ASL VIDEO

February 3, 2026

Chair Hai Pham
Vice-Chair Darcey Edwards
Vice-Chair Cyrus Javadi
Members of the House Committee on Behavioral Health
Oregon State Legislature

Dear Chair Pham, Vice-Chairs Edwards and Javadi, and Members of the Committee,

I am writing to respectfully urge the House Committee on Behavioral Health to require culturally and linguistically accessible behavioral health and crisis response services for Deaf, DeafBlind, and Hard-of-Hearing (D/DB/HH) Oregonians, including explicit standards for direct communication, qualified interpreter use, cultural brokerage, and partnerships with culturally specific community organizations. Without these requirements, Deaf survivors of violence, individuals in crisis, and those navigating court-ordered treatment continue to face systemic barriers that undermine safety, recovery, and the effectiveness of Oregon's behavioral health investments.

Since establishing our Domestic Violence and Sexual Assault Department in 2021, we have served hundreds of Deaf, DeafBlind, and Hard of Hearing victims and survivors of sexual and domestic violence. These are individuals who have endured profound trauma—and yet, despite their courage in seeking help, their options for mental health care remain dangerously limited.

- Much of the research detailing sexual assault in the Deaf population has focused on intimate partner violence (IPV) and has found that Deaf women are 2 to 4 times more likely than hearing women to experience forced sex in their lifetime (Pollard, Sutter, & Cerullli, 2013).
- An article from American Annals of the Deaf in 1987, written by McKay Vernon and his colleagues that "it is estimated that 50% of the Deaf community has been sexually abused as children." The same group of authors reported 54% of Deaf boys were sexually abused in comparison to only 10% of hearing boys."
- "Deaf prisoners are abused at three times the rate of hearing prisoners." (Vernon, 2005).

National research consistently demonstrates that Deaf and Hard-of-Hearing individuals experience significantly higher rates of mental health conditions than hearing peers, including depression, anxiety, and trauma-related disorders (National Deaf Center, 2022; National Association of the Deaf, 2019). Studies further indicate that Deaf adults experience higher prevalence of substance use disorders than hearing adults across multiple categories, including alcohol and illicit substances (McKee et al., Journal of

Substance Abuse Treatment, 2021; National Survey on Drug Use and Health analyses). One widely cited estimate suggests that approximately one in seven Deaf individuals experiences substance dependency, compared to one in ten hearing individuals (Guthmann & Sandberg).

Despite this elevated need, Deaf, DeafBlind, and Hard-of-Hearing individuals routinely encounter behavioral health and substance abuse treatment systems that are not equipped to provide effective communication access or culturally competent care. Research documents that treatment programs frequently rely on written English materials as a substitute for direct communication, despite English not being the primary or natural language for many Deaf people (Guthmann & Sandberg; National Deaf Center, 2022). These practices severely limit comprehension, participation, and therapeutic engagement and are associated with poor treatment outcomes and increased risk of relapse (McKee et al., 2011).

In court-ordered and involuntary treatment settings, these failures are especially harmful. Deaf individuals are frequently isolated, excluded from group therapy, or relegated to reading assignments rather than meaningful participation in treatment—conditions that research associates with poor treatment outcomes and increased risk of relapse (McKee et al., 2011; Guthmann & Sandberg). National experts have emphasized that lack of accessible communication is a primary contributor to unsuccessful treatment and recidivism among Deaf individuals in substance abuse programs.

In Oregon specifically, the lack of culturally competent behavioral health services for Deaf, DeafBlind, and Hard-of-Hearing individuals is especially acute. At present, there is no comprehensive, statewide culturally specific behavioral health program serving this community. The only known culturally and linguistically competent mental health service is provided by a single Deaf, licensed mental health therapist employed part-time by Northwest Human Services, and that position is funded through the federal Victims of Crime Act (VOCA) via the Oregon Department of Justice. This limited funding structure restricts eligibility and does not meet the broader mental health and substance use treatment needs of the Deaf community.

Outside of this program, Deaf individuals are often forced to rely on employment assistance programs that authorize, on average, only three therapy visits per identified issue, regardless of clinical need. This is only accessible to around 54% of Deaf adults who are employed, compared with approximately 70–73% of hearing adults nationally. This reflects a significant employment gap [and access to employment assistance program]. (National Deaf Center, 2023). These limitations are incompatible with the complex and often trauma-informed care required by Deaf individuals who experience abuse, language deprivation, systemic exclusion, and delayed access to services. Identifying a therapist who is both licensed and well-versed in Deaf culture and fluent in sign language is exceedingly rare, and Deaf individuals are frequently required to self-advocate for access to qualified providers out of state.

In many cases, the most appropriate therapists are located out of state, yet many health insurance plans do not cover out-of-state services, placing effective care financially out of reach. This reality further exacerbates disparities and leaves Deaf, DeafBlind, and Hard-of-Hearing individuals without meaningful access to behavioral health treatment. Mobile crisis intervention services present additional risks when accessibility is not embedded into program design. Without responders who can communicate directly in an individual's native sign language, crisis situations may be misunderstood or unintentionally escalated (National Association of the Deaf, 2019).

> Public testimony supporting 2017 HB 3714. Advocates shared that Deaf individuals are "exceedingly isolated" due to a tremendous dearth of mental health services available in sign language. They described that Deaf people trying to participate in state health system discussions were unable to be heard because interpreters did not show up — a stark illustration of access barriers in practice. (The Lund Report, 2017).
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> Public testimony supporting 2021 HB 2585. A mental health professional in Portland testified that Oregon has a chronic need for access to communication and education for Deaf, Deaf-Blind, and Hard-of-Hearing Oregonians with mental health needs. The testimony describes current barriers to affirmative and culturally responsive services, and asserts that the situation is "dishearteningly factual," characterizing it as an emergency requiring legislative action. (OLIS).

Based on our direct service experience and the research outlined above, we respectfully request the Committee consider the following policy requirements:

- Direct communication must be prioritized. Whenever possible, services should be delivered by workers who are members of the Deaf, DeafBlind, or Hard-of-Hearing community and who are fluent in the individual's native sign language. Direct communication has been shown to improve trust, engagement, and treatment outcomes (National Deaf Center, 2022).
- Cultural partnerships must be required. Behavioral health and crisis response providers should be required to partner with culturally specific nonprofit organizations serving Deaf, DeafBlind, and Hard-of-Hearing communities to ensure that individualized safety plans address all access needs, including communication, environmental, sensory, and informational access.
- Interpreter standards must be explicit and enforceable. When sign language interpreters are used, they must demonstrate advanced proficiency equivalent to a minimum rating of 4.0 (Advanced) or higher, particularly in high-risk behavioral health and crisis settings. Insufficient interpreter skill has been shown to compromise clinical accuracy, informed consent, and patient safety (National Association of the Deaf, 2019). Any interpreter with an American Sign Language proficiency rating below 4.0 shall be required to work in a team configuration with a professional Deaf advocate and/or a native Deaf certified and licensed interpreter to ensure linguistic accuracy, cultural mediation, and effective communication.

- Programs must demonstrate cultural and linguistic competence, including training in Deaf culture, language deprivation, trauma-informed care, and disability rights obligations under state and federal law.

Behavioral health systems cannot be considered effective, equitable, or trauma-informed if Deaf, DeafBlind, and Hard-of-Hearing individuals are routinely excluded from meaningful access to care. The disparities documented in both national research and Oregon's current service landscape underscore the urgent need for intentional policy design, sustainable funding, and enforceable access standards.

Thank you for your leadership and your attention to this critical issue. I would welcome the opportunity to provide additional research, stakeholder input, or testimony to support the Committee's work.

Respectfully,

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cc: Disability Rights Oregon
Northwest Human Services
Oregon Association of the Deaf
Oregon Department of Justice
Oregon Health Authority
Community
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