October 2019

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Abstract

There are few treatment programs for deaf children who have severe emotional or behavioral disturbances. Most programs are residential in nature. While these programs provide a much needed service, they are not available to every child that needs treatment. Further, many children do better in smaller, family oriented environments than they do in residential treatment programs. Therapeutic foster care approaches are increasingly being used in many places as an alternative to residential treatment for hearing children.

Until recently, such programs have not been greatly utilized as an alternative to treatment for deaf children. When deaf children are placed in such programs, they often fail, for all the same reasons that traditional hearing programs fail to meet the needs of deaf patients of any age. The model described in this article takes the emerging therapeutic foster family approach and adds a novel component; training deaf families to become therapeutic foster parents. This article will give specific information on how the program in Missouri was established and what problems arose, and what solutions were tried.

It is becoming increasingly apparent that the nature of the deaf child is changing. In the past most children were deafened by post natal disease or trauma, and some with hereditary deafness. Today a majority are deafened by a host of congenital syndromes (Harmer, 1999). These syndromes range from genetic mutations to fetal alcohol syndrome, from maternal prenatal problems to extreme premature birth. These conditions can effect the newborn’s hearing and may also have significant neurological impact (Steinberg, 1997). Such neurological impact can involve behavioral or emotional disturbances, especially when combined with delayed psycho-social development often encountered with deaf children raised in language deprived environments (DaCosta & Steinberg, 1997).

Researchers have long known that deaf children are at higher risk for emotional and behavioral disturbances than their hearing peers.

2 The authors are using the term "deaf" as a generic term for children who have a significant hearing loss. In addition, in this article, capitalizing Deaf denotes cultural usage, i.e., the Deaf community, Deaf families, as opposed to people with hearing loss.
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(Klopping, McTigue, & Critchfield, 1985; Steinberg, 1997). These same sources note that the prevalence of emotional and behavioral difficulties has been estimated at between 21% and 46% of all deaf children. Although there is no research on prevalence rates in Missouri, it appears that Missouri is no different from the rest of the country.

There are very few appropriate programs in the United States for deaf children who are also emotionally or behaviorally disturbed. None of these treatment options are in the Midwest. Additionally, it is rare for children's programs to be staffed with individuals who have expertise in deafness. For example, with the sole exception of an adult in-patient drug and alcohol treatment program in Kansas City, there are no specific treatment programs for deaf people in Missouri. As is the case with many states, Missouri's state education authority, the Department of Elementary and Secondary Education (DESE), does not authorize out of state placement for children in need of treatment. The state mental health authority, the Department of Mental Health, is also extremely reluctant to send consumers out of state. In this regard, Missouri is not alone. The "inclusion" approach used in most states tends to make out of state placement a very reluctant last resort.

Compounding the frequent reluctance of many states to utilize out of state services, the in-state children's services tend to be fragmented and difficult to negotiate. For example, in Missouri a child who is deaf may have caseworkers from three different cabinet level agencies and several divisions within those agencies. It is not unusual for a child's treatment planning meeting to be attended by representatives from the Division of Mental Retardation and Developmental Disabilities (MRDD), Division of Comprehensive Psychiatric Services, Children's Services (CPS), the Office of Deaf Services (ODS) from the Missouri Department of Mental Health (DMH). They will be joined by workers from Division of Family Services (DFS) and the Division of Youth Services (DYS), both from the Missouri Department of Social Services (DoSS). Education will be represented by individuals from the Missouri School for the Deaf (MSD), the child's Local Education Agency (LEA) and, in some cases, DESE. A dozen professionals sitting around the table is not at all uncommon.

This scene is repeated frequently in nearly every state, with only the acronyms of the agencies changing. Each agency has its own rules for service eligibility and delivery. In some cases, one agency's rules will contradict the rules of another agency. In other cases, the child becomes caught in the midst of overt and covert battles between agencies.
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Assuming that the treatment team can reach some consensus on the needs of the child, there is still the question of whether treatment resources that are geared for deaf children are even available. They usually are not. This frequently leads to a "merry-go-round" of trying to locate a treatment program that is willing to take the child and giving the program staff a crash course in working with deaf kids. Then the various referring agencies will begin bickering over who is responsible for the interpreters. Since no agency wants to assume this cost, interpreters are often not used at all. Because they lack knowledge and experience with deafness, the treatment program will struggle to make the environment accessible with appropriate visual signal alert systems, and modify treatment protocols to make them more appropriate for deaf children. The net result is that the child receives little benefit from the program. It might be postulated that any improvement or benefit derived from the "treatment" owes more to "incarceration therapy" than to any active therapeutic alliance.

Such dismal outcomes have special education administrators and state mental health authorities scrambling for solutions. The local education agency often sees the state school for the deaf as the "front-line defense" for deaf children with emotional or behavioral concerns. Many state schools, however, are uncomfortable with this role, asserting that they are a school in which the children happen to be deaf. This article does not debate the merits of this assertion. The reality is that in most states a high percentage of the children on the campuses of state schools for the deaf do, in fact, need psychological or counseling support. According to the Student Support Services Office at MSD, approximately 30% of the students there need such support. (A. Ensor, personal communication, January 18, 1995). This number is consistent with the trend developing across the country in which the most needy deaf children gravitate toward the state schools. This reality led the Missouri School for the Deaf to enter a dialog with the Missouri Department of Mental Health's Office of Deaf Services about how best to provide support for deaf children who are emotionally or behaviorally disturbed.

Program Development and Design

The two agencies conducted a joint survey and identified 32 children in Missouri between the ages of 8 and 21 who met some of the diagnostic criteria for "severely emotionally disturbed" (SED) and who were also Deaf. Several of these children were already in residence at MSD. The rest were scattered throughout the state, entirely at the mercy
of a social service system that had no programming or expertise in services for deaf children. The social service system (DFS, DYS, MRDD, CPS) has desperately tried to get these isolated and difficult to treat children admitted to MSD. MSD has been reluctant to accept these children because MSD felt it did not have the staffing or the expertise to provide appropriate services.

In an attempt to address the needs of these children a meeting of representatives from MSD, the Department of Mental Health, and the Division of Family Services was held to discuss program options. The Division of Youth Services declined to participate.

A sub-group of this committee then developed a plan for a traditional residential treatment program model with links to MSD for education. The project proposed blended funding from DMH, DFS, and DESE. Though DMH and DESE committed to funding part of the program, DFS declined to participate. Neither DMH nor DESE were willing to pick up the cost without active participation from DFS because a majority of the children identified in the survey were under DFS supervision in some form. Here the matter died. MSD was unable to expand their educational role without significant funding from DESE. DMH was unable to assume the entire cost of residential treatment programming. Different versions of the proposal were presented over the next several months but all were rejected for various reasons. The burden of taking care of SED deaf children again fell almost entirely on the shoulders of MSD, in spite of their justified concerns regarding the lack of resources for treating SED deaf children.

In some places the state-supported schools for the deaf have embraced the mission of serving SED deaf children and have worked cooperatively with other agencies to establish exemplary programs. An example of this is the PRYDE program at the Western Pennsylvania School for the Deaf (WPSD). This collaborative project, jointly run by WPSD and the Pressley Ridge Schools, has multiple treatment modalities centered on the campus of the school. Children in need of support can receive it either through: “out-patient” counseling, on-site residential in-patient treatment, off campus transition home, or community based residential options. The off-campus options stress using treatment foster homes.

It was clear that establishing a stand-alone treatment facility was not an option. MSD clearly could not function as a residential treatment center without significantly enhancing their staff with outside resources. Funding to do this was not readily available. There was, however, a program currently being run in DMH that was very similar to what the
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PRYDE program was doing with its treatment foster homes. We elected to try utilizing Missouri’s Treatment Family Homes program as an alternative to a structured residential treatment unit on the campus of MSD.

Treatment Homes: An Overview

Treatment Homes are families that are recruited to take a severely emotionally disturbed child in their home for treatment. Though they may have experienced abuse and/or neglect in their lives, children are placed in these homes for treatment rather than custodial purposes. Treatment Parents receive forty hours of training in subjects ranging from medication management to positive discipline. Treatment Homes participate as members of an interdisciplinary professional team, that may include therapists, schoolteachers, natural family members, juvenile officers, and case managers. The program attempts to use non-traditional types of resources that are able to address a variety of areas in a child’s life. These resources are often community based and reflect the individual child’s particular needs. The program depends on the input and perspective of all team members. Team members meet on a monthly basis to refine treatment plans and give the child feedback on progress in the treatment program. The Treatment Family philosophy is to focus on a child’s internal as well as external assets to replace problem behaviors with positive behaviors (Stroul, 1989).

The Deaf Treatment Family Homes project takes the same structure and philosophy of the general program and adds a component that calls for Treatment Family Home parents to have fluent signing skills. Other minor modifications in the training process are made to reinforce the focus on Deaf children. There was one significant program modification. A bed rock foundation of the treatment family homes concept is that the child is transitioned back to the home community as soon as possible (Stroul, 1989). In the Deaf Treatment Family Home project transitioning back to the “community” usually means transitioning in the campus community of MSD.

Serious work on the project began in March 1997 when representatives from MSD and DMH traveled to the Western Pennsylvania School for the Deaf to observe and interview the staff of the PRYDE program. Based on what was learned there, a memorandum of agreement between DMH and MSD was developed. DMH would be responsible for training Treatment Families as well as paying for placements and providing support services. MSD agreed to provide staff for case management and
crisis intervention. Initial placements were to come from students already attending the school and additional children could be placed in the program in from other parts of the state after the first year.

It was felt that the Deaf Treatment Family parents should be recruited from within the local Deaf community to the extent possible. At the very least, homes that were accepted for this project needed to have parents that were fluent in American Sign Language. Communication is a fundamental part of the therapeutic process and it made no sense to use treatment families who were not able to communicate with the children placed in the homes. Nor did it make sense to attempt to give “crash courses” in sign language, because such treatment parents would not become conversant to the extent needed to implement program components with such a limited exposure to ASL.

In considering the use of Deaf and ASL competent homes as Deaf Treatment Family Homes, there was a realization of the unique aspects of Deaf Culture posed significant strengths as well as systems obstacles to the treatment of deaf children. For example, though communication was significantly enhanced between the children and the Treatment Family Homes parents, communication with the hearing professionals in the system who do not sign was a barrier. Empathy between the Treatment Family Homes parents and the children has been very high and de-escalating most crises proved to be not overly difficult. When assistance was required, however, the Treatment Family Home parents who were deaf had a challenge trying to contain the crisis while dealing with a TTY call to the crisis intervention team. Unlike hearing treatment family parents, our deaf parents could not simply hit speed dial on a speakerphone. Handling crisis intervention services had to be carefully planned out in advance. A pre-meeting checklist was created to assure that the Treatment Family Homes program staff did not forget things like hiring an interpreter.

The initial task in program development was to recruit potential families. This was, perhaps, the simplest task we faced. Two orientation meetings were held, one at the school for the deaf and another at a community library. As a result of these meetings, a group of four families, three deaf and one hearing, whose mother and daughter were fluent in ASL, signed up for the training. The tendency for news to spread rapidly through the Deaf community definitely contributed in recruiting efforts. Of the original four families, all managed to complete the training and attain licensure as treatment homes. According in internal studies at the treatment family homes project at the Mid-Missouri Mental Health Center, 50% of the hearing families that start the training drop out.
Training the Deaf Treatment Families

Training consisted largely of value-based information that required discussion and input from participants. Due to the participants’ familiarity with each other, as well as the tendency for deaf people to communicate more directly on important issues, the discussions in class were lively and pertinent. The instructors had little experience with Deaf culture. They received assistance and consultation from the Office of Deaf Services, but a large part of the class involved educating the instructors on deafness. Information presented was discussed by the class from their perspectives as Deaf people. Class evaluations indicated that the trainees felt that they were involved and interested in the discussions. Some classes taught by instructors outside of the Treatment Family Homes project, such as CPR and first aid, were more difficult because the instructors were inexperienced in teaching deaf people. Specialists from ODS taught a few sessions. The bulk of training, emphasized discussion that allowed the group to contribute from their own experiences. As a result of this approach, a few units in the curriculum, written originally for training the hearing Treatment Family Homes recruits, needed more than minor modification to make them appropriate for the Deaf Treatment Family program. One example of such modification made by the instructor was bringing in a specialist to discuss in depth how deaf children in hearing homes might experience abuse and neglect. Another example was modifying the curriculum to deal with "I" messages and how to make them work in American Sign Language. For the most part, these modifications occurred as a result of interactive discussion between the treatment parents and the instructors.

There are eight modules or units in Missouri's training program. The Deaf Treatment Family Homes Program units were taught in sessions spanning a total of 40 hours of instruction over eight weeks.

Table 1. Missouri’s Curriculum for Deaf Treatment Family Homes Program

<table>
<thead>
<tr>
<th>Unit I Orientation:</th>
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<tbody>
<tr>
<td>Session I: Introduction</td>
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<tr>
<td>Session II: Foster Family Care Key Components</td>
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<tr>
<td>Session III: Foster Parent Job Description</td>
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<tr>
<td>Session IV: Impact of Placement on the Foster Family</td>
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</tbody>
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Session V: Licensure* (Addition of adaptive equipment needed to comply with licensure requirements.)

Unit II Human Development and Child Diagnosis
Session I: Child Growth and Development* (Brief discussion on congenital syndromes related to deafness.)
Session II: Common Childhood Diagnosis

Unit III: Child Abuse, Reasons Children Act Out, Communication
Session I: Child Abuse and Neglect* (Addition of discussion on linguistically impoverished environments.)
Session II: Reason Children Act Out
Session III: Describing Behavior
Session IV: Communication, Praise, and Rationales* (Addition of communication issues specific to deafness, i.e., how to communicate concepts foreign to ASL.)
Session V: "I" Messages, Components for Positive Communication.

Unit IV: Behavior Management and Discipline
Session I: Positive Approach to Discipline
Session II: Motivation, Rewards, and Consequences
Session III: Power Struggles
Session IV: Setting Rules and Goals for Better Behavior
Session V: Controlling Behaviors
Session VI: Conflict Resolution

Unit V: Special Problems and Pre-Behaviors
Session I: Handling Challenging Behaviors/Situations
Session II: Effective Teaching
Session III: Counseling
Session IV: Suicide Recognition and Prevention
Session V: Health and Medication Management

Unit VI: De-escalation Techniques
Session I: Helping the Child Who is Out of Control
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Session II: Self-Concept As It Relates to Out of Control Behavior
Session III: Verbal De-escalation Techniques

Unit VII: Professional Treatment, Foster Parenting
Session I: Professionalism
Session II: Working with Schools* (Addition of discussion on working with the state school for the deaf.)

Unit VIII: Placement
Session I: Children and Their Families: Supporting the Relationship* (Addition of discussion on helping biological parents understand communication issues.)

The sessions marked with an asterisk were modified to include issues specifically related to deaf children. Because the program is evolving, we will make additional modifications based on what we have learned from the Deaf Treatment Family Home parents.

Implementing the Deaf Treatment Family Program

After completing the training, each Deaf Treatment Family Home was required to be licensed by DMH as a treatment foster home. ODS worked with the Office of Quality Improvement in DMH to be sure that the homes had appropriate adaptive equipment and that their internal operating policies, which were required for licensure, were appropriate for deaf children.

Upon licensure, the Deaf Treatment Families were included in the monthly support meetings for all treatment families. There was concern about how well deaf and hearing groups would mix. The addition of deaf parents in these meetings, however, was soon seen as an asset by hearing families. Deaf parents were able to give fresh, stimulating input as well as a hands-on lesson in cultural diversity. Hearing treatment parents where able to contribute the benefit of experience in working with SED children. Activities, such as an annual picnic, have contributed to the integration of the group.

Children are assigned to Deaf Treatment Family homes based on a number of factors. These factors include the nature of the problems the child is presenting and the experience and comfort level of the Deaf
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Treatment Family in dealing with those problems. The gender and age preference of the Deaf Treatment Family is considered because some families have other children in the home.

After placement the children go through a period of adjustment with frequent contacts with the Deaf Treatment Family Home staff. Gradually, as problem behaviors become controlled, these contacts taper off. The case manager remains on call for crisis intervention and the Mid-Missouri Mental Health Center is prepared to admit immediately a child who is unable to maintain in the Deaf Treatment Family Home. While very rare, hospitalization for the purpose of stabilizing extreme out of control behavior is one of the available intervention options. In most cases the Deaf Treatment Family parents are able to de-escalate crisis situations with support from the Deaf Treatment Family Homes staff.

The Treatment Family parents provide stability, consistency and structure to the child. They provide clear behavior and linguistic role models. They model appropriate problem solving and negotiation skills. They teach how to use leisure time. In short, they attempt to make the child a normal part of the family.

Treatment Families As a Community Resource

The Deaf Treatment Families were highly motivated by the concept of the Deaf community helping deaf children. The Deaf community has often seen services provided by well intentioned, but misguided hearing providers, and is very accepting of the idea of helping deaf children. By serving as important members of the treatment team, Deaf Treatment Family parents become valuable resources in several different ways.

Deaf Treatment Family parents can relate to deaf children in ways that hearing providers cannot. They increase pride and self esteem by giving children healthy deaf role models (Bat-Chava, 1993; Marschark, 1993). They also demonstrate to hearing parents and professionals that deaf people can function in roles of authority. Deaf Treatment Families can provide children of hearing parents a valuable link into the Deaf community. In almost all the placements into Deaf Treatment Family Homes, it has been observed that signing skills of the deaf children have improved along with their behavior. It appears that as communication skills improve, other skills such as social, recreational, and problem solving will also show improvement. This would be a fruitful area for research.
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Program Barriers and Obstacles

One of the major barriers of this program (and indeed the PRYDE program at WPSD) was, and continues to be, the divergent perspectives of the Deaf Treatment Family Homes staff and the school staff. Most institutions have traditions and beliefs that have slowly evolved and have become a part of the institution's internal culture. Some staff view any type of change as a threat to this tradition. Programs implemented by entities outside of the institution are particularly suspect. Program facilitators, both inside MSD and with the Deaf Treatment Family Homes program had the challenge of convincing teachers and dormitory staff at MSD of accepting the job of working with severely emotionally disturbed youths through this new program.

Resistance from staff who felt unprepared was anticipated. The Deaf Treatment Family Homes program administrator from DMH provided some hands on training to the staff and made himself available for consultation when requested. This gave needed information to staff and also allowed a positive relationship to begin to develop between the two agencies. This relationship continues to evolve.

Teachers and dormitory staff are invited to treatment planning meetings because they often have more insight and knowledge of a child’s motivations than traditional service providers such as psychologists and social workers. By actively participating on the treatment teams, the staff also becomes more invested in the program. The hope is that school staff will view this program as an asset, although fostering this view continues to be a challenge for the DMH program staff.

DMH has also provided more of the case management than originally proposed. The school staff felt a need for additional support in running treatment teams.

Of course, in developing a program such as this, there are often elements that are overlooked. One such element is the need for auxiliary services. Due to the structure of the interagency agreement, there are no funds available for interventions outside of placement in a Treatment Family Home. These funds are referred to as “wrap-around” funds because they may be used to address any area of a child’s life, and are not the typical types of therapy provided by mental health. An example of “wrap-around” is providing swimming lessons as a way to increase a child’s recreation interests. These types of interventions can be an important part of the child’s treatment plan. “Wrap-around” funds can also be used to pay for mentors, community aides, and family assistance.
workers. The services that these individuals may provide range from transporting children, to teaching parenting skills to natural parents, to after school tutoring. These funds should also be utilized for a child who is in residence at MSD but does not require placement in a Deaf Treatment Family Home. Such early intervention and treatment could help avoid future placement in the more restrictive Deaf Treatment Family homes. The Deaf Treatment Family Home program is structured in such a way that MSD becomes the "mental health center" and because wrap-around funds were available only to case managers through the "official" administrative agents, the program was effectively locked out from this resource. This has limited therapeutic options.

Using the MSD as the main referral agency had its drawbacks also. Referrals were limited to children that have had behavioral difficulties in the classroom or dormitory. Children that have difficulties at home or have less overt emotional problems may be overlooked by the current referral system.

Though the Deaf Treatment Family Home program should be at the stage where students from outside MSD are accepted, changes in program administration on the DMH side has slowed down this process. In addition, DMH has not always been able to move children who are not MSD students into treatment homes, because one of the original criteria for admission was that the child already be enrolled in MSD. This means that a significant number of children who would benefit from the project have not been able to access it.

Some referrals have also been inappropriate for mental health placement. Children who display conduct problems, such as theft or aggression towards peers, do not always qualify as being severely emotionally disturbed. Unfortunately, the juvenile justice system in Missouri is unprepared and unable to address the needs of these children. The school, with few other choices, has tried to use Treatment Homes as an alternative to more appropriate actions for legal offenses. Of course, with time and experience, the program staff will gain a better understanding of the nature of emotional disturbances. With this knowledge, it is expected that both the number and appropriateness of referrals will increase.

Outcomes

There have been seven full-time placements made in the 24 months the program has been operational. There are usually two kids in
placement at any given time and the other homes are used as respite. Of the seven kids, two have been girls and five boys. They have ranged in age from 11 to 18. The average length of stay has been nine months. This usually coincides with the normal school year, although both girls and two of the boys have stayed with treatment parents during the summer months.

Successful completion of the Deaf Treatment Family Homes program has traditionally been defined as transitioning back into the regular school program and dormitory. By contrast, successful completion for the hearing treatment homes is transition back to the biological family. Of the eight kids in the program three are currently in treatment with Deaf Treatment Families. The youngest girl came to the program with a number of neglect and failure to thrive issues. She had been taken from her mother and had been placed in several foster homes. She was placed in the Deaf Treatment Family Home program in the Fall of 1998, and has made tremendous progress. She has been reunited with her biological mother for the weekends and is functioning reasonably well in the dormitory program at MSD during the week.

The oldest girl, who was the first kid placed in the program, had a history of sexual acting out and aggression. She was suspended from school numerous times and was involuntarily hospitalized three times in 18 months. She stayed in a Deaf Treatment Family Home for approximately nine months and was transitioned back to the dormitory program. Though she still has episodes of aggression, they are considered manageable and she has not been suspended since she entered the program. She graduated from MSD this Spring and is hoping to enter college.

The first boy accepted into the program was a 14 year old boy with a conduct disorder diagnosis. Considered incorrigible by his local school district, he was sent to MSD. Unable to maintain in the dormitory and facing several criminal charges, he was presented with an option of going into the Deaf Treatment Family Home program or going to a DYS detention facility. He stayed in the program for nine months and then withdrew from MSD to enter a mainstream program in St. Louis. This Spring he posted a straight A average in his mainstream school in St. Louis and is planning to enter college when he graduates.

One boy was referred to the program when his parents, who lived near the school, decided they could no longer put up with his behavior. He did fine in the program, but his transition back home has been rocky. The family has not changed how they interact with the child in the home. It is important that the biological family be willing to work with the
program staff and make adjustments in communication strategies, how discipline and boundary setting is handled, and how siblings relate to each other in the biological home if the goal is to transition back there.

One 15 year old boy with borderline personality disorder has been treated in a Deaf Treatment Family Home for six months and was then reintegrated back into the dormitory at MSD. He continues to go to the Deaf Treatment Family Homes on weekends. He can maintain with a high level of structure, something that most dormitory programs are unable to provide during the weekends.

Two boys are currently in treatment, both in middle school, both from families unable to maintain control of their behavior.

**Next Steps**

Two years into the project, changes to the program are now being considered to address identified weaknesses. The area mental health facility needs to take more control and ownership of the system. The mental health agency is currently planning on hiring a full time case manager, fluent in ASL. Children referred will become clients of Mid-Missouri Mental Health Center, and receive enhanced services through that agency. The Missouri School for the Deaf will continue to work in partnership with the program, but the primary administration and clinical planning will be provided by DMH. MSD will consult, provide education, and contribute to treatment planning for DMH without needing to handle case management. By making this change the Deaf Treatment Family Homes program will be able to access funds for “wrap-around” services.

There is a need to expand the program into other geographic areas, especially areas that have consolidated regional programs for deaf children. In Missouri, this means St. Louis and Kansas City. To make this expansion will require a mobile case manager and resources for training.

There is a large untapped resource of deaf individuals that are interested in serving their community as Treatment Parents, aides, and mentors throughout the state. These individuals could provide valuable services for youths at risk as well as auxiliary services for the children already placed in the Deaf Treatment Family Homes. The use of modern technology, such as tele-psychiatry for education, and experienced Treatment Parents as trainers could prepare these individuals to work with emotionally disturbed children. A case manager that could provide...
treatment planning in different parts of the state could justify and direct these efforts.

Conclusion

The Treatment Family Program with Missouri School for the Deaf has been a positive step in enhancing services for deaf children in Missouri. The relationship between the school and the Department of Mental Health has progressed, benefiting both agencies. Children are able to access some clinical services that are provided by people who are fluent in American Sign Language. It represents an attempt to jointly meet the needs of a vulnerable population.

The overall philosophy of the Deaf Treatment Family Program recognizes that the Deaf community has the greatest knowledge of what issues face their most vulnerable members. They also have greatest commitment and most motivation for helping those children. The breakdown of local communities in this country has contributed to the increase of emotional and behavioral problems of youths. The Deaf community has the advantage of being much more cohesive than the general community. To ignore this asset and to depend on the traditional system of the hearing providing services to the deaf is not only inefficient, but also disrespectful to the individuals being served.

References


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