr>
<td><strong>9. FOLLOW-UP CARE</strong></td>
<td>The psychologist participates, via phone or videoconference, in up to three one-hour meetings with the referral team and parents to answer questions.</td>
</tr>
<tr>
<td></td>
<td>If follow-up services or programs were recommended in the report, the program coordinator helps connect the family to resources.</td>
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<tr>
<td></td>
<td>The psychologist, if needed, consults with the child’s therapist, educational staff, and/or physician.</td>
</tr>
</tbody>
</table>
DATA COLLECTION

Since the program began in 2012 and approximately 21,000 miles later, 100 children have been served with the support of this grant. A large amount of data has been collected regarding the students’ degree of hearing loss, educational placement, communication methods, additional medical challenges, and additional mental health challenges. Table 1 provides a summary of the demographic data of children served from 2012 to 2015.

Table 1. Demographic Characteristics of the Children Served by GM-Launch PAD (FY 2012-2015, n=100)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Degree of Hearing Loss (HL):</td>
<td></td>
</tr>
<tr>
<td>- Severe to Profound</td>
<td>76</td>
</tr>
<tr>
<td>- Moderate</td>
<td>21</td>
</tr>
<tr>
<td>- Mild</td>
<td>3</td>
</tr>
<tr>
<td>Communication Method:</td>
<td></td>
</tr>
<tr>
<td>- Primary Speech</td>
<td>45</td>
</tr>
<tr>
<td>- Speech/ASL</td>
<td>31</td>
</tr>
<tr>
<td>- Primary ASL</td>
<td>24</td>
</tr>
<tr>
<td>Amplification Use:</td>
<td></td>
</tr>
<tr>
<td>- Hearing Aids</td>
<td>55</td>
</tr>
<tr>
<td>- Cochlear Implants</td>
<td>28</td>
</tr>
<tr>
<td>- None</td>
<td>17</td>
</tr>
<tr>
<td>Communication Method &amp; Degree of HL:</td>
<td></td>
</tr>
<tr>
<td>- Severe to Profound/Speech</td>
<td>32</td>
</tr>
<tr>
<td>- Severe to Profound/ASL</td>
<td>23</td>
</tr>
<tr>
<td>- Severe to Profound/ASL and Speech</td>
<td>21</td>
</tr>
<tr>
<td>- Moderate/Speech</td>
<td>12</td>
</tr>
<tr>
<td>- Moderate/ASL and Speech</td>
<td>8</td>
</tr>
<tr>
<td>- Moderate/ASL</td>
<td>1</td>
</tr>
<tr>
<td>- Mild/ASL and Speech</td>
<td>2</td>
</tr>
<tr>
<td>- Mild/Speech</td>
<td>1</td>
</tr>
<tr>
<td>Educational Placement:</td>
<td></td>
</tr>
<tr>
<td>- Special Education and Mainstream</td>
<td>43</td>
</tr>
<tr>
<td>- Special Education Classroom</td>
<td>31</td>
</tr>
<tr>
<td>- Deaf School</td>
<td>19</td>
</tr>
<tr>
<td>- Mainstream</td>
<td>7</td>
</tr>
<tr>
<td>Other Medical/Mental Health Diagnosis</td>
<td></td>
</tr>
<tr>
<td>- Developmental Delay</td>
<td>25</td>
</tr>
<tr>
<td>- Behavior Disorder</td>
<td>17</td>
</tr>
<tr>
<td>- DeafBlind</td>
<td>17</td>
</tr>
<tr>
<td>- ADHD</td>
<td>16</td>
</tr>
<tr>
<td>- Mood Disorder</td>
<td>16</td>
</tr>
<tr>
<td>- Autism</td>
<td>12</td>
</tr>
</tbody>
</table>
Programmatic Challenges

The greatest challenge lies in billing medical insurance. Due to the wide range of locations covered by the program, including mostly remote and rural towns, there have been more than 20 medical insurance companies involved in the process. For each insurance company, there are lengthy credentialing applications and billing processes. There are also many barriers to billing including out-of-network challenges, high deductibles and a lack of culturally affirmative mental health coverage. In addition, GM-Launch PAD psychologists provide assessments within a child’s school or at a public location within the child’s hometown. This practice is unorthodox to many health insurance companies, since psychological evaluations are typically conducted in a clinic setting. The practice of providing these assessments within schools often leads to difficulties with the health insurance claims process. In addition, the unique billing challenges faced by a program that serves children over such a large area has put a significant strain on the program budget. The hope is that the program can develop long-term contracts with health insurance companies that meet the unique needs of the program, but this remains challenging due to the high number of insurance companies covering the children served.

The next greatest programmatic challenge is providing adequate follow-up care. At times, the providing psychologist recommends a medication evaluation by a psychiatrist or to obtain therapy. Families struggle significantly to find psychiatrists and therapists in their area who have training and experience working with children with hearing loss. The DHHS-funded grantees funded are working diligently to provide mental health services in rural areas, but many areas remain underserved due to limited funding, staffing and resources.

Psychologists at GM-Launch PAD have also observed several challenges related to a lack of information, inadequate resources, low incidence rates and breakdowns in communication channels between various professionals and agencies. Some major challenges observed to date are:

- Late identification of hearing loss still occurs. When a hearing loss is not identified, children are often misdiagnosed with autism or language disorders.
- Many families, educational, medical and social services professionals are unaware of vital services available to children with hearing loss such as the Deaf Mentor Family Program, Minnesota State Academy for the Deaf and Metro Deaf School.
- Children with combined hearing loss and developmental delays are not always provided with an ASL interpreter based on the incorrect assumption that they would not benefit from one due to cognitive delays. Some children were actually misidentified with cognitive delays when in reality they were language deprived after having no exposure to language during their formative years.
- Children with hearing loss living in rural areas are often isolated from their peers with hearing loss. Many children have never met another person with hearing loss or another person who uses a similar mode of communication. Due to low incidence rates, children with hearing loss are often placed with children in other special education categories (i.e. developmental cognitive delay or autism spectrum disorders). In some cases, the lack of interaction with appropriate peers appears to contribute to significant academic and emotional challenges as well as severe social deprivation.
Over 80% of children seen by GM-Launch PAD psychologists have other mental health or medical diagnoses, which requires specialized training and knowledge on the psychologist’s part. This has contributed to significant difficulties establishing appropriate follow-up care over time.

Thirty-two percent of the children served by GM-Launch PAD were diagnosed with a severe to profound hearing loss, yet did not have access to a visual language (such as ASL) at home or school. All of those children demonstrated significant language delays in the spoken language used with them at home and school (according to formal language testing), yet a visual language was not added to their program, typically due to the misconception that adding a visual language would cause the child to rely on the visual language and subsequently lose auditory/speech skills.

**Programmatic Outcomes**

The Minnesota Department of Human Services adopted the Results-Based Accountability model in 2008 to measure program outcomes (whether run by the state or by the grantees). Results-based accountability is defined as a management tool that is clearly articulated, and that data is regularly collected and reported to address questions of whether or not results have been achieved (Friedman, 2005; Schilder, 1997;).

There are several outcome data that could be measured or evaluated through this model. GM-Launch PAD staff collected the following data: 1) parent and teacher satisfaction survey results, 2) children’s progress towards goals developed based on evaluation recommendations, 3) number and type of additional medical/mental health diagnoses, 4) type and degree of hearing loss, 5) amplification use, and 6) educational placements.

For this article, outcomes will be reported on the children’s progress on recommendation goals (based on evaluation recommendations) after three months, six months, nine months and twelve months during FY 2012-2014. The authors believe that this particular measure is the most important programmatic outcome, as it is an indicator of the impact of the evaluations provided by the program. The data for FY 2015 was not complete at the time of this article.

The GM-Launch PAD’s Results-Based Accountability project for FY 2012 indicated that 96% of the 149 individualized recommendation goals had either been achieved or were in good progress by children with hearing loss who were assessed in this fiscal year. In addition, 95% of the 22 children either had completed or were making good progress with their individualized recommendation goals at a minimum of three months. As indicated earlier, goals are measured every three months.

For FY 2013, 91% of the 56 individualized recommendation goals had either been achieved or were in good progress and 96% of the 28 children either had completed or were making good progress with their individualized recommendation goals at a minimum of three months.

For FY 2014, 97% of the 60 individualized recommendation goals had either been achieved or were in good progress and 96% of the 30 children either had either completed or were making good progress with their individualized recommendation goals at a minimum of three months.
Lastly, the GM-Launch PAD sent out 110 consumer satisfaction surveys in FY 2012 through 2015 and 88 surveys were returned for an approximate 80% response rate. The survey consisted of six questions asking consumers to rate the psychological assessment services that they had received. The program received an overall score of 4.63 (out of 5). These scores indicate that consumers in Minnesota who have received services from GM-Launch PAD are highly satisfied. In addition, numerous professionals and families have shared stories regarding the impact of the evaluation and associated follow up care. The following is a small sampling of those stories:

- The educational staff and parents of a kindergarten student who was profoundly deaf thought they were providing language to the student in ASL. They were in actuality signing key words in ASL while speaking. The child was not able to hear enough of the spoken language to fully comprehend the language in her environment. Since the team was signing only key words, the child was not able to access ASL as a comprehensive language. As a result, she was language deprived and socially isolated; she also demonstrated social withdrawal, did not participate in class and demonstrated aggressive behaviors. As a result of the psychologist’s recommendation, the entire team began using comprehensive ASL on a consistent basis. Within one year the child’s language skills improved from significantly below average to the average range. In addition, her aggressive behaviors decreased significantly and her social interactions with peers increased.

- A preschool student with combined hearing and vision loss was placed in a developmental cognitive delay classroom based on intellectual testing completed by a professional who was not fluent in ASL, nor had training working with children who were DeafBlind. A GM-Launch PAD psychologist completed intellectual testing and made sure her signing and the testing materials were positioned within the child’s very limited field of vision. Test results indicated the child’s intelligence fell within the average range. The child was placed in a mainstream classroom with an ASL interpreter. Within one year, the child achieved academic skills nearing the average range and her previous disruptive behaviors ceased.

- A profoundly deaf high school student who recently moved from Africa needed cognitive testing to determine post-secondary placement. The student communicated using a combination of gestures, spoken Swahili, and a rare tribal language. A GM-Launch PAD psychologist worked with a Swahili interpreter and the student’s sister to help with spoken communication. The psychologist also used her training, knowledge and experience of gestures commonly used by individuals with hearing loss, as well as a pictures and objects to bridge the spoken language gaps. A picture-based cognitive test indicated the student had above-average visual-motor skills. As a result, the student was placed in a training program for assembling very complex tools, considered a high-level technical position. The student reportedly loved the visual-motor challenge and succeeded in the training program. The student is currently working to increase his language skills so that he can add to his post-secondary training experiences.
Recommendations

For those considering a similar program to provide culturally affirmative psychological assessments, the following strategies are recommended:

1. Actively seek funding and other financial alternatives, including grants through the state, counties, school districts, and private foundations.

2. Attempt to utilize medical insurance reimbursement when appropriate, but do not plan to rely solely on this as a primary source of income. Unfortunately, obtaining health insurance reimbursement is complex and difficult due to unorthodox practices such as traveling to students, evaluating students within schools/social services offices, and serving a wide geographical area, which will likely lead to challenges in successfully obtaining reimbursement. If your claim is denied, educating the insurance companies about the uniqueness of your program during the appeal process is of paramount importance. Even so, this does not always resolve billing problems. Educating insurance companies is a complex and ongoing process.

3. Identify a medical billing specialist/program who specializes in billing for unique programs and attempt to establish a contract for services that is financially feasible.

4. Combine the role of program manager and primary providing psychologist to maximize financial resources and to allow for an effective screening process for referrals. This helps ensure children served are in need of a psychological evaluation before investing in the high cost of sending a psychologist to a rural area, and to increase continuity of services from referral to pre-evaluation interviews to the evaluation day to follow-up services.

5. Utilize a psychologist or mental health program that has an established relationship with educational programs for children with hearing loss. Parents and educational staff are, understandably, reluctant to trust unfamiliar professionals with such an important assessment, especially since these assessments typically occur only once every two to three years. If an unfamiliar psychologist/program is utilized, it will likely require significant time to establish a consistent referral system.

6. Establish and maintain an effective working relationship with a qualified network of professionals within the state who work with children with hearing loss. This includes teachers of the deaf and hard of hearing children, special education directors, county social service directors, and many others.

7. Respect the beliefs and goals of children, families and educational staff while also advocating the use effective psychological and educational strategies that are most likely to greatly benefit the children with hearing loss and their families.
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