

**Serving Severely Emotionally Disturbed Deaf Youth:
A Statewide Program Model**

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Abstract

This article presents an overview of the clinical issues that face deaf and hard of hearing children today. Current treatment options both in Alabama and nationwide that are available to severely emotionally disturbed deaf children are examined. Finally, a proposed statewide program model is detailed and its implementation is proposed.

Running Head: Statewide Deaf Children's Mental Health Services

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Introduction

The importance of child and adolescent mental health in the general population has come to the public's attention at a large cost. In the wake of the Columbine massacre and other similar school shootings, it has increasingly become apparent to lawmakers and the public at large that the mental health needs of children and adolescents requires immediate attention. Approximately, one in five children in the United States has a mental disorder. Five to nine percent of children ages 9-17 are affected by a serious emotional disturbance (SED) that causes severe functional impairment. Anxiety disorders, mood disorders, and disruptive disorders are the most common mental disorders among children (US Department of Health and Human Services, 1999). In fact, the Substance Abuse and Mental Health Services Administration (SAMHSA) contended in a 2000 report that it is time for child and adolescent mental health to be a major policy concern. Among children aged 6-17 with mental disorders, 79% of them do not receive mental health care (Katoaka, Zhang & Wells, 2002). As a result, SAMSHA recommended the advent of a nationwide State Children's Health Insurance Program.

The mental health crisis faced by deaf and hard of hearing children and adolescents is no less critical. (For purposes of this article, the authors will routinely use the word "deaf" to mean both deaf and hard of hearing populations unless indicated otherwise.) While we have not yet experienced a killing spree at a school for the deaf or at a public school by a deaf adolescent, it would be naïve to assume that there is any less need for deaf children to have appropriate mental health services. A review of the literature confirms that deaf children are more at risk of developing personality, emotional, and behavioral disorders than the general population. This consensus is not limited to the United States. Several studies confirm that a greater prevalence of emotional and behavioral disorders among deaf children seems to be an international phenomenon (van Eldik, Treffers, Veerman, and Verhulst, 2004; Mathos & Broussard, 2005; Hindley, 1999).

Clinical Issues

It has long been debated whether deafness, *per se*, is a risk factor for emotional and behavioral disorders. Those who are strong advocates of the cultural view of deafness may bristle at the idea that people with hearing loss are more susceptible to mental illness. In a sense, they are right. Not hearing is often biologically irrelevant to mental status. However, deaf children have challenges that the larger hearing population

do not normally experience. Additionally, many people with hearing loss contract it through congenital syndrome which many also have neuropsychological implications. So, while the biological hearing loss may not lead to higher risk for mental illness, the psycho-social impact of the hearing loss creates other risk factors that most certainly do raise the risk. Early childhood hearing loss creates barriers to interfamilial communication, which in turn contribute to developmental deficits. These deficits have been treated in detail in the literature and need not be addressed here. It is sufficient for the purposes of this discussion to note that these deficits have significant impact on how deaf children experience the world and how they adjust to it.

Early childhood hearing loss also changes how they react to abnormal stimuli. The rank order of diagnostic syndromes of deaf children is different than hearing children. Hearing children show a rank order pattern of mood disorders followed by behavioral issues and then psychoses. Deaf children, on the other hand, are shown to more frequently present with mood disorders, then psychoses, followed by behavioral issues (Willis & Vernon, 2002). Some of the more common diagnoses seen in deaf children are attention deficit hyperactivity disorder (ADHD), conduct disorder, oppositional defiant disorder, depression and anxiety (Hindley, 1999; Leigh & Anthony, 1999.)

As mentioned earlier, many causes of deafness also greatly impact neurological development of the child, leading to language and cognitive problems (Steinberg, 1997). The more severe the language and cognitive barriers are for the child, the more at risk they are of developing emotional and behavioral problems later in life (Willis & Vernon, 2002). The most notable of these causes are maternal rubella, spinal meningitis, and cytomegalovirus (CMV).

In the 1960s, the largest cause of deafness was maternal rubella. The rubella epidemic resulted in an explosion of the deaf population, overloading the educational system with students, some of whom presented unique challenges. In addition to deafness, maternal rubella carried with it a number of other conditions including mental retardation, blindness, and a higher risk of attention deficit disorders and psychotic disorders (Mathos & Broussard, 2005). In a study of Dutch deaf children, emotional and behavioral disorders were noticeably more prevalent in children deafened by rubella (van Eldik, Treffers, Veerman, & Verhulst, 2004).

Today, we are seeing more cases of children being deaf as a result of the CMV (Hindley, 1999). It has been noted that these children have a shorter attention span, impulse control issues, and a low tolerance for delayed gratification. According to Dr. Alan Cohen, the CEO of the National Deaf

Academy, children with CMV also have some significantly different language processing problems that are just now becoming obvious (personal communication, May 2005). These are just two of many examples of congenital causes of deafness with distinct neuropsychological sequela. Regardless of the etiology of either the hearing loss or the psychiatric challenges, deaf children are at risk for mental illness and the system is unprepared for them.

Willis and Vernon (2002) when recounting the reasons for serious mental illness among deaf children remarked that one of the things that puts them at greater risk are the "communication problems inherent in deafness, which are often compounded by inappropriate educational methodologies." Lack of communication in the home environment and inappropriate educational placements result in a considerable number of deaf children and adolescents having limited language proficiency in both spoken language and sign language (Hindley, 1999). Limited language skills result in frustration, poor social skills, poor self-image, and the inability to communicate basic needs of safety and desires.

Communication barriers cut both ways. Gregory (1995) reports 'many mothers of deaf children find physical punishment simpler than a verbal explanation when linguistic communication ability is low.' Most likely, maternal frustration also plays a role there, as deaf children are likely to

be less responsive and more disruptive than their hearing siblings (Marschark, 1993). Inadequate explanations foster the deaf child's inability to relate cause and effect, solve problems, and make thoughtful decisions about his or her own behavior. Coping mechanisms force the deaf child either to take control of the environment or to be controlled by it. Although the deaf children seen for therapy are of varied socioeconomic backgrounds and have had different environmental advantages and disadvantages, their common characteristic is a tendency to meet basic emotional needs in antisocial, rigid, or dependent ways. Thus, the types of emotional and behavioral difficulties typically displayed by deaf children and adolescents appear to be outgrowths of the unique circumstances present during a particular period of development and not expressions of psychopathology as is commonly assumed by clinicians without training in the psychosocial aspects of deafness. These assumptions are based on a lack of awareness or minimization of the unique biopsychosocial sequelae, which accompany deafness (Sarti, 1993).

Indeed, Kennedy (1989) suggests that the consequences of deafness often mirror those associated with abuse (p.160). Sexual abuse and molestation puts children and adolescents at a higher risk of developing emotional and behavioral disorders. Sexual abuse leaves children with the feeling of being "different" or "damaged." It forever colors the way the child views the world and the relationships around them.

The statistics are truly alarming. Deaf children are 2-3 times more likely to be sexually abused than their hearing peers (Kvam, 2004). Over 49% of deaf juvenile sex offenders have themselves been sexually abused (Willis & Vernon, 2002). In addition, over 85% of deaf adolescents in residential treatment centers have a confirmed or very strong suspicion of being sexually abused in the past (Willis & Vernon, 2002).

Deaf children are, then often traumatized, first by the lack of communication and familial support, then by excessive physical intervention that sometimes becomes outright physical abuse, and then by predators who see them as easy prey. This first author recalls, early in his career, treating a five-year deaf girl who was, at the time, pre-lingual. She exhibited behaviors that were sexually precocious and overtly provocative. Through the use of play therapy, it was revealed that this young girl was being regularly sexually abused, up to and including intercourse, by the mother's live-in boyfriend. When arrested, the perpetrator remarked that he did it because he did not think the girl could report what he was doing.

All these things, taken together, mean that the deaf child who is in need of mental health treatment presents a complex mix of presenting problems and symptomology that defy the application of traditional approaches by

clinicians who are not trained in deafness. "Treatment" which replicates the traumatizing experiences children have in their homes and schools are not therapeutic.

Determining the course of treatment is another area where deaf children are often slighted. For clinicians untrained in deafness and unable to communicate with deaf children, accurate assessment becomes extremely problematic. Clinicians must be aware that some instruments used to measure cognitive abilities have not been validated for use in the deaf population. Personality tests, which are normative for hearing American people, are frequently misinterpreted when used with deaf people. Diagnostic criteria need to be adjusted to account for differences due compensation for hearing loss. For example, many behaviors that are normal for deaf children, such as looking around the room for communication purposes, might be considered symptoms of ADHD in hearing children (Morgan & Vernon, 1994). Failure to take into account this phenomenological evidence of a qualitative difference in coping mechanisms can lead to over-diagnosis of ADHD in the deaf population with concomitant side effects from unnecessary drug treatment, and inappropriate school placements. Moreover, these inappropriate diagnoses remain in the child's records with significant subsequent impact in how the child is viewed by educators and other clinicians.

Results of such assessments may be skewed due to variations in communication abilities and cultural differences (Hindley, 1999). Poor English skills are often equated with poor language skills, even among children with exceptional fluency in American Sign Language. Additionally, deaf children with cognitive disabilities are likely to have impaired language use making assessment even more difficult.

It is our contention that these differences argue for treatment that is tailored specifically for deaf children. Unfortunately, such specialized programming is not available to most children who need it. Very few places in the country have a true continuum of care, in which there is a systemic approach to tailoring clinical services to the level of need while maintaining cultural and linguistic appropriateness. Even more rare is for such a continuum to be coordinated on a statewide basis.

Current Treatment Options - Nationwide

Some children are fortunate enough to either live near or have the resources to be referred to a specialized program. At the time of this writing, there are only a handful of specialized residential treatment centers for deaf children in the United States. By specialized we mean that these programs are noted for attempting to provide culturally affirmative mental health care. These programs provide, at a minimum, a core staff of

clinicians fluent in American Sign Language and treatment that is geared to deaf children specifically. (A thorough treatment of culturally affirmative care can be found in Glickman & Harvey, 1996).

It is acknowledged that other programs may claim to have a “deaf program” in their facility. For some programs, this may mean providing interpreting services. Some facilities may have a member of the staff who knows sign language. Other facilities simply house deaf children and call it a deaf program, with no attempt to modify treatment for the deaf child. The quantity and quality of these services vary widely, but none of them can be called a program specifically for deaf children.

Willis and Vernon (2002) define a residential treatment center (RTC) as a specialized 24-hour facility that provides psychological, educational, social, recreational, psychiatric, and medical therapeutic services to youth with severe emotional disturbances. Children requiring residential treatment care often come with a long list of emotional and behavioral disorders which often include destructive and/or self-injurious behaviors. For deaf children, severe mental health problems are compounded by special communication needs and the likelihood of additional disabilities (Mason & Braxton, 2004).

In almost all cases, deaf children who end up in an RTC do so with a history of inappropriate and inadequate interventions that did not take into account the specialized needs of visual communication and the nuances of Deaf culture (Willis & Vernon, 2002). Deaf children often arrive at RTCs with an extreme feeling of powerlessness which may cause them to lash out at staff or draw staff into conflicts. The powerlessness derives from the sense that the adults in their lives would not communicate with them, and perhaps even viewed their deafness as a medical problem – one to be solved – rather than as a social problem requiring accommodation (Mason & Braxton, 2004). The adults in their lives may even resent their deafness further exacerbating the mental health problems that the children face. Providing effective treatment for children who have such a challenging clinical presentation is a lengthy and complicated process that requires attending to not just the child, but also the entire social system surrounding the child. In other words, treatment requires a continuum of care.

A true continuum of culturally affirmative care for deaf children means that services are available in a variety of settings and are customizable to meet the specific clinical needs of the child. Ideally, there should be a range of services from in-patient to outpatient services, available in the home and in the school. It also means that such a program would have strong ties with schools serving deaf students. Regrettably, this is rarely the case.

For this article, seven RTCs were examined. Four of them have some type of relationship with a state school for the deaf (Children's Seashore House in eastern Pennsylvania, Buckeye Ranch in Ohio, Pressley Ridge in western Pennsylvania, and Desert Hills in New Mexico). The level of the relationship varies from program to program.

To illustrate the variance of how programs operate, on one hand there is the PRIDE Program, run by Pressley Ridge in collaboration with the Western Pennsylvania School for the Deaf. Educational services are provided on the campus in a school setting which is co-facilitated by staff from Pressley Ridge and WPSD. Group homes located off campus, but in very close proximity, are run by Pressley Ridge. Students move along a continuum of levels of support depending on how they are coping and their ability to maintain. A student can be served entirely by Pressley Ridge, partly mainstreamed into either the regular WPSD classrooms or dorms, fully mainstreamed into the classrooms or the dorms or some combination thereof. Additionally, some students reside in therapeutic foster homes rather than the dorms or group homes. This continuum allows for a great deal of individualization of treatment.

By contrast, the Desert Hills program in Albuquerque is embedded in a larger program for hearing children. All services are provided in residence

at the facility, although the staff has close ties with the New Mexico School for the Deaf. The facility provides consultation and assistance when children transition back to school.

The National Deaf Academy and the Tampa Bay Academy, which are located in Florida, and the Walden School, which is located in Massachusetts, are not associated with a school for the deaf. Instead they have their own charter school that provides education to residents year-round.

There are several advantages for a program to be associated with a school for the deaf. In addition to making it more likely that treatment will be individualized to meet the specific needs of a given child, such co-location also lends an important boost to staff recruitment efforts. As stated before in this article, staff must also be fluent in American Sign Language in order to provide culturally competent care. When a program uses hearing staff who are not fluent in American Sign Language, there is a risk of replicating the trauma of deficient communication in the home and in the school. Thus, the very place that is supposed to treating trauma is merely adding to it.

Often recruitment becomes a major challenge. There are simply more vacancies than there are people to fill them. When an RTC is affiliated

with a school for the deaf, the program is more readily able to attract high quality deaf professionals and paraprofessionals (Vreeland & Tourangeau, 2003). Deaf professionals and paraprofessionals are much more likely to be fluent users, if not native users, of American Sign Language. Thus, they are more likely to help facilitate the creation of an environment where deaf children will be able to communicate effectively.

Additionally, a vibrant deaf community provides a built-in support system for the RTC staff. This is critical because those who are working with deaf children in an RTC setting must be prepared to provide care for children who most likely will have multiple disabilities, arrive "sicker" and be in need of intensive treatment. Staff working in these programs are at notorious risk for burnout (Mason & Braxton, 2004). Social supports and activities outside work are an important part of any self-care plan.

Co-location is not only helpful in the prevention of burnout, but also, the presence of quality deaf professionals has important therapeutic benefits. These deaf adults can serve as role models for children who may never have had a deaf adult to look up to their whole lives. Deaf professionals and paraprofessionals can introduce deaf children to the Deaf community. By learning about Deaf Culture, deaf children are allowed to explore a new identity, one that they may have been unaware of at home.

In addition, by being affiliated on some level with a school for the deaf, the residents of the RTC can gradually mainstream back into the school for the deaf when they are ready to do so. Depending on their progress, they may also be allowed to participate in social and athletic events at the school as well. This is a powerful tool in the treatment of the deaf child.

Current Treatment Options in Alabama

According to the Gallaudet Research Institute at least 2 per 1,000 babies are born with a severe to profound hearing loss. In Alabama, this translates to some 20,212 children between the ages of 2 and 18 who have some degree of hearing loss that will affect their lives in some way. It is estimated that 8.6% of a given population will need mental health care at some point in their lifetime. Using this estimate, approximately 1,738 children will need our services.

In a survey done of the community mental health centers (CMHCs) in Alabama, the authors found 141 deaf and hard of hearing children and adolescents were served over the past twenty-four months. An additional 23 deaf and hard of hearing children and adolescents were under the care of the Department of Human Resources (DHR). All of these children are considered high-risk and high maintenance.

They are also extremely expensive. To illustrate, an example from the lead author's experience is instructive. During one notable six month period, the Missouri Department of Mental Health had two deaf teenage individuals admitted into a state-run children's inpatient facility. One youth consumed \$14,000 worth of interpreting services during a two week timeframe. This child was then released back into the same environment he came from, without significant modification of conditions that led to his hospitalization. The other deaf teenage boy utilized \$59,000 of interpreter services during his stay at that same facility (Hamerdinger, 2002).

At the time of this writing, there are several adolescents from Alabama at the National Deaf Academy (NDA) in Florida. To be sure, NDA is a valuable resource for the most severe cases, but some of these adolescents could be better served through a culturally and linguistically appropriate community program. But because no such community option exists for a deaf adolescent, the state is spending millions of dollars every year to keep these adolescents in that facility. The cost also puts pressure on the social service system to bring them back to Alabama without having appropriate services in place.

Even when the children are clinically ready to transition back home, the state faces the challenge of how to provide services for them. All too frequently what happens is the "revolving door" syndrome where the child

improves under treatment provided by a culturally and linguistically appropriate program, comes home and is referred to services that are not so appropriate. The child then decompensates because the system of care cannot respond in an affirmative manner and has to be readmitted to NDA or a similar program elsewhere.

The problem with RTCs is that they are used for children who may be “problem” kids for schools, but clinically are not severe enough for this type of placement. The Surgeon General’s report on mental health (1999) stated that too many children are inappropriately placed in the most restrictive RTCs simply because of the lack of community-based services. This is especially true with deaf children.

As it now stands, there are three main treatment options: the Alabama School for the Deaf at the Alabama Institute for the Deaf and Blind, Community Mental Health Programs, and incarceration in the state juvenile justice system. The latter option, while regrettably not infrequent, is not treatment at all.

The Alabama School for the Deaf (ASD) currently has a number of students who are severely emotionally disturbed and who also may have secondary disabilities. ASD has mental health professionals who do as much as possible to help these students. However, their resources and ability to help are limited. The mental health staff is limited in their ability to

provide family interventions, for example. They also have to be mindful of the implications for the school when a student becomes a danger to themselves or other students which means alternative placement has to be sought.

On the other hand, in Alabama, many deaf children, outside of ASD, receive services from their local community mental health centers (CMHCs.) The authors have found repeatedly staff members at CMHCs and DHR are not prepared to work with deaf children with emotional and behavioral disorders. Too often these clinicians and caseworkers are unfamiliar with deafness and its psychosocial implications. They are not aware that the treatment process needs to be modified to fit the deaf child. There are special nuances to watch out for. For example, some medications in high doses cause visual side effects which can affect the deaf child's ability to understand another person's signing (Hindley, 1999).

CMHCs and staff members with little experience with deafness may not fully understand the implications of using an interpreter. For them, treating a deaf child simply means contracting with the local interpreter referral agency. Clinicians may not understand that the very presence of an interpreter completely alters the dynamics of the treatment. Having a third person in the room changes the landscape of transference and countertransference and alliances (Hamerdinger & Karlin, 2003).

Proposed Continuum of Care for Deaf Children

The authors of this article are employed by the Office of Deaf Services (ODS) under the Alabama Department of Mental Health and Mental Retardation. ODS was established in 2002 as a result of the *Bailey* consent decree. The primary mandate of ODS is to provide services to deaf and hard of hearing consumers with mental illness who range in age from 18-64. ODS is also responsible for educating the public on standards for providing culturally affirmative mental health services to this population.

While technically an adult program, ODS is often called to consult in cases involving deaf children. Thus, the glaring gap in services for deaf children is increasingly highlighted with high profile and difficult to serve children. The need for a continuum of services for emotionally disturbed deaf and hard of hearing children and adolescents becomes distressingly more apparent with each new case that is referred. This need has led to the development of a program model now under consideration for adoption in Alabama.

This program model requires coordination of fragments of services already in existence or being developed. At the present time, a number of state agencies have been involved in attempting to serve deaf children with

psychiatric challenges. These agencies include the Department of Human Services, the Division of Vocational Rehabilitation, the State Department of Education, and the Division of Youth Services, as well as several divisions of the Department of Mental Health and Mental Retardation. That some kind systemic approach to serving deaf children is desperately needed is not disputed by the agencies. In fact, Alabama has set up a special task force for children with special needs that works across all the agencies and brings resources from each to the table. Thus the task force is able to plan programming for the most challenging children. They have not been able to effectively serve deaf children because a system of care does not exist for this population.

Implementing a system of care is best done by instituting statewide coordination by a person who is an expert in the mental health needs of deaf children and by developing some specific new programming. This Deaf Children's Mental Health Services Coordinator should be highly trained in working with deaf children with psychiatric problems. New programming should include a network of specialized therapeutic foster homes and a component of intensive residential care for the few children who cannot maintain stability in therapeutic foster homes.

Ideally, the state residential school for the deaf would be accessed for educational components as they are trained to meet deaf or hard of

hearing children cultural and linguistic needs. Crisis intervention would be provided by a special case manager, backed up by an acute crisis response system. Arrangements must be made with a nearby acute care facilities for crisis intervention and stabilization on an as-needed basis. Considerable training of staff at the acute care facility will be necessary in order to ensure that deaf children are not harmed by the placement.

An intensive transition home consisting of 6-8 beds should be created for children who are too unstable either the dormitories at ASD or for therapeutic homes, but need not be hospitalized. This home would be based on the PRIDE model where a small group of children living with primary care givers (teaching parents) supplemented by additional support staff. The goal for the transition home program would be to assist the children in preparing for placement in the therapeutic foster homes.

This program assumes all staff must be fluent in American Sign Language and knowledgeable of Deaf Culture or this program will be ineffective and fail to meet the child's needs. The intensive treatment home program will operate 12 months a year, for about 344 days. Staff should have a Bachelor's degree or at least 5 years of experience working with deaf children with emotional or behavioral problems. Pre-service and continual in-service training will be required to keep their knowledge current.

Statewide coordination of services and support for the therapeutic foster homes would be the responsibility of the Deaf Children's Mental Health Services Coordinator. In addition to program development aspects already mentioned, this person would work with school districts and other state agencies to ensure proper referrals to the program. The Deaf Children's Mental Health Services Coordinator will supervise the case managers, intensive treatment home director, and other necessary support staff.

Case managers hired should have at least a Bachelors Degree in a social services related field, and preferably a Masters. They will function as liaisons between the children's home, school, and treatment planning teams. These case managers should be spread out statewide and are most effective if they are mobile, thereby able to support children with less severe behavioral or emotional challenges in their local communities.

A training specialist would provide development and training for project staff, provide psychoeducational training pertaining to mental health issues, educational, and Deaf Culture issues to consumers, therapeutic foster parents, teachers, biological parents and/or guardians.

Several other support staff would need to be recruited. Interpreters must be hired to facilitate communication between deaf and hearing people

involved in each child's treatment. They can also provide sign language courses to parents, teachers, and other interested individuals involved with the program. Other support staff include an administrative assistant needed to manage the office needs and perform clerical, records management, and receptionist duties.

Certain clinical services may need to be contracted. These include:

- Psychiatrist

Using emerging Alabama's Tele-Psychiatry Project, this person will be responsible for day-to-day medication tracking of all children enrolled in the program (Hamerdinger, 2004). For the purposes of this proposed program, the staff psychiatrist assigned to the deaf unit at Greil could conceivably be utilized.

- Child Psychologist

The project will contract with one or two psychologists who specialize in deaf children. These clinicians will also access the Tele-Psychiatry Project for testing and therapy issues that need to be addressed within the children, DTFH, and biological family and siblings.

The intensive treatment home would replicate the highly successful PRIDE HOUSE program at Western Pennsylvania School for the Deaf. Staffing needs consist of Lead Teaching Parent(s) to supervise teaching

parents and behavioral aides. This person will be responsible for daily delivery and management of treatment services. The Lead Teaching Parent would report to the Statewide Deaf Children's Coordinator.

Four Teaching Parents who will have responsibility of working directly with the children in the transition home will be needed. Overnight staffing done by behavioral aides and backup staff will assist when Teaching Parents are unable to work their shift.

Ideally, the intensive treatment home would be on or near the campus of the state school. This, however, may be impractical for logistical and/or political reasons. The home should have 5 bedrooms, 3-4 bathrooms, kitchen, dining room, recreational room, and living room. The home would need to be renovated to meet Alabama's Community Program Standards for facility certification and the ADA (Americans with Disabilities Act) regulations for equipment such as signal systems for phones, fire alarms, doorbells, etc. A van will need to be readily available for transportation for appointments, recreational activities, and so forth.

As program participants become more stable and able to better cope, reintegration into the general community becomes the goal. For some children, this will mean mainstreaming into the general campus life of the state school. This process should be gradual and individualized. It would

require close cooperation between the school staff and the program staff. Program staff would need to be on-call to assist in intervening when students are having difficulty. Regular therapy would be provided either by project clinicians or the school counselor as determined by the treatment team.

Other children will be more appropriately served in a therapeutic foster home. For a state the size of Alabama, up to ten therapeutic foster homes would be needed to serve the deaf or hard of hearing children. These homes would replicate the pilot project done in Missouri in the late 1990's (Hamerdinger & Murphy, 2000). Foster parents must be able to communicate effectively in American Sign Language. There would be additional therapeutic benefit if the foster parents were deaf themselves, although this would not be an exclusionary criteria. Support for the foster parents would be provided by the case managers and the project staff.

Ultimately, the program would seek to assist the child's family in providing a better environment. The focus would be providing in-home assistance in the tradition of wrap-around in-home supports. These supports would include communication skills training, training in behavior management techniques

Conclusion

A system of care that provides a true continuum of services is the goal of every mental health program in the nation. For deaf children, this means a system that is designed to take into consideration their unique linguistic and clinical needs. Such a system must be implemented cohesively. It has to be coordinated from the state level and incorporate services already provided by various stakeholder agencies such as family services, education and the state mental health authority.

Bat-Chava, Y., & Martin, D. (2002). Sibling relationships of deaf children:

The impact of child and family characteristics. Rehabilitation Psychology, 47 (1), 73-91.

Center for Mental Health Services, Substance Abuse and Mental Health

Services Administration. (2000). Mental Health and Substance Abuse Services Under the State Children's Health Insurance Program. Designing benefits and estimating costs (DHHS Publication No. [SMA] 01-3473). Rockville, MD.

Gallaudet Research Institute. (2005). Can you tell me how many deaf

people there are in the United States? [Online]. Available:

<http://gri.gallaudet.edu/Demographics/deaf-US.php>

Gregory, S. (1995). Deaf children and their families. Cambridge:

Cambridge University Press (re-issue of *The deaf child and his family*, George Allen Unwin, 1976).

Glickman, N., & Harvey, M. (1996). Culturally Affirmative Psychotherapy

with Deaf Persons. Mahwah, NJ: Lawrence Erlbaum Associates, Publishers.

Hamerdinger, S.H. (2002). Serving Missouri's deaf children who have

severe emotional disorders. Unpublished manuscript.

Hamerdinger, S.H. (2004) Videoconferencing changes face of mental

health services. Signs of Mental Health 1 (4), 3.

- Hamerdinger, S.H., & Karlin, B. (2003). Therapy using interpreters: questions on the use of interpreters in therapeutic settings for monolingual therapists. JADARA 36 (3), 12 – 29.
- Hamerdinger, S.H., & Murphy, D. (2000). Using the deaf community as an alternative treatment strategy: Developing deaf treatment foster homes. JADARA, 33 (2), 26-41.
- Katoaka, S.H., Zhang, L., & Wells, K.B. (2002). Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status. American Journal of Psychiatry, 159, 1548-1555.
- Kennedy, M. (1989, Spring). The abuse of deaf children. Child Abuse Review, 3-7.
- Kent, B.A. (2003). Identity issues for hard-of-hearing adolescents aged 11, 13, and 15 in mainstream settings. Journal of Deaf Studies and Deaf Education, 8 (3), 315-324.
- Kvam, M.H. (2004). Sexual abuse of deaf children: A retrospective analysis of the prevalence and characteristics of childhood sexual abuse among deaf adults in Norway. Child Abuse & Neglect, 28, 241-251.
- Leigh, I.W., & Anthony, S. (1999). Parent bonding in clinically depressed deaf and hard-of-hearing adults. Journal of Deaf Studies and Deaf Education, 4 (1), 28-36.
- Marschark, M. (1993). Psychological development of deaf children. New York: Oxford University Press.

- Mason, A., Mason, M., & Braxton E.T. (2004). Creating and strengthening the therapeutic system for treatment settings serving deaf children. JADARA, 37 (2), 1-19.
- Mathos, K.K., & Broussard, E.R. (2005). Outlining the concerns of children who have hearing loss and their families. Journal of the American Academy of Child and Adolescent Psychiatry, 44 (1), 96-100.
- Morgan, A., & Vernon, M. (1994). A guide to the diagnosis of learning disability in deaf and hard of hearing children and adults. American Annals of the Deaf 139, 358-370.
- Roberts, C., & Hindley, P. (1999). Practitioner review: The assessment and treatment of deaf children with psychiatric disorders. Journal of Child Psychology and Psychiatry, 40 (2), 151-167.
- Sarti, D. M. (1993). Reaching the deaf child: A model for diversified intervention. Smith College Studies in Social Work, 63(2), 187-198.
- Steinberg, A.G. (1997). Deafness. Handbook of Child and Adolescent Psychiatry, 3, 364-377.
- U.S. Department of Health and Human Services. (1999). Mental health: A report of the surgeon general. Washington, DC: Author. Available: <http://www.surgeongeneral.gov/library/mentalhealth>.
- van Eldik, T., Treffers, P.D.A, Veerman, J.W., & Verhulst, F.C. (2004). Mental health problems of deaf dutch children as indicated by parents' responses to the child behavior checklist. American Annals of the Deaf, 148 (5), 390-396.

Vernon, M., & Miller, K.R. (2002). Issues in the sexual molestation of deaf youth. American Annals of the Deaf, 147 (5), 28-37.

Vreeland, J., & Tourangeau, J. (2003). Culturally affirmative residential treatment services for deaf children with emotional and behavioral disorders. In N.S. Glickman & S. Gulati (Eds.), Mental health care of deaf people: A culturally affirmative approach (pp. 239-260).

Mahwah, NJ: Erlbaum.

Willis, W.G., & Vernon, M. (2002). Residential psychiatric treatment of emotionally disturbed deaf youth. American Annals of the Deaf, 147 (1), 31-38.