



Missouri Department of Mental Health Practice Guidelines for Children / Youth Who Are Deaf

The following are identified as practice guidelines to assist clinicians and community mental health centers, which are contracted with the Missouri Department of Mental Health, when working with children and youth who are deaf or hard of hearing (DHH).

UNDERSTANDING PREVALENCE AND RISK

1. Individuals should understand the cultural and linguistic characteristics of DHH children.

Children who are DHH have a psychosocial impact from the hearing loss. Starting at birth and early childhood, attachments and bonds are typically created through relationships, communication of needs and responsiveness to communicated needs. Experiencing barriers to communication with primary caregivers can lead to deficits in language development, problem solving, coping and mastery skills and may negatively impact the development of resilience.

2. Individuals should understand the association between DHH and mental illness, developmental delays and/or substance use.

The cause of DHH can also impact other neurological development which may place the individual at higher risk for cognitive or language delays, and lead to problems with attention, concentration or impulse control. On the flip side of this, children who are DHH may erroneously be diagnosed with a developmental delay or thought disorder due to the impact on their ability to clearly communicate.

3. DHH Children's communication skills place them at higher risk for poor frustration tolerance, poor social skills, poor self-image and the inability to communicate needs for safety.

All of these issues lead to children who often fall behind in school and socially, and in the most serious circumstances are easy targets for physical, emotional and sexual abuse. Due to language barriers, studies show that deaf children are two to three times more at risk for sexual abuse than the general population. Language barriers are also correlated with higher rates of aggression, low self-esteem, and little ability to develop meaningful bonds with peers and adults. The trauma experienced by DHH children places them at high risk for poor social and health outcomes.

UNDERSTANDING CULTURE AND ENVIRONMENT

4. To understand a DHH child, the clinician must understand the family environment.

Many parents/family members of deaf children do not learn a formal mechanism to communicate with their child such as American Sign Language or Signing Exact English. More informal and idiosyncratic means of communication are then developed. A lack of linguistic communication may lead to the more frequent use of physical discipline. Inadequate verbal

communication can impact the child's ability to relate cause and effect or to solve problems. Learning to master their environment may also be challenging and result in what may be viewed as more dependent or anti-social behaviors.

5. DHH children may view themselves as different and unfortunately at times view themselves as damaged.

The child's acceptance within their family and educational and social environments has a strong impact on their self-esteem and self-image.

6. DHH children may have limited social opportunities creating more isolation.

If there are no adapted peer and social activities for DHH children, the child will not have the experiences to allow them to develop social skills and personal negotiation skills.

7. DHH children have a high rate of traumatic experiences.

This may start by a lack of support and communication within their family, followed by similar deficiencies in their social and educational environments. As noted above, they may also experience excessive use of physical discipline or possibly physical abuse, and become targets for sexual predators who may believe the DHH child cannot report the abuse.

SCREENING AND ASSESSMENT

8. Eligibility for services with DMH for a DHH child must take into account behavioral and social abilities that may mimic mental illness.

The DMH's eligibility for psychiatric services and developmental disability services requires a child to meet the criteria as having a serious emotional disorder which impacts two or more areas of their functioning or has a physical or mental disorder, other than mental illness, that causes two areas of functional limitation. Children with DHH may display social and behavioral delays related to their hearing impairment that may impact their functioning and/or mimic a mental illness or developmental disorders. It may be difficult to tease out what is causing the functional impairments but may need to identify if and what a mental health or habilitative intervention can do to address the functional impairment.

9. There are limited screening and assessment tools validated with a DHH population.

In making a mental health or developmental disability diagnosis for a DHH child the clinician must consider both false negative and false positive conclusions. Without a developed language system and/or the use of ASL or other sign languages some behaviors may be erroneously labeled as a psychiatric symptom or developmental disorder. Being able to differentiate a language system that is impacted by DHH rather than an underlying mental illness or developmental disorder can be difficult. As concerning as it is to label someone as having a mental illness or a developmental disorder when they don't, not diagnosing a person with a mental illness can prevent access to needed treatment services. Additionally, completing a mental status examination often relies on abstract concepts that a DHH child may not have developed due a lack of a formal language system. Similarly, severe delays in language development may make it very difficult to determine a child's intellectual abilities and the presence of learning disabilities. Judgments related to thought processes are often inferred

based on language content, processes and rate. Not having direct communication between the DHH child and clinician can impact the accuracy of any assessment.

Clinicians should keep in mind that the prevalence of mental illness in the deaf community is about the same as the hearing community. The exception to this is in Axis II diagnoses and *childhood behavioral problems* which are from three to six times more prevalent in the DHH population. In addition, approximately 9% of children with hearing loss also have learning disabilities and 8% have intellectual disabilities.

10. Selecting a screening/assessment tool

If using a formal assessment tool, the clinician should determine whether it has been validated or adapted for the DHH population. If modifications are made while using the tool to assess a child who is DHH, the clinician should note the modifications as well as the impact it might have on the results. Tools that are non-verbal or language reduced are typically most appropriate for DHH children.

TREATMENT SERVICES AND INTERVENTIONS

11. Have the DHH child accompanied by an individual that knows them and they are comfortable with for the first few sessions.

This can help in establishing rapport and learning typical ways the youth may communicate by observing the interaction.

12. The mental health professional needs to be aware of the child's mode of communication and have this mechanism available throughout their interaction with the child.

Different modes of communication can be: including an approved interpreter, picture boards, communication booklets or electronic devices. It may also be through idiosyncratic use of sounds and gestures. Misunderstanding is likely even with good interpreters. The mental health professional must frequently check for the child's comprehension as well as confirming the professionals understanding of the child's communication.

The National Association of the Deaf position statement on Mental Health Services for Deaf People recognizes American Sign Language (ASL) as 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.