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Interdisciplinary Collaboration to ensure the well-being of Deaf and Hard of Hearing Students with Complex Needs

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Introduction

Based on nationwide hearing examination data for youth aged 12-17 (www.cdc.gov/nchs/nhanes.htm), an estimated 1% of children in this age category have at least moderate hearing loss in one or both ears. The Center for Disease Control (CDC) estimates that between 2% and 6% of children with moderate or greater hearing loss are identified with a developmental disability of some type, and 27% of deaf and hard of hearing (D/HH) individuals aged 6-19 years have additional disabilities (Gallaudet Research Institute, 2008). Hearing loss or deafness may be related to cytomegalovirus, meningitis, or a congenital anomaly, conditions that are known to present a greater risk for the evolution of other conditions such as learning disabilities, autism, intellectual disabilities, anxiety, or physical health conditions (Mathos, 2005). Each D/HH child is unique, and the group represents a very broad range of functional limitations and strengths (Luft, 2011).

In this discussion, behavioral health is meant in the broadest sense of the word; it is defined as “the emotion, behaviors and biology relating to a person’s well-being, their ability to function in everyday life and their concept of self” (www.ncmhr.org). The focus here is on the behavioral/emotional health of transitioning D/HH students because the authors’ clinical experiences have led to recognition that unique gaps exist in service planning and availability as it relates to this sub-population. There are scarce behavioral health resources for D/HH students who have complex needs (Nolan, 2015). Thus, there is a need to share collaboration models where transition successes have taken place. This article discusses 1. Challenges encountered when working with transition age students with complex needs; 2. What follow-up exists for these students post-graduation; and 3. What collaboration efforts are in place to address challenges that exist between schools and social service system providers.

One of the substantial challenges facing educators, vocational counselors, and behavioral health providers working with D/HH students who have additional disabilities (DWD) is having the capacity and expertise to provide high-quality transition services meeting individual needs (Luft, 2015). Adolescents who are D/HH are already quite diverse, not only because of factors that affect all populations (i.e., cultural and linguistic diversity, socioeconomic status, and gender), but also because of their age of identification, when services began, use of amplification, and communication choices. Transition-age DWD students are also diverse due to their unique developmental and learning needs. All of these factors influence the program and intervention choices that can optimize each student's skills to lead to successful adulthood. Students who are D/HH with additional disabilities make up approximately 8.8% of the youth population (Gallaudet Research Institute, 2013). Because nearly 25% of D/HH individuals have one or more behavioral or developmental disability, there is a need for individualized treatment planning to best meet each’s needs.

Transition planning is a process mandated by the Individuals with Disabilities Education Act (IDEA) (2004) for all students who have an individualized education program (IEP) in K-12

education. This planning offers a forum to discuss behavioral health needs and to review academic and community-based service options. The IEP is to ensure higher success rates for the student's move from school to post-school activities. A postsecondary transition must include measurable postsecondary goals for students based on age-appropriate transition assessments related to training/education, employment, independent living skills as well as a description of transition services including courses of study which are needed to assist the students in reaching their goals (Clark, 2004). Much of the rationale for establishing these provisions was based on the recognition that many young adults with all types of disabilities were exiting high school unprepared for adult life (Luft & Huff, 2011). Follow-up studies among former special education students in the past two decades have consistently documented unsatisfactory outcomes as they leave school and attempt to access employment, postsecondary education programs, and adult community services (Johnson, McGrew, Bloomberg, Bruininks, & Lin, 1997.)

The population of D/HH children is a diverse group. It is important that the provider community is kept abreast of developments and best practice ideas that encourage collaboration, student guidance, and parental involvement in early high school. For many students, transition involves moving from high school to a post-secondary program and then entering the workforce. All the skills needed to be successful in the transition process must be considered, such as effective communication, cognitive clarity, emotional regulation, consistent work habits, awareness of school and life expectations, and complex problem-solving.

People with disabilities are grossly underrepresented in the workforce. Approximately 20% of disabled people are employed, compared to 69% of the non-disabled population. Only 15% of disabled teenagers aged 16-19 are employed compared to 26.3% of their non-disabled peers. Additionally, 26.7% of 20-24-year-old people with disabilities are employed, as opposed to 61% of those without disabilities (Office of Disability Employment Policy News Brief, 2012). One study indicated that training on individualized job development strategies, utilizing job coaches, and follow-up mentoring of employment consultants can help job seekers with disabilities in reaching their employment goals (Grigal et al., 2011). Additionally, this population of transition-age youth is known to have difficulty accessing the mental health and social service system (Mathos, 2015). There is a lack of certified sign language interpreters throughout the United States. Additionally, there are few agencies that have ASL fluent staff to provide mental health and social services. Health knowledge, resource awareness, and ability to communicate effectively with evaluators and care providers are additional service barriers.

For some students, a behavioral health problem may have been something that interfered with classroom learning as identified by a teacher. In other situations, the behavioral problem is short-term, and for yet others, such challenges may be lifelong and evolving. Emotional stress may be compounded by specific worries about life transitions and a sudden loss of support services that existed in the school setting. There is a need for providers and caregivers working with D/HH students to access behavioral health information, social service supports, and specialized mental health services prior to a student's high school graduation. In addition, those services should be

geographically feasible at the time the student leaves high school. Such supports are needed in the home and in the teen's community. In some regions, these services may have not been accessed prior to a student's graduation because they were provided directly in the school setting through the child's IEP.

There are major differences among schools in the nation regarding the degree of behavioral health services provided on the school premises. D/HH children are educated in a diverse array of settings, which might include resource room settings, traditional classrooms in mainstream settings, charter schools, or schools for the deaf. Nationally, the majority of D/HH children is being educated in mainstream school settings (Gallaudet Research Institute, 2013).

Since the mid-1980s, the U.S. Department of Education, Office of Special Education, and Rehabilitative Services have stressed the importance of improving transition services. In more recent years, there has been legislation focusing on more comprehensive transition services for high school students. This has resulted in increased emphasis for all students to have plans as they leave the K-12 system, including connecting with community supports. As part of the Workforce Innovation and Opportunity Act (WIOA) vocational rehabilitation counselors will attend IEP meetings on a more regular basis, and be made aware of the student's special needs and strengths earlier in the transition process. Hence, there will be increased opportunities for those counselors to work side-by-side with deaf educators and community-based providers. Collaborative meetings provide a forum to discuss and advocate for how to better develop and link resources for D/HH persons with behavioral health or developmental disability services. Unmet behavioral health or limited supports for DWDs also naturally affect employment potential and overall quality of life.

The National Longitudinal Transition Studies,(2009) showed several areas of concern such as D/HH young adults requiring extended time to complete their post-high school training. This study showed that on average, it takes most D/HH individuals eight or more years to complete training or to move into independent living situations (Newman et al., 2011). Additionally, 85% or more of the D/HH students who attend local school programs (U.S. Department of Education, 2013) may have limited access to disability-specific transition preparation; school offerings are typically designed primarily for general high school or special education populations. The transition preparation that does exist for this specific group more often is generic and superficial in content (Luft, 2013b, 2014a, 2014b; Luft & Huff, 2011). However, this study also found that up to eight years after leaving high school, D/HH students interact with friends at least weekly, and the majority participates in some type of community group or activity at least once weekly (Newman et al., 2011). Additionally, interpersonal connections on social media may provide opportunities for resource sharing among this population. Nationally, vocational rehabilitation counselors for Deaf people have served as role models and conduits for assessment and resource information for deaf persons (Nolan, 2015).

Students Who Are Deaf or Hard of Hearing and Have Emotional/Behavioral Disorders

According to the Graduate Research Institute (2013), 2.1% of the K-12 population has emotional/behavioral disorders (EBDs), including a range of conditions attributable to genetic and/or environmental factors. Childhood- and adolescence-onset conditions, including depression, anxiety, schizophrenia, and posttraumatic stress disorder, show evidence of substantial improvement when identified and treated early. The etiology of a child's deafness or developmental disabilities may also imply unique risks for the development of behavioral health problems (Boyle, 2011). A disproportionate number of hearing students display externalizing behaviors, manifested by acting out and making intense emotional displays, or internalizing behaviors that lead to anxiety, withdrawal, phobias, and depression (Raymond, 2000). Some research shows that D/HH students have a higher incidence of difficulty with self-control and impulse control (Hauser, Lukomski, & Hillman, 2008). Although all children have occasional episodes of disruptive behavior, those with patterns of persistent and severe behavioral difficulties should be assessed. Specific concerns include social and maladaptive functioning, aggression and destruction of property, and rules violation. However, providing a structured environment can improve performance (Baker et al., 2009).

A number of studies have identified behavioral problems in children with hearing loss or deafness as being linked to language and communication difficulties (Stevenson, McCann, Watkin, Worsfold, & Kennedy, 2010). The impact of language skill development on emotional and behavioral skills include the use of language to (a) make wants and needs known, (b) recognize specific emotions in oneself and others, and (c) control emotions and use this knowledge in social situations (Stevenson, McCann, Watkin, Worsfold, & Kennedy, 2010). The absence of pragmatic linguistic skills can lead to situations in which one may be unable to differentiate appropriate contexts for responses or lack the linguistic means to express feelings and frustrations. These premorbid linguistic inefficiencies may place D/HH children at greater risk during times of transition when communication partners with whom they are familiar may be lost (Luft, 2015).

Students Who Are D/HH on the Autism Spectrum

The identification and prevalence of autism spectrum disorder (ASD), found in 2.2% of the D/HH K-12 population, have increased not only within that group but also among other student populations (Gallaudet Research Institute, 2013). D/HH students show the same range, from mild to severe levels, of ASD. Those with milder forms of ASD, such as Asperger Syndrome, often struggle to interpret manner and intent of communication across instructional, social, verbal, and nonverbal content. Although an accurate diagnosis is important for instructional and transition planning, certain aspects of language and communication deprivation associated with deafness can mimic ASD (Collins & Carney, 2007). Sign language has been successfully used with students who are hearing and have autism, and provides an advantage to those who are D/HH-ASD. Those with severe levels of ASD are more often perceived as primarily D/HH and are therefore given access to sign language and visual communication, instead of placements in programs focused on autism or developmental delays paired with access to sign communication (Miller & Funayama, 2008).

Transition goals depend on the extent and nature of the student's ASD and its impact on language acquisition, communication, and cognitive abilities. The developmental disability service system is often ill prepared to address the multiple needs of transition-age hearing youth who have autism; for children who are D/HH, even more access issues exist (Mathos, 2015). With the ASD population, there is a tendency to misinterpret social contacts and to have inappropriate emotional responses, as well having the need for predictability and order (Collins & Carney, 2007). Students with severe levels of ASD need substantial supports to address communication and social interaction challenges, incomplete understanding and expression of emotions, incomplete understanding of facial expressions, unusual reactions to environmental situations, and resistance to changes in routines (Szymanski & Brice, 2008), each of which can affect work, community activities, and personal relationships. Evidence-based practices to help address these needs include the use of choice, prompting/ cueing, contingency contracts, token economies, modeling, schedules, and social stories (Borders, Bock, & Szymanski, 2015), all important for acquiring transition skills. School settings may be enhanced to provide structure, with clearly designated tasks or responsibilities, visual schedules, participation in developing these schedules, and preparation and practice for expected interactions (Bradley, Krakowski, & Thiessen, 2008). Some students will need a job coach or an on-site support person, who could also be a coworker, to monitor various aspects of work performance. Some students with severe ASD require supported living with daily or weekly staff monitoring, or need the ongoing support of living in a group home. These programs typically are identified and implemented through vocational rehabilitation services.

Much of the success in achieving transition and post-school goals will depend on the quality of instruction and services provided during high school and how those resources are conveyed to the youth's community. Particular vulnerability may exist for transition-age youth who are already identified with behavioral health problems, especially when they lose important social supports from the school system. Such known supports may not exist in their home community. At the time of transition, other youths may be at risk of onset of new anxiety and depression when they lose important peer supports, trusted adults, and people with whom they can easily communicate.

Currently, there is little, if any, information available regarding how successful D/HH students with emotional disturbance, autism, and/or intellectual disability are at finding community services following graduation.

Method

Using SurveyMonkey, a questionnaire (see Appendix A) was sent to professionals working with D/HH students. To reach a large number of service providers, the questionnaire was sent to a list server comprised of transition coordinators, teachers of deaf and hard of hearing students, social workers, and mental health and vocational rehabilitation counselors working with D/HH individuals. Respondents included mainstream, school for the deaf, independent school districts, and regional school district personnel, vocational rehabilitation counselors, and behavioral health service providers. Investigators also placed calls to each state school for the deaf. The survey asked questions in the following four categories: 1.) School demographics, such as referral source for

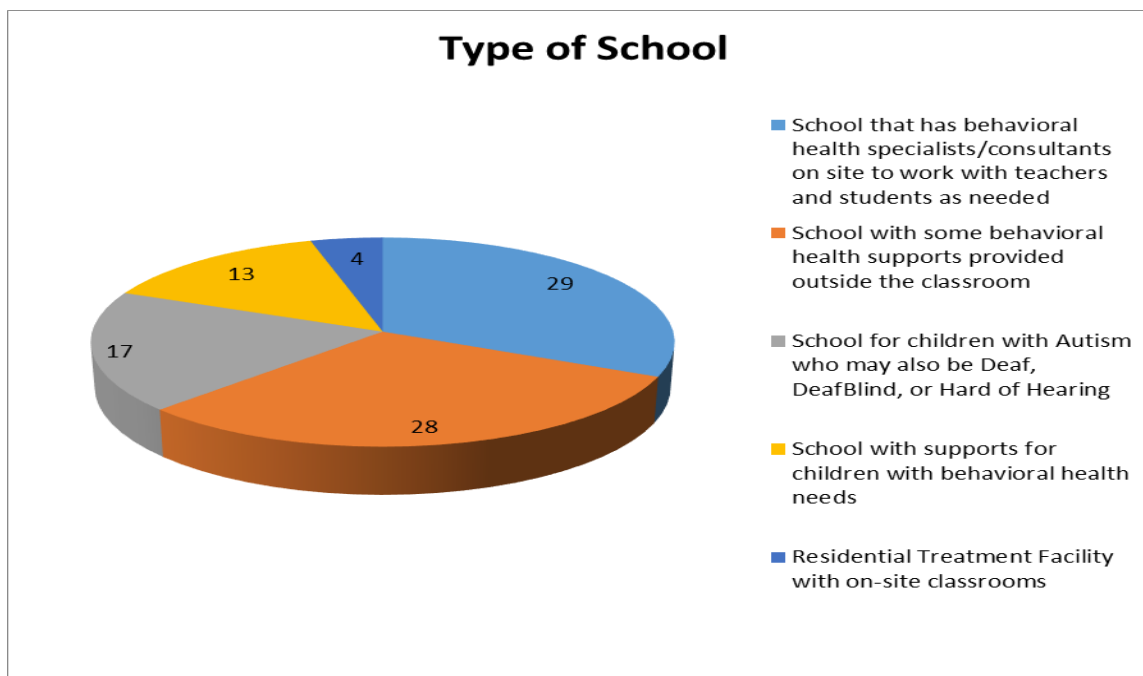
students, primary function of the school, average length of enrollment, and type of support personnel at the school; 2. The type of disabilities that school personnel encountered; 3. The school’s process for tracking outcomes of program graduates; and 4. The frequency that students and families successfully connected to community-based services. Additionally, investigators collected information related to barriers to such service acquisition.

Results

A total of 80 responses representing 27 states were received. Respondents had a variety of roles within the school system, including transition coordinators, hearing support teachers, special education directors, and social workers. Of the 80 respondents, 22 were employed at schools for the deaf, 32 represented independent school districts, and 10 represented state entities made up of vocational rehabilitation and state mental health service providers.

Figure 1 illustrates the nature of integration of behavioral health supports in the various school settings. There is great diversity in how behavioral supports are integrated into the school settings. It is evident from the data collected that there are some self-contained schools or classroom placements providing behavioral health services for D/HH children, children with intellectual disabilities and/or autism. The majority of school placements offering behavioral or itinerant supports have consulting services in the classroom.

Figure 1: Type of School



Fifty-two respondents indicated that state departments of education were a primary referral source. Thirty-three identified behavioral health system providers/case managers as a primary referral source. The remaining primary referral sources were foster care systems or juvenile

probation. The question focused on primary referral sources, so other secondary referral sources might exist, or sources that provide occasional referrals, depending on the area. The focus on primary referral sources attempted to identify what types of agencies were involved.

Next, we aimed to learn more about the kind of relationship that was established between the child, family and school personnel. Respondents shared that students typically stayed in the school setting to which they were referred for more than five years. Only two respondents reported typically knowing children for fewer than six months.

Respondents also reported that there were increasing opportunities for schools to address behavioral problems by bringing behavioral health services directly into the school setting. During the time the child is enrolled in school, staff may work hard to enlist the child in school- or community-based behavioral health services.

Respondents were asked to list the types of on-site personnel available to students. Behavioral consultants were the most common personnel listed, with 45 schools reporting having such personnel. Social workers were the second most common personnel, with consulting psychologists, and psychiatrists being less common. It is notable that 19 schools surveyed did not have any behavioral health supports on site.

Respondents also reported that behavioral health services that children receive might be funded using only educational dollars prior to a student's graduation. Consequently, children may not have open cases with the behavioral health or the intellectual disability service systems in their region prior to graduation.

Figures 2 and 3 illustrate the complexity of behavioral health diagnoses of students served. Respondents to the survey also identified the percentage of Deaf and hard of hearing students diagnosed with a variety of behavioral health conditions, the most frequently diagnosed conditions being anxiety and Attention Deficit Disorder. Intellectual disability and autism were also diagnosed at rates exceeding national standards found among hearing children (Boyle, 2011). The majority of respondents reported 10% to 50% of D/HH students had a behavioral health diagnosis. Several respondents reported that 90% to 100% of the Deaf and hard of hearing students at their schools also had a diagnosis of major depression, anxiety, or intellectual disability.

Figure 2: Behavioral Health Diagnoses of Students Served

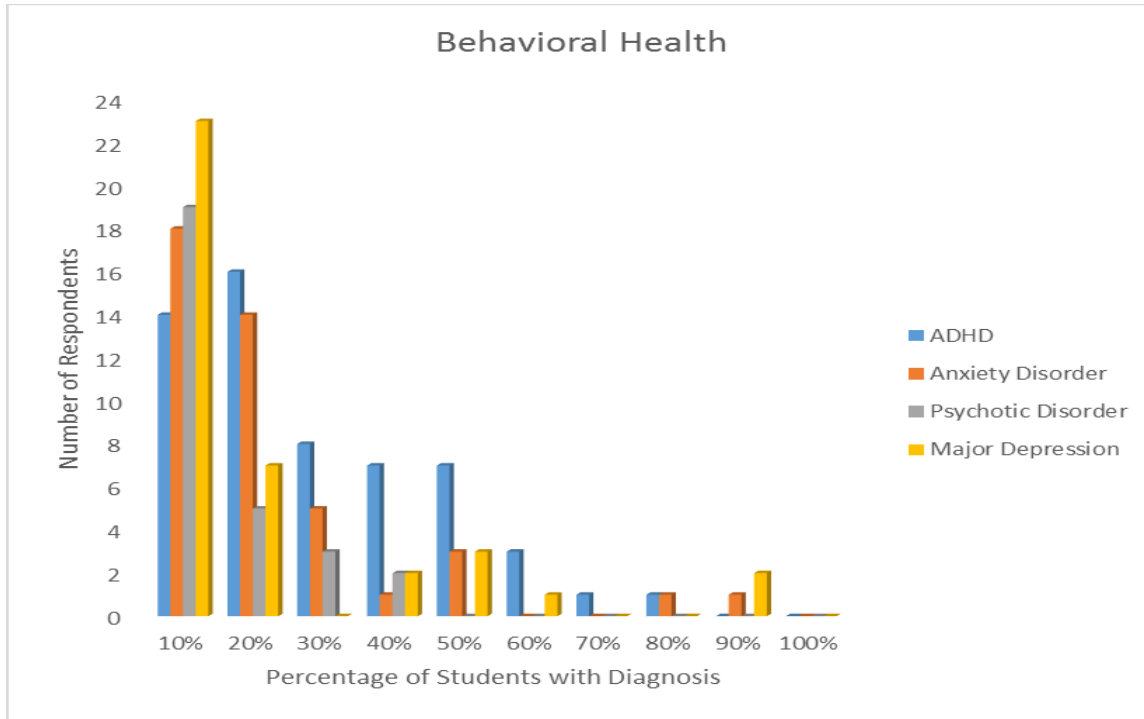


Figure 3: Diagnosis of Students Served-Intellectual Disability and Autism

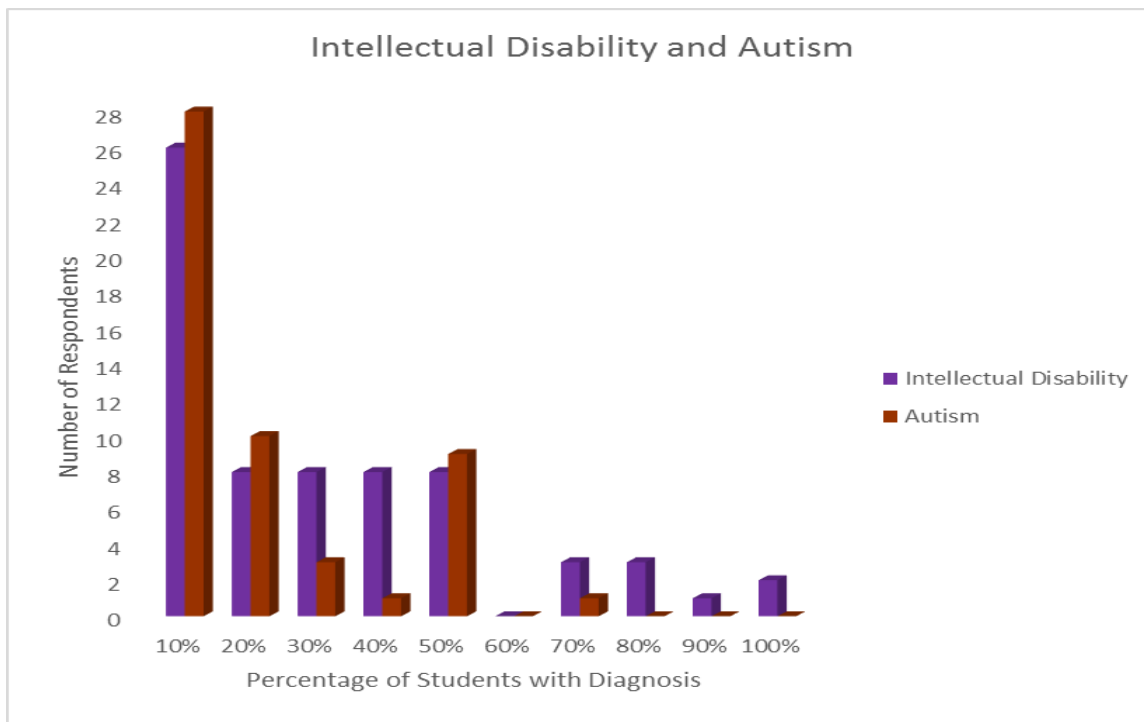
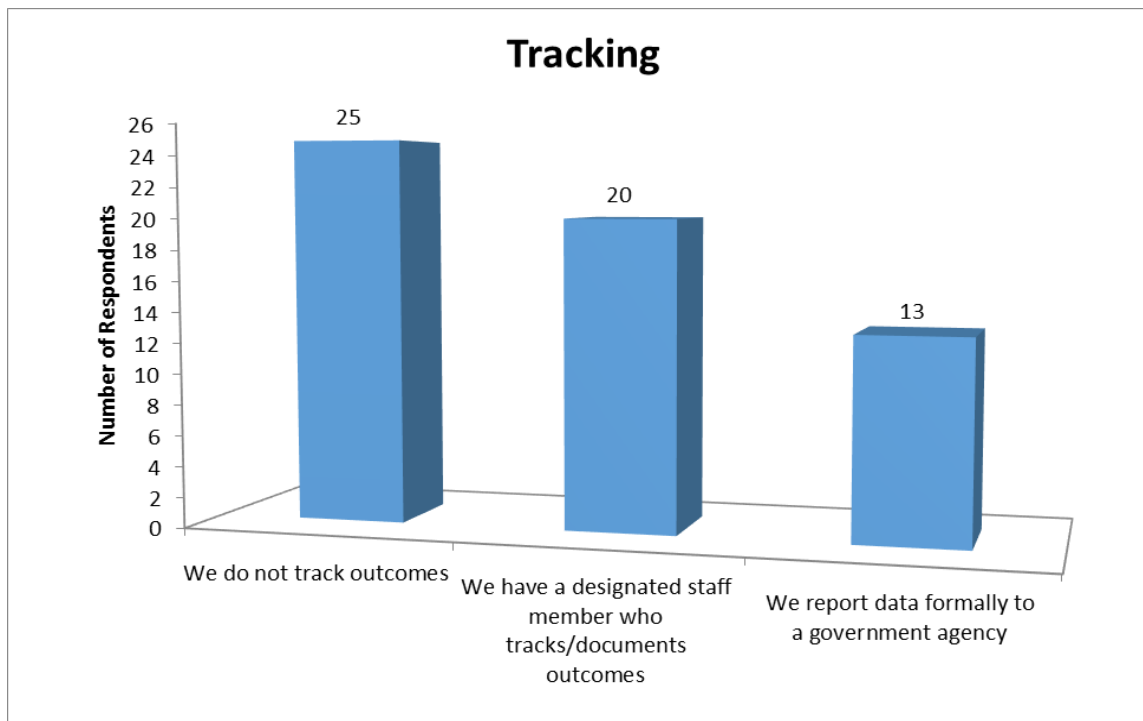


Figure 4 shows that 25 reported they did not track outcomes among graduating students, 20 reported having a designated staff person to track outcomes, and 13 indicated that they reported data formally to a government agency. A majority of schools surveyed does not have a transition coordinator assigned to track the whereabouts of graduates or to encourage their connection to community-based services.

Respondents were also asked what barriers they thought interfered with the acquisition of services for students needing behavioral health services outside of school. The two main barriers reported were a lack of providers fluent in American Sign Language (ASL) in the behavioral health clinics, and a lack of knowledge by the student/family about accessing services. Another commonly reported issue was a lack of interpreters available to work with non-signing behavioral health providers. It was also reported that students did not have appropriate insurance for accessing appropriate services.

Figure 4: Tracking Outcomes



Discussion

Respondents to this study reported that they commonly worked with students with varied and complex needs. Many of the transition-age youth that the respondents regularly worked with had emotional issues, intellectual disabilities, and/or autism. The respondents typically worked with the students for more than two years and often for over a period of five years. Despite the long time that these students were known to them, few schools had an established protocol for tracking or assisting students in acquiring behavioral health or intellectual disability supports following graduation. This

lack of follow-up may be related to a lack of funding earmarked for such tracking or resource coordination.

School personnel also reported that barriers to the successful acquisition of behavioral health supports often included a lack of trained community-based providers who were fluent in ASL, a lack of interpreters who could assist behavioral health providers, and a lack of knowledge of existing resources. Such findings are similarly noted in a 2015 national survey of services providers by Nolan et al.

Respondents noted a lack of awareness of existing academic and community-based counseling, along with behavioral health or intellectual disability-related resources among school personnel, students and family members. Given the scarcity of providers fluent in ASL across the country, it is imperative that students and families learn to advocate the need for such services even when such services may not be available. Students with Intellectual Disabilities need to be registered and linked to appropriate funding sources within their communities, and be connected to advocacy organizations.

If a student's behavioral health needs are not well defined when in a K-12 setting, more issues are likely to surface once they leave that environment. If risk factors are not identified, the odds of them getting services when they leave the school system are slim. Students and their families must gain familiarity with national advocacy networks such as the Protection and Advocacy for Individuals with Mental Illness (PAIMI). This agency helps to ensure that interpreters are available at community-based behavioral health facilities and that appropriate behavioral health services are obtained. Schools and community agencies may need to collaborate far in advance of a student's graduation in order to identify resources, even when appropriate linguistically-accessible resources may not exist for children from rural areas.

Because students typically spend many years in a school, there may be opportunities for transition coordinators or other school personnel to teach teens about self-advocacy and community resource awareness. Several respondents indicated that they had successfully initiated projects to raise awareness about existing resources and teach about ideal mental health care, and they have begun to bridge the void in services that often exists when a student graduates. Some school systems and communities hold resource fairs to share information about advocacy, intellectual disability and behavioral health supports. Other regions have begun to offer concierge services or have created resource directories to assist transition coordinators, students, and parents.

Some respondents offered examples of how they worked to assist family members and students in finding community resources. Some schools for the deaf identified staff to manage calls and to connect and provide support for graduates as well as assist with resource awareness. Other counseling programs, especially at schools for the deaf, incorporated behavioral health supports directly into their high school programs. Those personnel onsite at the schools are directly available to assist in the transition to ASL-fluent adult service providers and resource coordination.

Various states departments of education have provided resource and informational networks as well as parent email lists. Due to changing federal regulations, state vocational rehabilitation agencies have established summer programs for transition planning. Some of these programs have included an emphasis on collaboration with behavioral health personnel, peer counselors, social service agencies, health care systems, post-secondary education programs, D/HH teachers, and vocational rehabilitation counselors. Some communities have utilized email lists and social media to raise awareness about resources.

A local program in one state was designed collaboratively by an interagency taskforce convened by the county mental health system. As a result of this collaboration, the program design was informed by the collective expertise of professionals working in mental health, education, juvenile probation, child welfare, vocational rehabilitation, mental retardation, child and family services, drug and alcohol services, and advocacy groups. The task force members wrote a successful funding proposal for a state mental health agency grant. Collective workgroup efforts by professionals from various disciplines invested in the wellness needs of D/HH individuals have been instrumental in forming specialized evaluation consulting teams and fostering service development in other parts of the country as well (Mathos, 2015).

Continued collaboration efforts between school personnel and behavioral health providers for children with hearing loss and deafness prior to graduation are needed. New mandates for vocational rehabilitation intervention through the Workforce Initiative Opportunity in early high school years may present an opportunity for discussions about accessing behavioral health service and other services in the community setting as a part of the IEP process earlier in the student's transition planning process. The role of the transition facilitator will no doubt evolve over time (Clark, 2004).

Clark (2004) has used the term "transition facilitator" to emphasize that this person's role is as a facilitator of the youth's transition. Transition facilitators mentor transition-age youth to help them develop self-determination skills and connect to existing resources. Transition coordinators are in a position to review cases where existing developmental disabilities or behavioral health needs have been identified and to foster the teen to develop to the fullest potential. In some geographical locales, no ASL fluent resources exist in the teen's community. Some coordinators have begun to identify complex cases and encourage students and families to enroll in community supports prior to graduation to work with the community agencies in informing the agencies of the child's needs more fully. Interdisciplinary consultation on a case-by-case basis may be valuable as a means to build partnerships between ASL-fluent staff and community agencies that may not previously had experience serving D/HH individuals.

Challenges

One challenge to the provision of transition service to this low incidence population is the supply and demand across the overall D/HH population. Young people ages 14-21 years make up 47.7% of the K-12 population (Gallaudet Research Institute, 2013), and should receive a

proportionally equal quantity and quality of specialized services offered to younger students. Efforts to support this sizable transition-age group are complicated by a lack of training to support high quality transition services related to this group's unique needs (Morningstar et al., 2010).

Transition teams are beginning to collaborate with individuals beyond the school site and seek expertise across districts and regions to include adult agencies, as well as state and regional D/HH and transition resources. For D/HH students, a key source of networking is the rehabilitation counselor of the deaf, who often has contacts among a variety of agencies and resources that can expedite these linkages. Schools for the deaf are historically another important resource, as they often have expertise in transition planning, career development, work preparation strategies, and other disability-specific services (Luft, 2013b; 2014a). Successful programs utilize expanded transition teams that connect people across the student's present and future adult settings, thereby increasing the personnel and resource networks he or she can draw upon.

Implications of the Study

To improve the likelihood of successful transition for D/HH students leaving high school who have behavioral health, autism or intellectual disabilities, we must collectively prioritize accurate and timely assessments, advocacy, and resource awareness, improve follow up with graduating students, and assist the family to identify viable community-based behavioral health services.

State, regional and local stakeholders need to engage in strategic planning so that existing resources can be better identified and gaps in service can be addressed. Some recommendations are below.

Recommendations:

1. Transition plans should involve behavioral health and developmental disability assessments and screenings to document possible service needs.
2. Schools should be encouraged to track outcomes for students with behavioral health and developmental disability needs.
3. Continued discussion about follow-up support for students with behavioral health needs is of paramount importance in all IEP meetings.
4. School personnel should inform the student and family about advocacy resources when ASL-fluent providers are unavailable.
5. A network of resources for children and families should be established in each community.
6. Transition consultation or peer support should be offered remotely via teletherapy as a means to better track and support youth in transition. Case consultation should also occur on an individual basis for children at particular risk.
7. Resource fairs should be offered for students, parents and caregivers to learn more about advocacy organizations, vocational rehabilitation, and the behavioral health system.
8. Task force development or interagency partnerships should be considered from a cross-agency perspective and include health, mental health, child welfare, parole/probation

professionals, relevant case managers, and natural supports from family, friends, mentors, and others.

9. Employers should promote competitive employment for youth with mental health and behavioral needs, and provide opportunities for work-based experiences and career exploration.
10. Rehabilitation counselors for the deaf could consider sub-specialization to align resources and better serve transition-age youth with multiple disabilities.

In order to be effective, schools need to build relationships with adult service agencies. Such interagency networking is of paramount importance to promote comprehensive transition planning. Schools can begin to invite adult agencies to IEP meetings by the time the student is a high school sophomore or junior, and be aware of what support services the student may need after graduation. Training should be held for high school faculty on transition services, including training on legal requirements. Schools should also develop an Adult Transition Program where students walk with their class but do not graduate if they are not yet ready to leave special education. If needed, this enables students to continue receiving services until age 22 and may allow more time for effective transition planning.

Limitations of the Study

In this exploratory study, it was sometimes difficult to identify the person from each school system as the most informed about transition-related issues. There was not standardization in the information that respondents shared about the diagnoses of children served and the manner in how various school personnel tracked this information. Some respondents based their answers on collected data, while others seemed to respond based on personal knowledge.

Respondents were largely recruited from email lists comprised of social service providers, including vocational rehabilitation counselors, and other professionals in deaf education. Transition coordinators or school personnel who work in mainstream programs or schools for autism that serve D/HH children may have been underrepresented in this study.

Summary

In this exploratory study, we found that there is limited service coordination and collaboration among schools and community service agencies serving children with hearing loss prior to graduation. Best practice models promoting school/community networking must be better studied and quantified.

New vocational-related derivatives bringing together school personnel and community providers early in a student's high school years will no doubt benefit children with behavioral health and developmental disability-related needs. When case discussions take place with providers aware of community resources and who have the best interest of a teen in mind, a "can do" spirit and a problem-solving approach can be fostered. Such discussions may present the opportunity to find scarce resources involving ASL-fluent providers and behavioral health or developmental disability

providers who may previously have been unfamiliar with serving the needs of D/HH persons. This kind of support may lead to better employability and more successful transitions, since such meetings promote improved reflection by students and families as well as assessing and redefining a child's needs. D/HH children who are represented among the respondent schools in this survey have significant rates of behavioral health disorders, intellectual disabilities and autism. These diagnoses place them at risk for finding employment, suitable housing, or satisfying peer relations if left untreated (Wagner, 1993).

New mandates for comprehensive transition planning may help inform students, parents, and other school personnel about the value of acquiring good mental health and/or developmental disability services at an earlier point during the transition planning process. While new mandates may be driven by employment initiatives, case-by-case discussions allow teens, parents, educators and counselors to reflect together about the youth as a whole person with unique strengths and challenges.

Although there are a significant number of students who have additional disabilities, including emotional behavioral disorders, the field lacks evidence-based strategies for school personnel to implement with this population of learners. When schools can effectively identify community supports and behavioral health counselors on a case-by-case basis, long-lasting partnerships with community providers can be built to benefit D/HH students for generations to come.

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Appendix A: Transition Survey Questions

1. Which of these are primary functions of your agency? Check all that apply.

- A school with some behavioral health supports provided outside of the classroom setting
- A Residential Treatment Facility (RTF) with on-site classrooms
- A school with supports for children with behavioral health needs
- A school that has behavioral health specialists/consultants on site to work with teachers and students as needed
- A school for children with autism who may also be Deaf, DeafBlind, or Hard of Hearing
- Other (please specify)

2. What are the primary referral services for your program? (Check all that apply)

- The State Department of Education
- Behavioral Health System providers or case managers
- Foster Care System
- Juvenile Probation
- Other (please specify)

3. Approximately what percentage of your students are:

Deaf, DeafBlind, Hard of Hearing or Hearing

4. Please select the appropriate response:

- Average length of stay
- Number of children served per year

5. If your agency offers behavioral health services on site, what personnel exist on site to offer these services? (Check all that apply)

- Social worker
- Psychiatrist
- Psychologist
- Drug and alcohol counselor
- Behavioral specialist/consultant
- We do not offer on-site behavioral health services
- Other (please specify)

6. Approximately what percentage of children/students who are enrolled in your program have the following diagnosis?

- Intellectual/developmental disability
- Autism
- Major Depression
- ADHD
- Drug and alcohol abuse

- Anxiety disorder
- Psychotic disorder
- Other (please specify)

7. Does your agency track outcomes of children who graduate or leave your program? (Check all that apply)

- We do not track outcomes
- We have a designated staff member who tracks/documents outcomes
- We report data formally to a government agency
- We track for a period less than 6 months
- We track for a period of 6 months to 1 year
- We track for a period of 1 year up to 3 years
- We track for a period of 3 years up to 5 years
- We track for a period of more than 5 years
- Other (please specify)

8. How often do children/students connect to needed behavioral health, intellectual disability, or autism related services within 2 months of leaving your program?

- We do not follow children after they leave the program
- less than 10% of the time
- 10% to 50% of the time
- More than 50% of the time, but less than 100% of the time

9. If children/students need behavioral health, intellectual disability, or autism related services and do not connect with services in their area, what do you see as the barriers to acquisition of services? (Check all that apply)

- No ASL fluent providers in the area
- Lack of interpreters at the behavioral health provider office
- Students and children do not know where to turn to access services
- Students do not have the appropriate insurance
- Other (please specify)

10. In order to gather accurate data, please provide agency/school name (required) and state (required). If you would like to be contacted to share your ideas with the research team, please provide your name and other contact information below (optional).

Name:

Company:

Address:

Address 2:

City/Town:

State:

ZIP:

Email Address:

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