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**STATE OF MAINE
121st LEGISLATURE
FIRST REGULAR SESSION**

**Final Report
of the
Task Force to Study the Needs of Deaf and Hard
of Hearing Children and Adolescents**

February 2004

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Executive Summary

The Task Force to Study the Needs of Deaf and Hard of Hearing Children and Adolescents (“Task Force”) was established in the First Regular Session of the 121st Legislature by Public Law, 2003, Chapter 84. The Task Force was created to examine the behavioral, developmental, social, emotional and educational needs of deaf and hard-of-hearing children and adolescents who are not receiving adequate services because of a lack of appropriate resources in the State. As created, the 18-member Task Force¹ included four Legislators, four State agency officials representing the Department of Behavioral and Developmental Services, the Department of Education, the Department of Human Services, and the Department of Labor, five mental health service providers experienced in serving both hearing and deaf and hard-of-hearing children, three educators representing public schools and the Governor Baxter School for the Deaf, one advocate for deaf students in special education proceedings and one parent of a hard-of-hearing child.

The Task Force was convened on November 22, 2003 and held three additional meetings. Task Force members received program information and data regarding the provision of behavioral and mental health services to deaf and hard-of-hearing children and adolescents from State agency officials and social service providers responsible for mental health, child protection, education and early identification and intervention services.

The Task Force made nineteen recommendations to address the duties delegated to it by the 121st Legislature. These recommendations intend to address the following key problems:

- The significant mental health needs of Maine’s deaf and hard-of-hearing youth go undiagnosed, untreated, and over time evolve into more severe problems requiring more intensive and expensive interventions.
- The availability of mental health professionals capable of communicating directly with deaf and hard-of-hearing youth and knowledgeable in cultural issues impacting this population is extremely limited.
- Existing community based and institution based mental health services and programs serve “hearing” youth but these organizations and models are not able to successfully serve deaf and hard-of-hearing youth.
- These so-called “hearing” agencies attempt to serve deaf and hard-of hearing youth by simply involving interpreters in the treatment program, which has limited clinical effectiveness and is costly.

¹ Task Force appointees Senator Betty Lou Mitchell and Jeannie Shacker were unable to participate in any Task Force meetings

The Task Force presents its recommendations in three phases to be implemented over a period of several years as economic conditions improve. The intent of the recommendations is to provide the steps necessary to develop a comprehensive system of “linguistically accessible” and “mpetent” mental health services as quickly as possible.

Phase 1

Newborn Hearing Screening Initiative

Recommendation #1: The Task Force recommends that the Department of Human Service’s Newborn Hearing Screening Initiative develop and disseminate resource materials to parents with children that have been identified as having an audiological condition that includes information regarding how to access mental health services in order to assist families in coping with having a child with a hearing loss.

Recommendation #2: The Task Force recommends that the State continue to fund the Department of Human Service’s Newborn Hearing Screening Initiative once federal funding ends in June 2005. *The Task Force further recommends that legislation be introduced to implement this recommendation.*

Data Collection

Recommendation #3: The Task Force recommends that the Department of Behavioral and Developmental Services, the Department of Human Services, the Department of Education and the Department of Corrections convene a working group to identify ways to develop data collection resources across agencies, including but not limited to the creation of a cross-agency data system to identify and track deaf and hard-of-hearing children and adolescents. *The Task Force further recommends that legislation be introduced to implement this recommendation.*

Recommendation #4: The Task Force recommends that the Legislature’s Office of Fiscal and Program Review conduct an audit of State agency programs to determine State expenditures on services for deaf and hard-of-hearing children and adolescents. *The Task Force further recommends that legislation be introduced to implement this recommendation.*

Training

Recommendation #5: The Task Force recommends that Maine’s postsecondary education institutions collaborate with professionals skilled and knowledgeable in deafness to develop deaf specialization tracks within existing two and four year post-secondary education programs in the State, including programs in social work, mental health counseling, case management training, and other social services.

Recommendation #6: The Task Force recommends that existing social service providers and agencies, including but not limited to, the Muskie School of Public Service, the Sweetser Training

Institute, and the Behavioral Health Sciences Institute develop deaf training modules and integrate them into existing training programs for all workers, including training programs for Child Protective Services workers in the Department of Human Services and contracted service providers in the Department of Behavioral and Developmental Services.

Waivers

Recommendation #7: The Task Force recommends that the Department of Behavioral and Developmental Services convene a working group with “signing” mental health providers to develop a process for creating waivers and/or modifications in degree and education requirements and/or parallel requirements to allow deaf individuals to work as mental health resources (“paraprofessional”) within communities. *The Task Force further recommends that legislation be introduced to implement this recommendation.*

Recommendation #8: The Task Force recommends that the Department of Education convene a working group to develop a process for creating waivers and/or modifications in degree and education requirements and/or parallel qualifications to allow deaf individuals to work as education resources (“paraprofessional”) within Maine schools. *The Task Force further recommends that legislation be introduced to implement this recommendation. A minority report was filed by one Task Force member regarding this recommendation and is attached as Appendix G).*

Modifying the Role of Interpreters

Recommendation #9: The Task Force recommends that the Department of Behavioral and Developmental Services convene a working group with professional interpreter groups to identify ways to modify current ethical and professional standards for interpreters to allow them to function as part of a therapeutic treatment team. The working group should also develop recommendations on the new Registry of Interpreters for the Deaf (RID)/National Association of the Deaf (NAD) proposed Code of Ethics for interpreters. *The Task Force further recommends that legislation be introduced to implement this recommendation.*

Recommendation #10: The Task Force recommends that the University of Southern Maine develop a mental health specialization within its interpreter training program to enable those in training to become certified interpreters to develop the necessary mental health skills to function more effectively in mental health settings.

Baxter Outreach Partnerships

Recommendation #11: The Task Force recommends that the Governor Baxter School for the Deaf (GBSD) convene a working group with mental health providers skilled and knowledgeable in deafness to discuss the opportunities for partnership regarding the provision of outreach services including:

- Developing a mechanism to “red flag” children being served by educational outreach workers and to provide follow-up assessment and intervention services to families and schools; and
- Pairing mental health workers with educational outreach workers in order to incorporate a mental health component to outreach services.

The Task Force further recommends that legislation be introduced to implement this recommendation.

Improving Geographic Accessibility to Services

Recommendation #12: The Task Force recommends that the Department of Behavioral and Developmental Services reallocate existing resources within the department to furnish BDS Children and Youth Services with the funds necessary to provide case management services to deaf and hard-of-hearing children and adolescents in Region 3. *The Task Force further recommends that legislation be introduced to implement this recommendation.*

Utilization of Technology

Recommendation #13: The Task Force recommends that Maine’s telemedicine and distance learning networks be utilized to provide access to mental health professionals that are only available in population centers. The network should be utilized to provide the following: psychiatric assessments, medication reviews, crisis intervention/assessment, psychological services, family therapy, clinical consultation, clinical team management, and assessment.

Children and Family Community Support Services

Recommendation #14: The Task Force recommends that State agencies and social service providers develop a community support program as defined in the MaineCare Benefits Manual, Chapter II, Mental Health Services, Section 65 G of MaineCare regulations to provide intensive support to deaf and hard-of-hearing children and families in their homes, communities and social environments that is culturally and linguistically appropriate. (See Appendix F for an outline of this proposal)

Department of Human Services (DHS)/Department of Behavioral and Developmental Services (BDS) Merger

Recommendation #15: The Task Force recommends that the DHS/BDS Unification Advisory Council consider the staff impact of the recommendations of this report when developing its final plan for the merger of the Department of Human Services and the Department of Behavioral and Developmental Services. The Office of Deaf Services in the Department of Behavioral and Developmental Services should be expanded and strategically located so as to impact across all branches and functions of the new department. *The Task Force further recommends that legislation be introduced to implement this recommendation.*

Recommendation #16: The Task Force recommends that the DHS/BDS Unification Advisory Council include the creation of a special job category or an addition to an existing position that would require at least one staff person in each district office to be conversant in American Sign Language and knowledgeable of deaf culture. *The Task Force further recommends that legislation be introduced to implement this recommendation.*

Out of State Placements

Recommendation #17: The Task Force recommends that the Department of Education, the Department of Human Services and the Department of Behavioral and Developmental Services convene a working group with key out-of-state treatment providers to improve the current process for out-of-state placements. The working group should develop a plan to streamline the process for referral and payment for out-of-state residential treatment placements and develop a plan to create transition and “step down” services to assist providers with reintegrating children back into their homes, schools and communities. *The Task Force further recommends that legislation be introduced to implement this recommendation.*

Phase II

Continuation of the Task Force

Recommendation #18: The Task Force recommends that the Legislature authorize the continuation of the Task Force to Study the Needs of Deaf and Hard of Hearing Children and Adolescents and expand its membership to include additional state agency representatives,

consumer representatives and other key stakeholders. The duties of the Task Force should include but are not limited to the following:

- Developing a comprehensive service delivery model;
- Examining the issue of waivers and parallel qualifications for deaf individuals;
- Examining mechanisms to utilize and access distance technology to provide deaf and hard-of-hearing children and families access to culturally competent, linguistically accessible mental health service providers;
- Examining ways to strengthen collaborative agreements with other states;
- Identifying opportunities for partnerships between providers and agencies within and outside the state; and
- Serving in an advisory capacity to the Department of Human Services/Department of Behavioral and Developmental Services Unification Advisory Council.

The Task Force further recommends that legislation should be introduced to implement this recommendation.

Phase III

Developing In-State Specialty Services

Recommendation #19: The Task Force recommends that the State should identify organizations and providers along the treatment continuum that are willing to develop and maintain treatment programs and models appropriate for deaf and hard-of-hearing children that provide services including but not limited to the following:

- Mentors;
- Bridge services;
- Behavior management specialists;
- Transition services (“School to work”); moving children successfully from more restrictive to less restrictive settings;
- Mobile assessment and intervention services;
- Treatment foster care;
- Family-to-family programs;
- Experiential education programs;
- Experiential vocational training for transition age youth;
- Specialized case management;
- Day treatment programs;
- Acute, short-term in-patient psychiatric services; and
- Mentor families for non-local students in day treatment program.

I. INTRODUCTION

The Task Force to Study the Needs of Deaf and Hard of Hearing Children and Adolescents (“Task Force”) was established during the First Regular Session of the 121st Legislature by Public Law 2003, Chapter 84. A copy of the law is attached as **Appendix A**. As created, the 18-member Task Force included four Legislators, four State agency officials representing the Department of Behavioral and Developmental Services, the Department of Education, the Department of Human Services, and the Department of Labor, five mental health service providers experienced in serving both hearing and deaf and hard-of-hearing children, three educators representing public schools and the Governor Baxter School for the Deaf, one advocate for deaf students in special education proceedings and one parent of a hard-of-hearing child. The Task Force membership roster is listed in **Appendix B**.

The Task Force was established to examine the behavioral, developmental, social, emotional and educational needs of deaf and hard-of-hearing children and adolescents who are not receiving adequate services because of a lack of appropriate resources in the State. The Task Force was charged with the following duties:

1. To examine services currently available to serve the needs of deaf and hard-of-hearing children and adolescents and the availability of the providers of those services to provide culturally competent, linguistically accessible services. Educational services shall be reviewed within the context of the behavioral and mental health needs of the children and adolescents;
2. To examine demographic data of the numbers of deaf and hard-of-hearing children and adolescents in need of such specialized services and projections regarding the number of deaf and hard-of-hearing younger children who may require such services in the future; and
3. To examine proposals designed to improve the delivery of services to meet the needs of deaf and hard-of-hearing children and adolescents, including but not limited to, the development of in-state specialty services, collaborative agreements with bordering states and states with specialized facilities and training initiatives.

The Task Force was convened on November 22, 2003 and held three additional meetings on the following dates: December 17, 2003; January 8, 2004; and January 14, 2004. Task Force members received program information and data regarding the provision of behavioral and mental health services to deaf and hard-of-hearing children and adolescents from State agency officials and social service providers responsible for mental health, child protection, education and early identification and intervention services. A list of presenters is attached as **Appendix C**. In addition, recognizing the extensive knowledge and experience of its collective membership, the Task Force also relied heavily on the expertise of its members in identifying and framing policy issues and developing its recommendations.

The Task Force used its first meeting to formulate a work plan and gather information regarding the current system of service delivery and data collection as well as other effective service delivery models. The Task Force invited testimony from representatives of the Department of Behavioral and Developmental Services, Community Counseling Center, Portland, Maine, the Department of Education and the Governor Baxter School for the Deaf on the following issues:

- Improving the capacity and delivery of culturally competent, linguistically accessible services to deaf and hard-of-hearing children and adolescents;
- Identifying and tracking deaf and hard-of-hearing children and adolescents in need of specialized services; and
- Strengthening in-state specialty services and collaborative efforts with other states

During its second and third meetings, the Task Force invited testimony from representatives of the Department of Behavioral and Developmental Services (BDS) and the Department of Human Services (DHS) to provide information on the current services provided by the Departments as well as the impact of the proposed DHS/BDS merger on the service delivery needs of this population.

During its third and fourth meetings, the Task Force reviewed the range of perspectives and data provided to them and discussed these findings and reached a consensus on a number of findings and recommendations for consideration by the 121st Legislature.

The enabling legislation established December 5, 2003, as the reporting date of the Task Force to the Second Regular Session of the 121st Legislature. Due to the abbreviated time period in which the Task Force had to complete its work after the November 22nd convening date, the Task Force chairs petitioned the Legislative Council for an extension of the reporting deadline and the Task Force was granted an extension until January 23, 2004. Unfortunately, the Task Force did not have adequate time to complete its work and fully address the duties charged to it under the authorizing legislation. Given these circumstances and the breadth and scope of the Legislature's charge to the Task Force, Task Force members recommend that the Legislature authorize the continuation of this Task Force to allow the Task Force to continue its work and to build upon the foundation and frameworks it has established in this report.

II. SUMMARY OF KEY FINDINGS REGARDING THE BEHAVIORAL AND MENTAL HEALTH NEEDS OF DEAF AND HARD OF HEARING CHILDREN AND ADOLESCENTS

The following sections summarize the information received by Task Force members related to the duties charged to the Task Force to study the behavioral and mental health needs of deaf and hard-of-hearing children and adolescents. The Task Force findings are presented in the following subject headings: (1) identification and tracking children and adolescents in need of specialized services; (2) the current system of “in-state” service delivery; (3) out-of-state placements for children with severe mental health needs; and (4) best methods to deliver behavioral and mental health services to deaf and hard-of-hearing children and adolescents.

1. Identifying and Tracking Children and Adolescents in Need of Specialized Services

Identifying the number of deaf and hard-of-hearing children and adolescents with additional mental health issues is problematic at best. The lack of statistics on deafness in the population makes it extremely difficult to identify both the number of deaf and hard-of-hearing children and adolescents affected by mental health issues and their specific mental health needs. National statistics estimate that 8.5% of the general population has some form of hearing loss, 10% of whom have a profound hearing loss.² Applying these estimates to Maine yields the following statistics:

- Total population of children under age 18³ = 303,654
- Number of deaf and hard-of-hearing children (8.5%) = 25,810
- Number of profoundly deaf children (10%) = 2,581
- 3% Mental illness rate in the Maine population = 774 deaf and hard-of-hearing and 77 profoundly deaf children with mental illness

While these statistics provide a general estimate, the number of deaf and hard-of-hearing children and adolescents with mental health issues in the state is unknown. State agency officials and social service providers briefed the Task Force on the challenges facing current early identification and data collection efforts in the State, including the following:

- The lack of data collection; both internal and in a coordinated, cross agency system;
- The lack of a clear distinction between the definition of deaf and hard-of-hearing; health providers are sometimes hesitant to label children with profound hearing loss as “deaf”;
- Not all deaf and hard-of-hearing children with social and emotional difficulties are served by State agencies; some children are simply struggling in mainstream programs with no

² 2002 Department of Behavioral and Developmental Services “Deaf Services: Biennial Report to Maine

³ <http://quickfacts.census.gov/qfd/states/23000.html>

psychological services or are passed as “normal” when serious deficits and disabilities do exist;

- Communication barriers and lack of capacity (too few providers with adequate training) may often result in misdiagnosis of children as developmentally delayed or learning disabled; and
- The mental health problems of deaf and hard-of-hearing children are often undiagnosed due to the lack of parent and physician awareness; and these problems are often labeled as temporary or due to the child’s lack of acceptance regarding their disability.

During the briefing, Task Force members were provided with an overview of existing early identification and data collection practices in the State:

Newborn Hearing Screening Initiative

The Newborn Hearing Screening Program is a grant-funded program created in 2000 within the Department of Human Services, Bureau of Health. The program, which is now operational in all 32 birth hospitals statewide, screens infants for hearing loss. Of the 99.9% of infants that are screened (excluding home births), approximately 400-500 fail the initial screening and 50-60 infants are subsequently identified with a hearing loss ranging from mild to profound. Approximately 10 percent of these children will become deaf. Children identified with a hearing loss are then referred to the Department of Education’s Child Development Services for early intervention services. The program tracks data on these infants in collaboration with the University of Maine “Child Link” database. In addition to tracking children through the screening and referral process, the program provides resource materials and information for families to help them cope with having a child with a hearing loss.

The program is funded by federal grants from the Centers for Disease Control and Prevention (CDCP) and the Health Resource Services Association (HRSA) that will end in June 2005. Federal grants were provided with the understanding that the State would absorb the cost of the program after its initial five years of operation, however given current budgetary constraints, there is no alternate funding source in place. Once the program loses its funding, it will cost approximately \$120,000 per year to maintain current staffing levels and keep the program operational.

The Task Force acknowledged the achievements of the program and the critical role early identification plays in preventing the misdiagnoses and the potential onset of unnecessary developmental delays in children with hearing loss. The Task Force members also emphasized the need to identify ways to maintain the Newborn Hearing Screening Program once it loses funding in June 2005.

Department of Education (DOE) Child Count

The Department of Education's Child Development Services conducts a count of public school children with disabilities on December 1st of each year. While DOE collects data on the category of deaf students, they do not collect data on deaf children that have additional mental or behavioral health problems. Because current federal law requires students with disabilities to be categorized under a "primary disability", DOE data mostly categorizes deaf children with additional mental health conditions under "multiple disabilities." Deaf children with additional disabilities can be captured under different data categories and there is currently no way to extract the total number of deaf children with additional mental and behavioral health conditions from the different data categories. Federal trends appear to be heading in the direction of collapsing data into fewer categories. DOE would need additional resources and staff to be able to fulfill new or expanded data collection and analysis requirements.

Governor Baxter School for the Deaf (GBSD) Statewide Outreach and Consulting Services

The Governor Baxter School for the Deaf (GBSD) continues to monitor and track children once they have been identified by the Newborn Screening Initiative as having a hearing loss and are enrolled in GBSD Early Childhood Intervention Services. There are approximately 450 deaf and hard-of-hearing children in Maine schools with only 3.5 full-time equivalent (FTE) GBSD consultants to provide services for this population. Testimony from program officials expressed particular concern for the 180 adolescents enrolled in grades 7 through 12 who are not included in the Department of Education's "child count" data, but who still are "at risk" children who are experiencing significant mental health issues and need intervention services.

2. Current System of "In-State" Specialty Services

The Task Force met with a panel of State agency officials and social service providers to review the scope of mental and behavioral health services available to deaf and hard-of-hearing children and adolescents and the availability of the providers of those services to provide culturally competent, linguistically accessible services. There is no data collection or tracking system and multiple points of entry for deaf and hard-of-hearing children to access mental health services as they are provided through a number of different State agencies and social service providers. Participants acknowledged the need to develop a coordinated system of care but also noted that the lack of a "critical mass" of deaf and hard-of-hearing children with mental health needs and the range of service delivery needs within this population which are dependent on geographic area, age, and level of care, make it difficult to do so. The Task Force was provided with an overview of the following agencies that serve deaf and hard-of-hearing children and adolescents.

Department of Behavioral and Developmental Services (BDS)

The Department of Behavioral and Developmental Services (BDS) provides services to children and adolescents who have a primary mental health or mental retardation diagnosis. As a result of the Risinger Settlement Agreement (a copy of the settlement agreement is attached as

Appendix D)⁴, there are two entitlements under MaineCare for the provision of BDS children's services: (1) in-home support services, including day habilitation services for children with mental retardation and autism and children's behavioral health services, for children with mental health treatment needs, and (2) targeted case management services. Approximately 2,400 children statewide receive in-home support services. As of September 2003, approximately 37 children were waiting greater than 180 days to receive in-home support services (down from 860 children waiting more than 180 days in February 2003). Under the Risinger Settlement Agreement, children are required to receive services within 180 days from the later date of becoming MaineCare (or Medicaid) eligible or requesting this service. Approximately 6,000 children receive targeted case management services. Additionally, BDS provides the following services: respite care, outpatient therapy and medication management, crisis, family support, community support, home based family services and residential services.

Children and Youth Services within the department does not have specialized deaf services, however the department contracts with Community Counseling Center (CCC) in Portland to provide mental health services to its deaf population. CCC provides case management, individual and family therapy and consultative services to deaf children and their families with a range of behavioral and mental health needs, including but not limited to psychosis, abuse and neglect, language deprivation, attention deficit disorder and social isolation. CCC currently serves approximately 55 deaf children, however case management services are only currently available in Region 1 and parts of Region 2 and are not available in Region 3.

Department of Human Services (DHS)

The Bureau of Child and Family Services within the Department of Human Services (DHS) provides child welfare services to children and parents who are deaf and hard-of-hearing. Because there is not a "critical mass" of families at any one time to warrant the need to create specialized caseloads, DHS has instead provided training to management and casework supervisors about deaf culture, resources and issues. In May and June of 2000, senior managers, program specialists and casework supervisors attended a workshop in "Culturally Appropriate Interventions for Families with Deaf/Hard of Hearing Members Interacting with the DHS System." The training was provided by Community Counseling Center in collaboration with the Department of Labor's Division of Deafness and provided an overview of deaf culture, services and resources, and issues in working with families with deaf members. Subsequent training was provided to one staff member in each District office to allow that staff person to serve as the designated "resource person" for that office. Every person that attended training also received a deaf and hard-of-hearing resources book. Follow-up training is under consideration.

Task Force members expressed concerns that given the overall lack of knowledge of deaf culture and resources by DHS staff, cases involving deaf family members entering the child protection system are more likely to experience longer lengths of stay in care, are less likely to

⁴ The Risinger Settlement Agreement is a court-approved settlement agreement reached in *Risinger v. Maine Department of Human Services* and establishes timeliness standards for the provision of in-home behavioral health services under MaineCare Manual, Chapter II, Sections 65.04-3(H) and 24.01-2, as well as for case management services under MaineCare Manual, Chapter II, Section 13.12.

achieve permanency through reunification with their natural families and are more likely to result in the termination of parental rights.

Department of Education (DOE)

Maine law requires each school administrative unit in the state to provide children with disabilities “free and appropriate education” in the “least restrictive environment” in compliance with the federal requirements of the Individuals with Disabilities Education Act (IDEA). When the needs of deaf and hard-of-hearing children cannot be met by a local school district, they may be placed in another district or in the case of children with severe mental health needs, another state upon approval from the Department of Education. For the five deaf and hard-of-hearing children that are currently placed in out-of-state facilities, the Department of Education provides funding for educational services.

The Task Force also received information regarding the Department of Education’s Child Development Services, which provides early intervention services by qualified individuals to children with disabilities ages birth to five. Information provided by DOE staff indicated that there is a lack of awareness among some Child Development Services system staff regarding the existing services and resources for deaf and hard-of-hearing children with mental health needs.

Governor Baxter School for the Deaf (GBSD) Statewide Outreach and Consulting Services.

The Governor Baxter School for the Deaf (GBSD) offers a Public School Outreach program that provides free consultative services to schools that serve students who are deaf or hard-of-hearing, to assist service providers with implementing an appropriate and positive educational experience for students in grades K-12. GBSD also offers an Early Childhood and Family Services outreach program that provides free consultative services to Maine families with children ages birth to five who are deaf, hard-of-hearing or have a suspected hearing loss.

Task Force members noted that seven education outreach workers have direct access to approximately 500 deaf and hard-of hearing children statewide, however they focus solely on education and language issues and lack information regarding mental health issues and resources. Task Force members concluded that there is an opportunity for education outreach workers to form partnerships with mental health providers to expand outreach services to include a mental health component.

Department of Corrections

The Department of Corrections submitted information to the Task Force indicating both deaf children and adolescents as well as deaf parents of hearing children have interacted with the Department of Corrections in the past few years. The Department of Corrections utilized interpreters and their TTY (telecommunications device for the deaf) to communicate with these parents and children.

Limitations of Current “In-State” Specialty Services

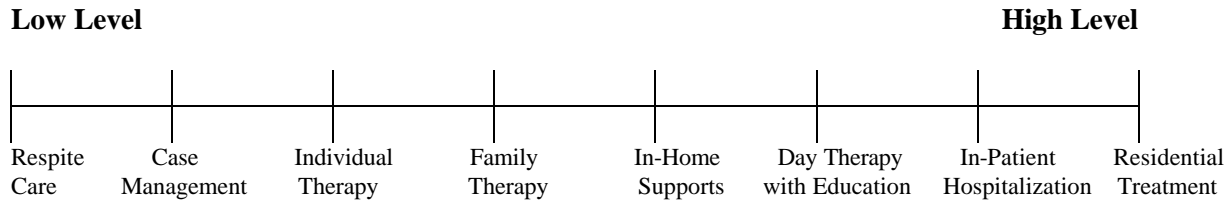
Task Force members also received considerable testimony regarding the limitations of current “in-state” specialty services summarized below:

- The lack of adequate early intervention and prevention services cause the significant mental health needs of Maine’s deaf and hard-of-hearing youth go undiagnosed, untreated, and over time evolve into more severe problems requiring more intensive and expensive interventions;
- The lack of awareness and coordination among social service agencies and providers can result in interruption of service provision and education for children;
- Mental health services for deaf and hard-of-hearing children are not provided equitably across geographic regions of the state as services are concentrated in Region 1 and parts of Region 2 and are unavailable in Region 3;
- The availability of mental health professionals capable of communicating directly with deaf and hard-of-hearing youth and knowledgeable in cultural issues impacting this population is extremely limited;
- There is a lack of adequate in-home and respite care services available for deaf and hard-of-hearing children and their families, especially for children in residential treatment who return home on weekends;
- Existing community based and institution based mental health services and programs serve hearing youth but these organizations and models are not able to successfully serve deaf and hard of hearing youth;
- These “hearing” agencies attempt to serve deaf and hard of hearing youth by simply adding interpreters in the treatment program, which has limited clinical effectiveness and is costly;
- Because deaf and hard-of-hearing youth have less resources available to them, their conditions both escalate and deteriorate more quickly than hearing youth; and
- Increased mainstreaming will result in increased mental health needs of deaf and hard-of-hearing children and adolescents due to the isolation experienced by these children.

3. Out of State Placements for Children with Severe Mental Health Needs

Social service providers and State agency officials provided the Task Force with an overview of out-of-state placements for deaf and hard-of-hearing children with severe mental

health needs. It was noted that the typical range of mental health services available to hearing children falls along the following treatment continuum:



While Maine does have the ability to provide “low level” mental health services to deaf and hard-of-hearing children through its existing provider network, the State lacks intensive therapeutic services for children with more extensive needs. State agency officials noted that there have been efforts in the past to develop an in-state treatment facility for deaf and hard-of-hearing children, but they have been unsuccessful. Task Force members were provided an overview of a 1997 joint “request for proposal” (RFP) developed by the Department of Mental Health, Mental Retardation and Substance Abuse services (precursor to BDS), Department of Education and Department of Human Services to create an in-state therapeutic treatment program for deaf adolescents with serious emotional disturbances, based on the Western Pennsylvania School for the Deaf and funded by grants available at the time. Although there was interest from both in-state and out-of-state providers, and even though the RFP was circulated twice, there was only one proposal submitted by the National Academy for the Deaf in Florida, which was rejected due to its high cost and inability to meet certain clinical and residential requirements of the RFP.

Given the State’s lack of capacity to provide intensive therapeutic services in-state, children with severe behavioral and mental health needs are often placed in out-of-state treatment facilities capable of meeting their specialized health, education and emotional needs. There are currently five children in out-of-state treatment programs at the Walden School in Massachusetts, the American School for the Deaf in Connecticut and the National Deaf Academy in Florida. These facilities provide a spectrum of services along the treatment continuum including but not limited to, deaf units with signing and/or deaf staff, full educational programs in American Sign Language (ASL), deaf educators, and residential intensive treatment programs, all of which are culturally and linguistically sensitive. A profile of these institutions is attached as **Appendix E**.

The Task Force also received testimony about the challenges surrounding out-of-state placements. Social service providers noted that out-of-state placements are extremely expensive, costing the State approximately \$200,000 per year. In addition, the payment mechanism for out-of-state placements is unwieldy, requiring payments from three separate agencies. The Department of Education provides payment for education-related services, the Department of Behavioral and Developmental Services provides payment for room and board and MaineCare provides payment for mental health services. This complex payment system makes other states more reluctant to accept Maine children into their treatment programs, due to concerns about Maine’s inability to provide payment for services or for paying a different reimbursement rate than

the in-state rate. (e.g., Massachusetts law prohibits differential Medicaid reimbursement rates for different children)

Providers also noted that there are certain therapeutic limitations of out-of-state placements. Successful mental and behavioral health treatment often includes family involvement. Out-of-state placements make it difficult for families to participate in the treatment process due to the increased financial and travel demands. Moreover, the progress made during treatment received out-of-state can be limited by the lack of adequate transition services in Maine to help children readjust to the community. Providers noted that there is an expectation by the Department of Behavioral and Developmental Services that “in-state” agencies providing case management for children placed out-of-state to keep cases open and arrange for “take back” transition services for out-of-state placements to reintegrate the child into their home, school and community, however these agencies lack the capacity and resources to do so.

Task Force members expressed concerns regarding the need to streamline current funding mechanism for out-of-state placements and develop a clear treatment path to ensure the successful reintegration of children returning from out-of-state placements.

4. Best Methods to Deliver Behavioral and Mental Health Services to Deaf and Hard of Hearing Children and Adolescents

The Task Force concluded that deaf and hard-of-hearing children and adolescents with mental and behavioral health needs fall into two main categories: (1) those children and adolescents that need prevention, early intervention, and basic services; and (2) those children and adolescents with severe mental and behavioral health needs who need more intensive treatment services. These two categories have different service delivery needs and given Maine’s limited capacity, those severe cases may be best served in out-of-state residential placements at this time. With this in mind, the Task Force focused its discussions on methods for improving in-state service delivery and considered the following strategies:

Modifying the Role of Interpreters

It was emphasized throughout Task Force discussions that current interpreter assisted treatment models are clinically ineffective. These therapeutic treatment environments are based on hearing models, which isolate deaf children and adolescents and do not provide direct access to treatment by preventing the development of direct relationships with providers and peers. Consequently, interpreters often become treatment providers, however they lack the appropriate mental health training. While there is the potential for interpreters to become an integral part of a clinical team, their role is prescribed by existing professional licensure and ethical standards and is therefore limited, to the roles defined by their particular certification.

Current ethical standards for interpreters are governed by the Codes of Ethics of the Registry of Interpreters for the Deaf (RID) and the National Association of the Deaf (NAD). These Codes of Ethics are currently in the process of being merged and updated to form one set of ethical standards for the interpreting profession. The Task Force concluded that this upcoming

review offers an opportunity for the interpreting community in Maine to provide input as to ways to expand current ethical standards to allow interpreters to utilize their unique linguistic and cultural knowledge to function as part of a mental health clinical team to assist deaf and hard-of-hearing children and their families.

The Task Force also considered the need to redefine the role of interpreters to allow them to serve as “bridge people.” A “bridge person” facilitates communication between a child and their parents in the home and provides language training for families. “Bridge people” can also help with implementing behavior management plans to assist families in becoming a therapeutic foster care family.

Utilization of “wraparound” community based treatment models:

Because current mental health services for deaf and hard-of-hearing children and adolescents focus on “therapist centered” treatment models they do not receive the benefits of community-based treatments. Given the lack of qualified in-state providers Task Force members considered the need to shift to more community based treatment models. One Task Force member proposed the utilization of “wraparound” services, which involve the creation of a coordinated, collaborative team of clinical providers that meet regularly and work toward a shared goal. The clinical team creates a “milieu without walls” which allows deaf children and adolescents to benefit from community-based treatment models. In addition, representatives from the Department of Behavioral and Developmental Services noted that BDS has been conducting “wraparound planning and service delivery” training for the past two years to assist providers of targeted case management services with the implementation of the wraparound planning approach in the delivery of services to children and their families.

Utilization of distance technology

Maine currently has an extensive telemedicine network that has been used successfully to bring medical expertise to areas where there is little or no access to physicians and other specialists. Task Force members proposed that distance technology, including the existing telemedicine network and ATM technology can and should be utilized for assessment, intervention and monitoring cases, in order to ensure equal access to qualified professionals across geographic regions in the state. The telemedicine network is also able to provide Video Relay Interpreting (VRI) at hospitals and program sites that have the videoconferencing equipment, to provide stop-gap interpreting where and when needed.

Training

The availability of mental health professionals that are capable of communicating directly with deaf and hard-of-hearing children and adolescents and are knowledgeable in cultural issues impacting this population is extremely limited. Maine, like most states, has experienced great difficulty in recruiting qualified interpreters and “signing” mental health providers to the state. The lack of linguistic and culturally competent mental health professionals and programs available nationally requires that such expertise be developed in-state. Task Force members recognized,

however, that becoming culturally competent is only a first step and not a solution to addressing the mental and behavioral health needs of deaf and hard-of-hearing children and adolescents.

Task Force members considered the following strategies to improve the capacity of “signing” mental health providers capable of delivering culturally competent, linguistically accessible services across the state:

- Incorporating deaf specialization tracks within existing two and four year post-secondary education programs in the state, including programs in social work, mental health counseling, case management training, and other social services;
- Developing and providing professional training resources such as classes, workshops, conferences to improve the skills and knowledge of professional providers who deliver services to this population;
- Requiring existing social service providers and agencies, such as the Muskie School of Public Service, the Sweetser Training Institute, and the Behavioral Health Sciences Institute to develop deaf training modules and integrate them into existing training programs for all workers, including DHS Child Protective Services workers, BDS contracted case managers and in-home support workers;
- Because the Department of Human Services, Bureau of Child and Family Services experiences a caseworker turnover rate of approximately 15% - 20%, providing training on working with deaf and hard-of-hearing families on a regular basis to ensure the information is institutionalized;
- Requiring that training on working with deaf and hard-of-hearing families be included as part of the training for all new Department of Human Services and Department of Behavioral and Developmental Services employees;
- Creating a special job category or an addition to a position that would require at least one caseworker in each District office of the Department of Human Services to be fluent in ASL; and
- Creating positions within BDS/DHS for signing case workers, which would increase the flexibility and access of interpreter services and would reduce expenditures by half.

Creating a statewide continuum of care

Task Force members noted that the availability of providers with the capacity and flexibility to work with deaf and hard of hearing children and adolescents is not consistent within or between different organizations. One Task Force member provided an example of a program director at a social service agency who worked with mental health professionals to develop a specialized deaf treatment program within the organization, however when this program director subsequently changed positions within the organization, the program was not maintained. The

Task Force noted the frustration felt by many mental health professionals that work with deaf children of having to redevelop treatment programs for each deaf child because agencies do not provide the flexibility to institutionalize a deaf treatment module into their existing structure. Given the State's lack of capacity to develop a residential treatment facility in-state, the Task Force emphasized the need to identify organizations and providers along the treatment continuum that are willing to develop and maintain treatment programs and models appropriate for deaf children and adolescents.

III. RECOMMENDATIONS

The Task Force To Study the Needs of Deaf and Hard of Hearing Children and Adolescents makes the following recommendations and presents them for immediate consideration of the 121st Legislature. With the exception of one recommendation, these recommendations were formulated and adopted through a consensus process by the Task Force members present at the final Task Force meeting.^{5 6} Task Force members urge state policymakers to reflect upon the extraordinary needs of deaf and hard-of-hearing children and adolescents as they review these recommendations and consider appropriate steps to fully implement policies that support and sustain a comprehensive social service delivery system for Maine’s deaf and hard-of-hearing children and adolescents.

Task Force Recommendations

The Task Force makes the following recommendations to address the behavioral and mental health needs of Maine’s deaf and hard-of-hearing children and adolescents. Specifically, these recommendations intend to address the following key problems:

- The significant mental health needs of Maine’s deaf and hard-of-hearing youth go undiagnosed, untreated, and over time evolve into more severe problems requiring more intensive and expensive interventions.
- The availability of mental health professionals capable of communicating directly with deaf and hard-of-hearing youth and knowledgeable in cultural issues impacting this population is extremely limited.
- Existing community based and institution based mental health services and programs serve “hearing” youth but these organizations and models are not able to successfully serve this population.
- These “hearing” agencies attempt to serve deaf and hard of hearing youth by simply involving interpreters in the treatment program, which has limited clinical effectiveness and is costly.

The Task Force presents these recommendations in three phases to be implemented over a period of several years as economic conditions improve. The intent of these recommendations is to provide the steps necessary to develop a comprehensive system of “linguistically accessible” and “culturally competent” mental health services as quickly as possible. The children and adolescents in need of these specialized services cannot afford to wait.

⁵ Task Force members Suzanne Chadwick and Toni Wall were not present for the final Task Force meeting. Following a review of the final report, these two members endorsed the recommendations presented here.

⁶ Task Force appointees Senator Betty Lou Mitchell and Jeannie Shacker were unable to attend any task force meetings and did not endorse any Task Force recommendations.

Phase 1

A. Newborn Hearing Screening Initiative

Finding: The initial discovery of a child's hearing loss is an overwhelming experience for parents who often lack awareness of the physical, emotional and cultural issues of deafness. The ability of parents to cope with their child's hearing loss directly impacts the child's communication skills and cognitive development. Current resource materials and information provided by the Newborn Hearing Screening Initiative to families with children identified with a hearing loss do not include information to assist parents in accessing mental health services. Increasing parent awareness of existing mental health resources for families with deaf and hard-of-hearing children is critical in assisting families in coping with their child's hearing loss.

Recommendation #1: That the Department of Human Service's Newborn Hearing Screening Initiative develop and disseminate resource materials to parents with children that have been identified as having an audiological condition that includes information regarding how to access mental health services in order to assist families in coping with having a child with a hearing loss.

Finding: Early identification and intervention services are critical in preventing the onset of unnecessary developmental delays and mental health conditions in deaf and hard-of-hearing children. The Department of Human Service's Newborn Hearing Screening Initiative provides hearing screening tests to infants in all 32 birth hospitals statewide. The initiative was established in 2000 through federal grants and will lose its funding in June 2005. Maintenance of a statewide hearing screening program is crucial in maximizing the potential of infants' communication skills and cognitive development and to assist in planning for their future needs.

Recommendation #2: That the State continue to fund the Department of Human Service's Newborn Hearing Screening Initiative once federal funding ends in June 2005. **The Task Force recommends that legislation be introduced to implement this recommendation.**

B. Data Collection

Finding: Maine lacks an adequate data collection system to appropriately identify and track deaf and hard-of-hearing children and adolescents. The current identification system is fragmented across several agencies, each with varying definitions, categorizations and levels of data in its database. These differences make it extremely difficult to accurately identify and track this population. In addition, the State lacks adequate information regarding State expenditures on deaf and hard-of-hearing services. Until we can establish a data collection system that is capable of accurately identifying who is included in this population, what services they are accessing and how much money the State is investing in these services, we will never be able to truly assess the service delivery needs of this population.

Recommendation #3: That the Department of Behavioral and Developmental Services, the Department of Human Services, the Department of Education and the Department of Corrections convene a working group to identify ways to develop data collection resources across agencies, including but not limited to the creation of a cross-agency data system to identify and track deaf and hard-of-hearing children and adolescents. **The Task Force recommends that legislation be introduced to implement this recommendation.**

Recommendation #4: That the Legislature’s Office of Fiscal and Program Review conduct an audit of State agency programs to determine State expenditures on services for deaf and hard-of-hearing children and adolescents. **The Task Force recommends that legislation be introduced to implement this recommendation.**

C. Training

Finding: The availability of mental health professionals who are capable of communicating directly with deaf and hard-of-hearing children and are knowledgeable in cultural issues impacting this population is extremely limited. Historically, Maine has experienced great difficulty in recruiting qualified interpreters and “signing” mental health providers to the state. The lack of “linguistically competent” and “culturally competent” mental health professionals and programs requires that such expertise be “grown/developed” locally in addition to continuing recruitment efforts.

Recommendation #5: That Maine’s postsecondary education institutions collaborate with professionals skilled and knowledgeable in deafness to develop deaf specialization tracks within existing two and four year post-secondary education programs in the state, including programs in social work, mental health counseling, case management training and other social services.

Recommendation #6: That existing social service providers and agencies, including but not limited to, the Muskie School of Public Service, the Sweetser Training Institute, and the Behavioral Health Sciences Institute develop deaf training modules and integrate them into existing training programs for all workers, including training programs for Child Protective Services workers in the Department of Human Services and contracted service providers in the Department of Behavioral and Developmental Services.

D. Waivers

Finding: Existing postsecondary education programs are not linguistically and culturally accessible to deaf individuals. Because they do not typically participate in these postsecondary education programs, deaf individuals do not hold the credentials that would permit them to work in certain capacities as service providers for deaf children and families. The Task Force believes that creating waivers from existing degree requirements and developing a set of parallel qualifications for deaf individuals is necessary in order to enable communities to utilize the unique linguistic and cultural knowledge of these individuals.

Recommendation #7: That the Department of Behavioral and Developmental Services convene a working group with “signing” mental health providers to develop a process for creating waivers and/or modifications in degree and education requirements and/or parallel requirements to allow deaf individuals to work as mental health resources (“paraprofessional”) within communities. **The Task Force recommends that legislation be introduced to implement this recommendation.**

Recommendation #8: That the Department of Education convene a working group to develop a process for creating waivers and/or modifications in degree and education requirements and/or parallel qualifications to allow deaf individuals to work as education resources (“paraprofessional”) within Maine schools. **The Task Force recommends that legislation be introduced to implement this recommendation.** A minority report was filed by one Task Force member regarding this recommendation and is attached as **Appendix G.**

E. Modifying the Role of Interpreters

Finding: Current therapeutic treatment environments for deaf and hard-of-hearing children and adolescents are based on “hearing” models, which isolate deaf children and prevent direct access to treatment by preventing the development of direct relationships with providers and peers. Consequently, interpreters are used, placed between the trained mental health provider and the child, however they lack the appropriate mental health training. While there is the potential for interpreters to become an integral part of a clinical team, their role is prescribed by existing professional licensure and ethical standards and is therefore limited to the roles defined by their particular certification.

The Registry of Interpreters for the Deaf (RID) and National Association of the Deaf (NAD) Codes of Ethics govern current ethical standards for interpreters. These Codes of Ethics are currently in the process of being merged and updated to form one set of ethical standards for the interpreting profession. The Task Force believes that this upcoming review offers an opportunity for the interpreting community in Maine to provide input as to ways to expand current ethical standards to allow interpreters to utilize their unique linguistic and cultural knowledge to function as part of a mental health clinical team to assist deaf and hard-of-hearing children and their families.

Recommendation #9: That the Department of Behavioral and Developmental Services convene a working group with professional interpreter groups to identify ways to modify current ethical and professional standards for interpreters to allow them to function as part of a therapeutic treatment team. The working group should also develop recommendations on the new RID/NAD proposed Code of Ethics for interpreters. **The Task Force recommends that legislation be introduced to implement this recommendation.**

Recommendation #10: That the University of Southern Maine develop a mental health specialization within its interpreter training program to enable those in training to become certified interpreters to develop the necessary mental health skills to function more effectively in mental health settings.

F. Baxter Outreach Partnerships

Finding: While education outreach workers have direct access to approximately 500 deaf and hard-of hearing children and adolescents statewide, they focus solely on education and language issues and lack information regarding mental health issues and resources. The Task Force feels there is an opportunity for education outreach workers to form partnerships with mental health providers to expand outreach services to include a mental health component.

Recommendation #11: That the Governor Baxter School for the Deaf (GBSD) convene a working group with mental health providers skilled and knowledgeable in deafness to discuss the opportunities for partnership regarding the provision of outreach services including:

1. Developing a mechanism to “red flag” children being served by educational outreach workers and to provide follow-up assessment and intervention services to families and schools; and
2. Pairing mental health workers with educational outreach workers in order to incorporate a mental health component to outreach services.

The Task Force recommends that legislation be introduced to implement this recommendation.

G. Improving Geographic Accessibility to Services

Finding: Mental health services for deaf and hard-of-hearing children are not provided equitably across geographic regions of the state as services are concentrated in Region 1 and parts of Region 2 and are unavailable in Region 3. While a long-term goal should be the development of specialty mental health services to serve this population, the Task Force feels the immediate needs of this geographic region can be served by working within existing resources.

Recommendation #12: That the Department of Behavioral and Developmental Services reallocate existing resources within the department to furnish BDS Children and Youth Services with the funds necessary to provide case management services to deaf and hard-of-hearing children and adolescents in Region 3. **The Task Force recommends that legislation be introduced to implement this recommendation.**

H: Utilization of Technology

Finding: Maine currently has an extensive telemedicine network that has been used successfully to bring medical expertise to areas where there is little or no access to physicians and other specialists. Because mental health services for deaf and hard-of-hearing children and adolescents are not provided equitably across geographic regions of the state and are concentrated in population centers, the Task Force believes this existing network can be utilized to provide deaf and hard-of-hearing children and adolescents access to qualified mental health professionals.

Recommendation #13: That Maine’s telemedicine and distance learning networks be utilized to provide access to mental health professionals that are only available in population centers. The network should be utilized to provide the following: psychiatric assessments, medication reviews, crisis intervention/assessment, psychological services, family therapy, clinical consultation, clinical team management, and assessment.

I. Children and Family Community Support Services

Finding: Early intervention and prevention services provided in the child’s home and school would significantly reduce or resolve long-term and/or chronic emotional and behavioral conditions. Best mental health practices for school aged children include providing comprehensive treatment to children and their families within their community and school. Community support services allow for changes to the systems and relationships necessary for children to change and to maintain these changes long after treatment is discontinued.

Recommendation #14: That State agencies and social service providers develop a community support program as defined in the MaineCare Benefits Manual, Chapter II, Mental Health Services, Section 65 G of MaineCare regulations to provide intensive support to deaf and hard-of-hearing children and families in their homes, communities and social environments that is culturally and linguistically appropriate. **(See Appendix F for an outline of this proposal)**

J. Department of Human Services/Department of Behavioral and Developmental Services Merger

Finding: The future merger of the Department of Human Services (DHS) and the Department of Behavioral and Developmental Services (BDS) provides an important opportunity to improve the efficiency and quality of service delivery for Maine’s children and families. The Task Force concluded that consideration of the specialized service delivery needs of deaf and hard-of-hearing children must be considered when developing a plan to merge these departments.

Recommendation #15: That the DHS/BDS Unification Advisory Council consider the staff impact of the recommendations of this report when developing its final plan for the merger of the Department of Human Services and the Department of Behavioral and Developmental Services. The Office of Deaf Services in the Department of Behavioral and Developmental Services should be expanded and strategically located so as to impact across all branches and functions of the new department. **The Task Force recommends that legislation be introduced to implement this recommendation.**

Recommendation #16: That the DHS/BDS Unification Advisory Council include the creation of a special job category or an addition to an existing position that would require at least one staff person in each district office to be conversant in American Sign Language and knowledgeable of deaf culture. **The Task Force recommends that legislation be introduced to implement this recommendation.**

K. Out of State Placements

Finding: While Maine does have the ability to provide “low level” mental health services to deaf and hard-of-hearing children through its existing provider network, the State lacks intensive therapeutic residential and inpatient psychiatric services for children with more extensive needs. Given this lack of capacity, there will be an ongoing need to send children with the most severe needs to specialized treatment programs out-of-state.

The Task Force recognizes that current referral and payment processes make it increasingly difficult to find such out-of-state residential treatment placements. Requiring three separate payments from the Department of Education, the Department of Behavioral and Developmental Services and MaineCare for out-of-state treatment services limits the placement options for these children. The Task Force also recognizes that long-term treatment outcomes depend on the State’s ability to provide appropriate transition and “step down” services for children returning from out-of-state placements to help children reintegrate into their homes, schools and communities.

Recommendation #17: That the Departments of Education, Human Services and Behavioral and Developmental Services convene a working group with key out-of-state treatment providers to improve the current process for out-of-state placements. The working group should develop a plan to streamline the process for referral and payment for out-of-state residential treatment placements and develop a plan to create transition and “step down” services to assist providers with reintegrating children back into their homes, schools and communities. **The Task Force recommends that legislation be introduced to implement this recommendation.**

Phase II

L. Continuation of the Task Force

Finding: Due to the limited available time to meet and the magnitude and complexity of the duties charged to this legislative study, Task Force members concluded that the continuation of this Task Force is necessary in order to continue this important work. Task Force members also concluded that the Task Force should expand its membership to include additional State agency representatives, consumer representatives and other key stakeholders and should further address the recommendations proposed in this report.

Recommendation #18: That the Legislature authorize the continuation of the Task Force to Study the Needs of Deaf and Hard of Hearing Children and Adolescents and expand its membership to include additional state agency representatives, consumer representatives and other key stakeholders. The duties of the Task Force should include but not be limited to the following:

1. Developing a comprehensive service delivery model;
2. Examining the issue of waivers and parallel qualifications for deaf individuals;
3. Examining mechanisms to utilize and access distance technology to provide deaf and hard-of-hearing children and families access to culturally competent, linguistically accessible mental health service providers;
4. Examining ways to strengthen collaborative agreements with other states;
5. Identifying opportunities for partnerships between providers and agencies within and outside the State; and
6. Serving in an advisory capacity to the Department of Human Services/Department of Behavioral and Developmental Services Unification Advisory Council.

The Task Force recommends that legislation be introduced to implement this recommendation.

Phase III

M. Developing In-State Specialty Services

Finding: While it would be financially advantageous and desirable for other reasons to keep deaf and hard-of-hearing children and adolescents with mental health needs in the state, Maine does not provide the necessary continuum of mental health services and placements to meet the full range of their specialized needs. Existing mental health services and programs are based on “hearing” models, which have limited clinical effectiveness for deaf and hard-of-hearing children and adolescents. The Task Force recognizes that many mental health professionals are forced to redevelop treatment programs for each deaf child because social service agencies do not provide the flexibility and capacity to institutionalize deaf treatment modules into existing structures. We believe that in order to improve in-state specialty services for this population, we must identify organizations and providers along the treatment continuum that are willing to develop and maintain treatment programs and models appropriate for deaf children.

Recommendation #19: That the State identify organizations and providers along the treatment continuum that are willing to develop and maintain treatment programs and models appropriate for deaf and hard-of-hearing children and adolescents that provide services including but not limited to the following:

- Mentors;
- Bridge services;
- Behavior management specialists;
- Transition services (“School to work”); moving children successfully from more restrictive to less restrictive settings;
- Mobile assessment and intervention services;
- Treatment foster care;
- Family-to-family programs;
- Experiential education programs;
- Experiential vocational training for transition age youth;
- Specialized case management;
- Day treatment programs;
- Acute, short-term in-patient psychiatric services; and
- Mentor families for non-local students in day treatment program.

Suggested Legislation

Since the Task Force was not authorized to submit legislation to implement the recommendations proposed in this study, the Task Force will not introduce legislation on its own. Because of the importance of this issue, we recommend that individual legislators and appropriate joint standing committees include the following twelve Task Force recommendations in legislation for immediate consideration during the Second Special Session of the 121st Legislature:

1. That the State continue to fund the Department of Human Service’s Newborn Hearing Screening Initiative once federal funding ends in June 2005;
2. That the Department of Behavioral and Developmental Services, the Department of Human Services, the Department of Education and the Department of Corrections convene a working group to identify ways to develop data collection resources across agencies, including but not limited to the creation of a cross-agency data system to identify and track deaf and hard-of-hearing children and adolescents;
3. That the Legislature’s Office of Fiscal and Program Review conduct an audit of State agency programs to determine State expenditures on services for deaf and hard-of-hearing children and adolescents;

4. That the Department of Behavioral and Developmental Services convene a working group with “signing” mental health providers to develop a process for creating waivers and/or modifications in degree and education requirements and/or parallel requirements to allow deaf individuals to work as mental health resources (“paraprofessional”) within communities;
5. That the Department of Education convene a working group to develop a process for creating waivers and/or modifications in degree and education requirements and/or parallel qualifications to allow deaf individuals to work as education resources (“paraprofessional”) within Maine schools⁷;
6. The Task Force recommends that the Department of Behavioral and Developmental Services convene a working group with professional interpreter groups to identify ways to modify current ethical and professional standards for interpreters to allow them to function as part of a therapeutic treatment team. The working group should also develop recommendations on the new Registry of Interpreters for the Deaf (RID)/National Association of the Deaf (NAD) proposed Code of Ethics for interpreters;
7. That the Governor Baxter School for the Deaf (GBSD) convene a working group with mental health providers skilled and knowledgeable in deafness to discuss the opportunities for partnership regarding the provision of outreach services including (1) developing a mechanism to “red flag” children being served by educational outreach workers and to provide follow-up assessment and intervention services to families and schools; and (2) pairing mental health workers with educational outreach workers in order to incorporate a mental health component to outreach services;
8. That the Department of Behavioral and Developmental Services reallocate existing resources within the department to furnish BDS Children and Youth Services with the funds necessary to provide case management services to deaf and hard-of-hearing children and adolescents in Region 3;
9. That the DHS/BDS Unification Advisory Council consider the staff impact of the recommendations of this report when developing its final plan for the merger of the Department of Human Services and the Department of Behavioral and Developmental Services. The Office of Deaf Services in the Department of Behavioral and Developmental Services should be expanded and strategically located so as to impact across all branches and functions of the new department;
10. That the DHS/BDS Unification Advisory Council include the creation of a special job category or an addition to an existing position that would require at least one staff person in each district office to be conversant in American Sign Language and knowledgeable of deaf culture;

⁷ A minority report was filed by one Task Force member regarding this recommendation and is attached as Appendix G.

11. That the Department of Education, the Department of Human Services and the Department of Behavioral and Developmental Services convene a working group with key out-of-state treatment providers to improve the current process for out-of-state placements. The working group should develop a plan to streamline the process for referral and payment for out-of-state residential treatment placements and develop a plan to create transition and “step down” services to assist providers with reintegrating children back into their homes, schools and communities; and
12. That the Legislature authorize the continuation of the Task Force to Study the Needs of Deaf and Hard of Hearing Children and Adolescents and expand its membership to include additional state agency representatives, consumer representatives and other key stakeholders. The duties of the Task Force should include but not be limited to the following:
 - Developing a comprehensive service delivery model;
 - Examining the issue of waivers and parallel qualifications for deaf individuals;
 - Examining mechanisms to utilize and access distance technology to provide deaf and hard-of-hearing children and families access to culturally competent, linguistically accessible mental health service providers;
 - Examining ways to strengthen collaborative agreements with other states;
 - Identifying opportunities for partnerships between providers and agencies within and outside the state; and
 - Serving in an advisory capacity to the Department of Human Services/Department of Behavioral and Developmental Services Unification Advisory Council.

APPENDIX A

**Authorizing Legislation
Resolve 2003, Chapter 84
(S.P. 193 - L.D. 553)**

Resolve, To Study the Needs of Deaf and Hard-of-hearing Children and Adolescents

Resolve 2003, Chapter 84
First Regular Session of the 121st Legislature
(S.P. 193 - L.D. 553)

Resolve, To Study the Needs of Deaf and Hard-of-hearing Children and Adolescents

Sec. 1. Task force established. Resolved: That the Task Force to Study the Needs of Deaf and Hard-of-hearing Children and Adolescents, referred to in this resolve as "the task force," is established; and be it further

Sec. 2. Task force membership. Resolved: That the task force consists of 18 members appointed as follows:

1. Two members of the Senate, appointed by the President of the Senate;
2. Two members of the House of Representatives, appointed by the Speaker of the House;
3. Five members appointed by the Speaker of the House as follows:
 - A. A behavioral health service provider providing specialized services for deaf or hard-of-hearing youths;
 - B. A behavioral health service provider not serving deaf or hard-of-hearing youths;
 - C. A parent of a deaf or hard-of-hearing youth;
 - D. A representative of a hospital with an inpatient psychiatric unit; and
 - E. A representative of a public school district;
4. Six members appointed by the President of the Senate as follows:
 - A. A representative from the Governor Baxter School for the Deaf;
 - B. A representative of educators of deaf students;
 - C. A representative of the Department of Labor, Bureau of Rehabilitation Services, Division of Deafness;
 - D. A representative of providers of behavioral health services;
 - E. A representative of persons who advocate for deaf students in special education proceedings; and
 - F. A representative of a nationally accredited, statewide provider of behavioral health services providing specialized mental health services for deaf or hard-of-hearing youths in a day treatment model;
5. The Commissioner of Human Services, or the commissioner's designee;
6. The Commissioner of Education, or the commissioner's designee; and
7. The Commissioner of Behavioral and Developmental Services, or the commissioner's designee; and be it further

Sec. 3. Chairs. Resolved: That the first-named Senate member is the Senate chair of the task force and the first-named House of Representatives member is the House chair of the task force; and be it further

Sec. 4. Appointments; convening of task force; meetings. Resolved: That all appointments must be made no later than 30 days following the effective date of this resolve. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. Within 15 days after appointment of all members, the chairs shall call and convene the first meeting of the task force. The task force may hold up to 4 meetings; and be it further

Sec. 5. Duties. Resolved: That the task force shall examine the behavioral, developmental, social, emotional and educational needs of deaf and hard-of-hearing children and adolescents who are not receiving adequate services because of a lack of appropriate resources in the State. In examining these issues, the task force shall specifically examine:

1. Services that are currently available to serve the needs of deaf and hard-of-hearing children and adolescents and the ability of the providers of those services to provide culturally competent, linguistically accessible services. The task force shall review educational services within the context of the behavioral and mental health needs of the children and adolescents;

2. Demographic data of the numbers of deaf and hard-of-hearing children and adolescents in need of such specialized services and projections regarding the number of deaf and hard-of-hearing younger children who may require such services in the future; and

3. Proposals designed to improve the delivery of services to meet the needs of deaf and hard-of-hearing children and adolescents, including, but not limited to, the development of in-state specialty services, collaborative agreements with bordering states and states with specialized facilities and training initiatives; and be it further

Sec. 6. Staff assistance. Resolved: That, upon approval of the Legislative Council, the Office of Policy and Legal Analysis shall provide necessary staffing services to the task force; and be it further

Sec. 7. Compensation. Resolved: That the legislative members of the task force are entitled to receive legislative per diem, as defined in the Maine Revised Statutes, Title 3, section 2, and reimbursement for travel and other necessary expenses related to their attendance at meetings of the task force. Public members not otherwise compensated by their employers or other entities that they represent are entitled to receive reimbursement of necessary expenses and, upon a demonstration of financial hardship, a per diem equal to the legislative per diem for their attendance at authorized meetings of the task force; and be it further

Sec. 8. Report. Resolved: That the task force shall submit a report that includes its findings and recommendations, including suggested legislation, to the Second Regular

Session of the 121st Legislature no later than December 3, 2003. The task force is not authorized to introduce legislation; and be it further

Sec. 9. Extension. Resolved: That, if the task force requires a limited extension of time to complete its study and make its report, it may apply to the Legislative Council, which may grant an extension; and be it further

Sec. 10. Task force budget. Resolved: That the chairs of the task force, with assistance from the task force staff, shall administer the task force's budget. Within 10 days after its first meeting, the task force shall present a work plan and proposed budget to the Legislative Council for its approval. The task force may not incur expenses that would result in the task force exceeding its approved budget.

Upon request from the task force, the Executive Director of the Legislative Council or the executive director's designee shall promptly provide the task force chairs and staff with a status report on the task force's budget, expenditures incurred and paid and available funds.

Effective September 13, 2003, unless otherwise indicated.

APPENDIX B

Task Force Membership List

**TASK FORCE TO STUDY THE NEEDS OF DEAF AND
HARD-OF-HEARING CHILDREN AND ADOLESCENTS**

Resolve 2003, Ch 84

Membership

Appointment(s) by the President

Sen. Betheda G. Edmonds **Chair**
122 Hunter Road
Freeport, ME. 04032

Sen. Betty Lou Mitchell
P.O. Box 6
Etna, ME 04434

Jan DeVinney
Bureau of Rehabilitation - Div. Of Deafness
150 State House Station
Augusta, ME 04333

Representing the Division of Deafness at the Department of
Labor

Mary Edgerton
Maine Center on Deafness
68 Bishop Street, Suite 3
Portland, Maine 04103

Representing Advocacy for Deaf Students in Special
Education Proceedings

Rita LaBarbera
c/o Sweetser
50 Moody Street
Saco, ME 04072

Representing a Nationally Accredited, Statewide Provider

Mary Martone
Governor Baxter School for the Deaf
Mackworth Island
Falmouth, ME 04105

Representing Educators of Deaf Students

Jenn McCann
Community Counseling Center
343 Forest Avenue
Portland, ME 04101

Representing Providers of Behavioral Health Services

Doug Moody
Governor Baxter School for the Deaf
Mackworth Island
Falmouth, ME 04105

Representing the Governor Baxter School for the Deaf

Appointment(s) by the Speaker

Rep. Elaine Makas **Chair**
10 Sheffield Avenue
Lewiston, ME 04240

Rep. Richard B. Brown
160 Ogunquit Road
South Berwick, ME 03908

Suzanne Chadwick
PO Box 944
Gardiner, ME 04345

Representing Parents of Deaf or Hard-of-Hearing Youths

Kathy Fries, Director
Special Edu/South Portland High School
637 Highland Avenue
South Portland, ME 04106

Representing Public School Districts

Stephen Greene, Ph.D.
15 Western Ave. Suite #4
Augusta, ME 04330

Representing Behavioral Health Service Providers Not Serving
Deaf or Hard-of-Hearing Youths

Jana Harbaugh
Community Counseling Center
343 Forest Avenue
Portland, ME 04101

Representing Behavioral Health Service Providers
Serving Deaf or Hard-of-Hearing Youths

Jeannie Shacker, SW
Spring Harbor Hospital
175 Running Hill Road
South Portland, ME 04106

Representing a Hospital With an Inpatient Psychiatric Unit

Commissioner, Behavioral & Developmental Services

Meryl Troop
Department of Behavioral & Developmental
40 SHS
Augusta, ME 04333-0040

Representing the Department of Behavioral & Developmental
Services

Commissioner, Department of Education

Christine Bartlett
Department of Education
23 State House Station
Augusta, ME 04333

Representing the Department of Education

Commissioner, Department of Human Services

Toni Wall
Key Bank Plaza, 7th Floor
11 State House Station
Augusta, ME 04333 – 0011

Representing the Commissioner, Department of Human
Services – Designee

Staff: Nicole Dube, OPLA, 287-1670
Phil McCarthy, OPLA, 287-1670

APPENDIX C

**Individuals Providing Testimony:
Practitioners, Resource People and Interested Parties**

**Practitioners, Resource People and Interested Parties
Who Provided Testimony to the Task Force**

Angela Bruno, Public School Outreach Services, Governor Baxter School for the Deaf

Sabra Burdick, Acting Commissioner, Department of Behavioral and Developmental Services

Kim Church, Nurse Coordinator for the Newborn Hearing Screening Program

Karen Hopkins, Early Childhood Intervention Services, Governor Baxter School for the Deaf

Michael Norton, Director of Public Affairs and Quality Assurance, Department of Human Services

Romy Spitz, Ph.D., Advisory Committee Member, Newborn Hearing Screening Initiative and Technical Consultant on Deafness to the Department of Behavioral and Developmental Services

Larry Taub, Superintendent, Governor Baxter School for the Deaf

Ron Taglienti, Children's System Manager, Department of Behavioral and Developmental Services

**Task Force to Study the Needs of Deaf and Hard of Hearing Children and Adolescents
Interested Parties List**

Ms. Beth Hudson
Eaton Peabody
77 Sewall St., Suite 3000
Augusta, Maine 04333

Ms. Roberta Scruggs
19 Darnit Road
Buckfield, ME 04220

Dr. Romy Spitz
47 Forest Park #2
Portland, ME 04101

Ms. Terry Thompson
44 Sebago Lake Road
Gorham, ME 04038

APPENDIX D

Risinger Settlement Agreement

SETTLEMENT AGREEMENT

RISINGER, ET AL. v. MAINE DEPARTMENT OF HUMAN SERVICES, ET AL.
Civil Action No. 00-116-B-C (D. Me.)

May 3, 2002

WHEREAS, the plaintiffs Michael and Susan Risinger, on behalf of their minor daughter, Jill Risinger, Annmarie Fitzpatrick, on behalf of her minor son, Eric Fitzpatrick, all on behalf of themselves and all others similarly situated, and the Disability Rights Center of Maine, Inc., and defendants Kevin Concannon, Commissioner of the Maine Department of Human Services ("DHS"), and Lynn Duby, Commissioner of the Maine Department of Behavioral and Developmental Services ("DBDS"), desire that the pending litigation be resolved in a manner that will timely deliver services to the children of the State of Maine;

The parties hereby agree as follows:

1. The DHS and DBDS will develop and comply with the timeliness standards herein for the provision of medically necessary in-home behavioral health and case management services for children under the age of twenty-one (21) who are Medicaid eligible. "In-home behavioral health services" mean services defined in Chapter II, Section 65.04-3(H) and Section 24.01-2 of the Maine Medical Assistance Manual. "Case management services" mean services defined in Chapter II, Section 13.12 of the Maine Medical Assistance Manual.

2. For the purpose of calculating the various agreed upon durations under those standards, the Start Date will be deemed to be the later of:

(a) A request for screening services by or on behalf of the child/child's family. For the purposes of this settlement, "request for screening services" means a request for a behavioral health screen, a request for assistance in identifying behavioral health needs or a request for a behavioral health service for a child under the age of twenty-one, and any such request must be made to: a DBDS-approved agency that is a participating provider of Medicaid covered case management or in-home behavioral health services to children. The request can be made by a parent or a guardian, or a school district or a health care provider with the parent's or guardian's permission; or

(b) The date upon which financial eligibility under Medicaid is determined which will normally be the date of the letter to the client informing her/him of eligibility provided, however, that this date shall in no event be later than forty-five (45) days from the date upon which a completed application for Medicaid is received by DHS, in accordance with 42 C.F.R. 435.911, unless otherwise modified by federal law:

3. The timeliness standards shall include:

(a) In accordance with 42 C.F.R. 441.56(e), an Individual Treatment Plan for in-home behavioral health services will be prepared if the child has a medical need for a service that can be provided as a Medicaid covered service under MMAM, Chapter II, Section 65.04-3(H) or 24.01-2. An Individual Treatment Plan which addresses that identified need will be developed in accordance with reasonable behavioral health

practice, and in no case later than one hundred and twenty (120) days after the Start Date. Services consistent with the plan will commence promptly in accordance with reasonable standards of behavioral health practice, generally within an outer limit of one hundred and eighty (180) days from the Start Date.

(b) In accordance with 42 C.F.R. 441.56(e), an Individual Support or Service Plan for case management will be prepared if the child has a medical need for case management that can be provided as a Medicaid covered service under MMAM, Chapter II, Section 13.12. An Individual Support or Service plan which addresses that identified need will be developed in accordance with reasonable standards of case management practice, and generally within an outer limit of one hundred and eighty (180) days after the Start Date.

(c) The parties agree that when a new or different need for in-home support service or case management is identified for a child for whom there already is a Start Date under paragraph 2 of this Agreement, the Start Date for that identified need for the new or different service shall be the date that the need is identified.

4. The foregoing timeliness standards are outside deadlines, gauged to be long enough generally to complete the determination and preparation of the Individual Treatment Plan or Individual Support or Service Plan, and the commencement of the delivery of services, thereunder. DBDS may develop other standards with respect to services, for example, medical eligibility for and the delivery of such services, but only if such standards do not change the requirements of this Settlement Agreement.

5. When making a request for screening services, the parent or guardian shall sign a release that allows providers to communicate with one another to facilitate the provision and tracking of services and avoid duplication of effort. In addition, the parent or guardian requesting screening services shall be requested to inform the provider at the time of the request of any other requests made on behalf of the child and thereafter shall make good faith efforts to keep each provider informed of further requests made to other providers. None of the provisions in this paragraph shall be considered a Medicaid eligibility criterion. In the event the parent or guardian of a child requesting case management or in-home behavioral health services has been notified of the availability of a qualified provider and has declined the offered service (other than for reasons related to the safety or welfare of the family based on prior dealings with the offered provider), the State will be deemed to have fulfilled its obligation to provide Medicaid benefits with reasonable promptness.

6. In the event of an interruption in case management or in-home behavioral health services due to events outside the reasonable control of the recipient family (e.g., resignation or continued unavailability of a case manager or provider), a new case manager or provider will be supplied with due haste without recommencing any of the time periods specified herein.

7. Within one hundred and twenty (120) days of the date of this Agreement, DBDS will develop and implement a system that allows DBDS to identify and track each individual child under the age of 21 for whom a request has been made to an approved

agency as defined in paragraph 2(a) above, in order to disclose whether, for that child, the timeliness standards specified in the foregoing paragraphs 2, 3, and 6, above have been complied with and in order to be able to generate data disclosing the nature and extent of compliance with the timeliness standards set forth in this Agreement. The system need not track de minimis non-recurring interruptions in the provision of case management or in-home behavioral health services.

8. The DBDS will share with Plaintiffs' counsel on a quarterly basis for six quarters beginning with the quarter ending on September 30, 2002, data or reports generated by the foregoing system described in paragraph 7. The reports will be provided within forty-five (45) days of the end of the quarter and will include the following information: the names of children for whom the standards in paragraph 3 have not been met as well as each of their Start Dates, date of Individual Treatment Plan, commencement of services, interruptions and level of services.

9. Defendants will pay Plaintiffs' attorneys' fees in the amount of one hundred thousand dollars (\$100,000.00) and costs in the amount of eleven thousand one hundred fifty nine dollars (\$11,159.00) for all of the work done to date and for those incurred in securing approval, giving notice of the Agreement, and for monitoring compliance with this Agreement. All such payment of fees will be to Maine Equal Justice Project, and all costs shall be paid to Pierce Atwood.

10. The timeliness standards will be adopted as an emergency rule by DBDS. A final rule will be adopted within the time periods established by the Administrative Procedures Act.

11. The Agreement will be subject to approval by the Court in accordance with Federal Rule of Civil Procedure 23(e).

12. The lawsuit will be dismissed with prejudice and without costs based on the parties' settlement, with the Court retaining jurisdiction for the limited purpose of entertaining claims that the Agreement has been violated brought by the parties brought no later than two years after the date of the Agreement. The "date of the Agreement" shall be the date of entry of the Order of Dismissal.

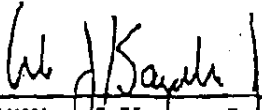
13. Plaintiffs shall provide to defendants and the Attorney General reasonable notice in writing of any alleged violation of this Agreement prior to commencing or filing any suit based upon such alleged violation. Absent circumstances that would warrant a need for relief in a shorter time period, "reasonable notice" is deemed to be sixty (60) days. After reasonable written notice, the parties shall engage in reasonable efforts to resolve any dispute prior to filing any suit or motion.

14. The DHS and DBDS will provide a notice that has been jointly prepared with the Plaintiff's counsel to all class members currently awaiting in-home behavioral health services as of April 16, 2002, and to case management agencies, and to the agencies providing services under section 24 and section 65 to the class members, and such other notice as the Court might require.

15. This Agreement sets forth the full agreement between the parties, and any amendment hereof shall be in writing. Representations not contained in this Agreement shall have no effect.

On behalf of Plaintiffs:

Dated: 5-3-02

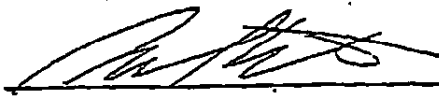


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On behalf of Defendants:

Dated: 5/7/02



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APPENDIX E

Examples of Treatment Facilities in Other States That Provide Mental and Behavioral Health Services to Deaf and Hard of Hearing Children and Adolescents

Examples of Treatment Facilities in Other States That Provide Mental and Behavioral Health Services to Deaf and Hard of Hearing Children and Adolescents

	Mental and Behavioral Health Services	Family Support Services	Specialized Education	Residential Program
<p>American School for the Deaf (ASD) PACES Program W. Hartford, CT</p>	<p>Counseling - Full-time counselors using a variety of counseling and therapeutic approaches</p> <p>Support Services - Access to ASD's comprehensive services in the areas of speech and audiology, psychological testing and evaluation, medical and health-related services, interpreter services for deaf or Spanish-speaking parents. Individual, structured behavior management programs, developed to meet each student's needs</p> <p>Consultants - In psychiatry, neurology, occupational and physical therapy, and behavior management.</p>	<p>Family Services - PACES parents group, home visits by counseling and administrative staff, parent training and counseling</p>	<p>Academic - Small, individualized classes</p> <p>Vocational - Pre-vocational and vocational training; assessment, job training, work experience and job placement services.</p> <p>Transitional Services - Support for students returning to regular academic and vocational programming</p>	<p>Residential –Monday through Friday during the academic year, emphasizing development of independent living skills, problem solving skills, appropriate use of leisure time, and socially appropriate behaviors. 2 programs, one for students ages 5-13 and one for students ages 14-21; Small 12-month program for boys with severe mental health needs.</p> <p>Extracurricular - A wide variety of social and recreational after-school activities, including sports, student work programs and supervised community field trips.</p>
<p>The Walden School/The Learning Center Framingham, MA</p>	<p>Counseling - Full-time counselors provide services to students on an individual or group basis, either for ongoing support or in response to acute need. Counselors also serve as a resource to staff and parents.</p> <p>Support Services – Include Cochlear Implant Services, Communication Services, Interpreting Services Occupational & Physical Therapy Medical services, Audiology services</p>	<p>Family services - Individually designed based on the needs of each family and may include on-going therapy, home visits, training, consultations, and/or parent support groups.</p>	<p>Academics - The educational program offers students a full range of academic and enrichment courses, and life skills, social skills, and work skills training. Students are taught in self-contained classrooms with teachers and associates trained to address their therapeutic, behavioral, and educational needs. As students progress, they may begin taking classes in the Learning Center elementary, middle school, or high school programs.</p>	<p>Residential - Offers school-calendar and 12-month residential services, as well as an option for day programming only for students ages 8-21.</p>

Examples of Treatment Facilities in Other States That Provide Mental and Behavioral Health Services to Deaf and Hard of Hearing Children and Adolescents

	Mental and Behavioral Health Services	Family Support Services	Specialized Education	Residential Program
<p>The National Deaf Academy Mount Dora, FL</p>	<p>Counseling – Each patient is assigned a treatment team of professionals trained in both mental health treatment and Deafness. The treatment team develops and implements an individual plan for treatment generally includes an Individual Education Plan (IEP), short and long term goals and objectives, tentative discharge plans, a Behavioral Intervention Program, and family therapy goals.</p> <p>Each Deaf resident receives individual, group, family therapy, and transition services.</p>	<p>Family Services - Parent Support and Educational Programs, family therapy, on-site visitation</p>	<p>Academics - The Charter School at National Deaf Academy (CSNDA) provides year-round education to Deaf and Hard of Hearing patients age 6 through 22. Each student has a personalized Individual Education Plan developed by CSNDA staff. Classes are taught by certified Deaf Education Instructors with additional support staff provided at a 3:1 patient-to-staff ratio. State-of-the-Art computer lab offers computer training and technology education.</p> <p>Vocational - Pre-vocational assessments and programs such as campus employment; education regarding employment; and preparation for ongoing education</p>	<p>Residential deaf and hard of hearing children, ages 6 to 17, identified with a psychiatric disorder.</p>

APPENDIX F

**Task Force Proposal to Create an In-State Children and Family
Community Support Services Program**

Task Force Proposal to Create an In-State Children and Family Community Support Services Program

Goal: To provide intensive support to children and families in their homes, communities and social environments that is culturally and linguistically appropriate.

Overview: A Community Support Program as defined in Section 65G of the MaineCare regulations would provide the following services:

- Family support;
- Promote community integration and continuity of care;
- Reduction of symptoms;
- Maintain quality of life and family intactness among children and adolescents with emotional disturbances;
- Supportive counseling or guidance for child and family members;
- Discharge planning and placement;
- Outreach;
- Reunification and mediation;
- Crisis management planning;
- Arranging for medication monitoring;
- Medical and special needs information and referral;
- Assistance in obtaining services, entitlements and benefits and other basic necessities;
- Development of behavior management plans and skill building activities;
- Ensuring continuity and consistency of such activities across school, home and community settings;
- Language training;
- Bridge services;
- Mentors; and
- All services listed above are provided according to the developmental level of the identified child.

Program Structure: The ideal program would be housed within an agency familiar with services to deaf consumers, which is able to financially assume the limitations of the billing/reimbursement amounts.

The ideal structure for the program would consist of 1 FTE Program Supervisor, 4 FTE Community Support Workers and 1 FTE behavioral management specialist position. All positions require ASL proficiency on at least the “superior level” as rated by a completed SCPI. The program would utilize a team approach to treatment.

The program should be prepared to serve identified children and families on a statewide level. This would include significant travel for some staff, which should be built in to the job descriptions for the 4 Community Support Workers. Services would be provided in the home in collaboration with schools and could also utilize telecast technology for additional services such as case coordination, medication management, and advocacy.

APPENDIX G

Minority Report Recommendation

Minority Report Regarding Task Force Recommendation #8
Submitted by Task Force Member Christine Bartlett

As the representative for the Department of Education on this Task Force, I cannot support Recommendation #8. While I appreciate the concerns leading to this recommendation, there are several reasons why I am adding a minority position.

Under the provisions of the federal No Child Left Behind Act (NCLB), Maine is required to demonstrate how it is providing for highly qualified teachers, increasing the standards for individuals entering the education field. For programs utilizing NCLB funds for paraprofessionals, the standard has also already been raised. It is anticipated that the reauthorization of the Individuals with Disabilities Education Act will contain similar language regarding higher standards for both professional and paraprofessional staff in the field of education.

The Department of Education and the State Board of Education both have responsibility for standards for certification of education personnel in this state. Both have already spent considerable time in reviewing proposals to develop alternative systems for certification and have determined that this approach will not work for Maine. The decision was based in part on the ability of the department to manage such a system with limited personnel.

Provision has already been made to allow individuals who were prelingually deaf to have an extended period of time to pass required assessments in order to be certified, a provision which will go into effect by August 2005. The Certification Unit of the Department of Education already works individually with deaf and hard of hearing applicants for paraprofessional approval, to assist them in meeting the criteria for those positions.