

## **Mental Health Services for Deaf Children**

### **Position Statement**

#### **National Association of the Deaf**

The National Association of the Deaf (NAD) asserts that balanced mental health is an essential component of a deaf<sup>1</sup> child's psychological development. The NAD recognizes that service delivery for deaf children poses particular challenges that are unique and different from the service delivery challenges for deaf adults.

#### **Failures of the System to Address the Mental Health Needs of Deaf Children**

Deaf children with mental health needs face a service delivery system that is sorely inadequate and too often fraught with ideological and monetary battles between multiple agencies (Hamerdinger & Hill, 2005). Additionally, because deaf children are a low incidence population, providers are typically unaware of the specialized needs and training required to work with this population, resulting in misdiagnoses of mental retardation or thought disorders (Morgan & Vernon, 1994; Hindley, 1999). Assessment tools are not modified to take into account the linguistic characteristics of this population, as well as cultural norms and values. Moreover, evidence-based practices are largely untested for low incidence populations, such as deaf children.

Because of the mental health system's failure to address the unique needs of deaf children, they are subject to increased risks and barriers to their mental health (Hamerdinger & Hill, 2005; Willis & Vernon, 2002). The system also does not adequately address these higher risks and harm to healthy self-image that deaf children face primarily as a result of lack of linguistic access (Willis & Vernon, 2002; Gregory, 1995; Marschark, 1993). Due in large part to language barriers, studies show that deaf children are two to three times more at risk for sexual abuse than the general population (Kvam, 2004; Willis & Vernon, 2002). Language barriers are also correlated with higher rates of aggression, low self-esteem, and little ability to develop meaningful bonds with peers and adults (Kennedy, 1989; Marschark, 1993; Sarti, 1993). In addition, the mental health system has not been prepared to deal with deaf children who have additional disabilities or cognitive impairments that may accompany certain causes of deafness such as cytomegalovirus, meningitis, and prematurity, to name a few (Hindley, 1999; Steinberg, 1997; Mason & Braxton, 2004). All of these factors accentuate the need for a comprehensive mental health system that is equipped to address this unique population.

The NAD urges each state to review its programs and services for deaf children to ensure that those children receive appropriate mental health programs and services across the board. This position statement provides the framework for optimal mental health care for deaf children in this country.

---

<sup>1</sup> The term "deaf" is to be interpreted to include individuals who are hard of hearing, late deafened, and deaf-blind.

## **Deaf Children Require Appropriate Cultural and Linguistic Access and Development**

All services provided to children should also be available to deaf children in an accessible manner that takes into account each child's culture and is provided in each child's language and preferred mode of communication. Each time a deaf child requires services, an assessment must be made of the child's language and culture to determine the optimal means of meeting that child's needs. Mental health services should be made culturally affirmative and linguistically accessible to deaf children regardless of educational placement, urban or rural residency, additional disabilities, and/or family and socio-economic status. Additionally, states should implement safeguards to ensure deaf children achieve linguistic development in a manner appropriate to their respective age and culture, and through those safeguards foster these children's development of balanced mental health.

The NAD urges full and equal access to mental health services, including linguistic and cultural access, for all deaf children regardless of mode of communication. Further, the NAD believes that language is a human right for all children, and that deaf infants and children should be given the opportunity to acquire and develop proficiency in American Sign Language (ASL), a fully accessible visual language, as early as possible. Linguistic and cultural competencies also contribute to healthy development of identity and self esteem in deaf children, with appropriate balancing of mental health needs. As is explained in the NAD position statement on Mental Health Services for Deaf People, ASL is considered an evidence-based practice for this population and efforts must be made to increase the number of trained clinicians who are fluent in ASL and culturally affirmative (Hamerdinger & Hill, 2005; Glickman & Harvey, 1996; Willis & Vernon, 2002; Mason & Braxton, 2004).

## **Deaf Children Require Comprehensive Services that are Coordinated on a Statewide Basis**

States should have a lifespan developmental approach to mental health with an emphasis on the right of deaf children to linguistic development and with a comprehensive array of services that is coordinated on a statewide basis. An array of services with a life span developmental approach includes many components. It is critical that each of these components be seen as a piece of a service continuum to ensure that there is a smooth transition as the needs of the child and family change over time. At a minimum, this service array should include:

- Early Hearing Detection and Intervention (EHDI) services

States need to ensure that EHDI teams partner with mental health and deafness experts to help parents adjust to the reality of their child's hearing loss and recognize the centrality of language development to healthy psychological development. Parents of newly identified deaf infants and children must receive accurate information about the benefits of acquiring and developing proficiency in both ASL and English.

- Language and communication development

States need to increase linguistic and cultural development programs for deaf children in conjunction with educational systems. Such efforts should begin at birth and continue throughout deaf children's education. Emphasis should be on maximizing language

proficiency in deaf infants through the implementation of a dual language approach; that is, incorporating early acquisition and learning of both ASL and English.

- School-based services at residential, self-contained and mainstream programs

Mainstream educational programs often lack trained personnel who are able to address the mental health needs of deaf children, including those whose primary language is ASL. Residential educational programs may have such personnel; however, there may not be enough to serve the needs of enrolled deaf children. Efforts need to be made to recruit, train and retain qualified staff to provide support at all educational programs, across the placement continuum.

- Case management services

States need to ensure that case management staff members are cognizant of and trained to coordinate culturally affirmative and linguistically accessible mental health services to deaf children.

- Outpatient therapy

States need to develop resources to ensure that deaf children receive appropriate therapy from clinicians who are linguistically fluent and culturally affirmative. While not the optimal means of therapy, the shortage of ASL-fluent clinicians necessitates the interim use of sign language interpreters trained to work in mental health settings.

- Family education

States need to develop resources and training for state and local agencies that provide family education services to work with deaf children, including ensuring that services provided take into account the linguistic and cultural needs of the child and family.

- A continuum of residential alternatives which must include, at a minimum:

- Wraparound providers

For families who need intensive in-home services that are coordinated by wraparound providers, providers must be able to communicate with both parents and the child (either directly or with interpreters trained to work in mental health settings) and provide services which are sensitive to the needs and inherent challenges of parents of deaf children.

- Therapeutic foster homes and foster placement

In situations where deaf children are removed from their homes because of abuse and/or neglect, it is absolutely imperative that the array of services includes the existence of foster placement options that are accessible and appropriate (Hamerdinger & Hill, 2005). Removal from one's home is a traumatic experience,

and the NAD reaffirms that linguistic and cultural needs of deaf children must be addressed and accommodated in any placement.

- Group homes

States need to develop group homes and other community-based options that meet the cultural and linguistic needs of deaf children.

- Residential treatment facilities

States need to develop, prepare, and train staff and clinicians within residential treatment facilities to work with deaf children and meet those children's cultural and linguistic needs.

- Inpatient facilities

States need to develop, prepare, and train staff and clinicians within inpatient facilities to work with deaf children and meet those children's cultural and linguistic needs.

- Programs serving deaf children who have other disabilities

All mental health treatment for deaf children, including deaf children with other disabilities, must address the child's linguistic and cultural needs, as part of a holistic approach to treatment.

These options within the state's existing array of services need to take into account the unique needs of deaf children, and have appropriate planning and resources to meet those needs. Because deaf children are a low incidence population and there is a shortage of qualified clinicians able to meet their needs, proactive long-term strategies are necessary.

### **Long-Term Strategic Recommendations**

The NAD recommends that states take proactive steps to address the critical and urgent needs of deaf children who require mental health treatment. Three recommendations are proposed:

1. Develop regional programs to serve the needs of the relatively small number of deaf children needing inpatient hospitalization or residential treatment.
  - The number of deaf children requiring any mental health service tends to be small in each state.
  - There is a shortage of qualified clinicians fluent in ASL and knowledgeable about the cultural aspects of the deaf population.
  - There is a small number of qualified interpreters familiar with the unique needs of deaf children requiring mental health services.
  - Consequently, there may not be enough qualified professionals to meet the needs of deaf children if each state were to implement its own treatment program for this population.

- States can collaborate to set up regional mental health treatment programs serving deaf children, pooling resources and hiring from the limited ranks of ASL-fluent clinicians.
  - States need to develop interstate agreements allowing professionals who are licensed in other states but trained to deal with the unique mental health needs of deaf children to provide services across state lines to meet the needs of this low incidence population.
2. Encourage the recruitment, training, and licensure of members of the deaf community to serve as therapeutic and respite foster home personnel.
    - Placement options are limited for deaf children due to the lack of language accessibility and cultural compatibility in each option.
    - Increasing placement options will require states to invest in the recruitment, training, and licensure of people from the deaf community.
    - States need to review their foster care system and determine changes necessary to meet the mental health, linguistic, and cultural needs of deaf children.
  3. Invest in research priorities which focus on the linguistic, cultural, and systemic needs of this population.
    - Current mental health treatment models and services are based on the social and systemic needs of children who have linguistic fluency (in English or in another language) and who share that linguistic fluency with their parents, families, peers and neighborhood. That experience of linguistic fluency and access is not experienced by most deaf children.
    - Effective mental health treatment relies to a great extent on the culture and language of each person.
    - States need to invest resources in research and study of the mental health needs of deaf children to develop an array of optimal treatment options, including the application of the evidence-based practices that are effective with deaf children.

This framework with recommended steps is urgently needed to immediately address the mental health needs of deaf children nationally. The NAD urges all states to incorporate these steps into their programs and services at the earliest possible time. When states have adopted these recommendations, parity will be achieved with respect to mental health services for deaf children.

*This position statement was prepared by the Mental Health Subcommittee of the Public Policy Committee, and approved April 2008 by the NAD Board of Directors.*

## References

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., & Hill, E. (2005). Serving severely emotionally disturbed deaf youth: A statewide program model. *JADARA*, 38 (3), 40-59.
- 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.
- 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.
- 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.
- Willis, W.G., & Vernon, M. (2002). Residential psychiatric treatment of emotionally disturbed deaf youth. *American Annals of the Deaf*, 147 (1), 31-38.