There are often questions and, sometimes, confusion when looking at services to a child who is deaf or hard of hearing. Because very young children are not yet ready to work on specific strategies for speech such as fluency and articulation, deaf and speech services can look very similar for an infant or toddler. However, services from a teacher of the deaf and services from a speech-language pathologist are not the same service, not matter how much they might look alike. Today we are going to look at both of these services including their similarities and differences.
This is where it all begins – in our amazing brains. Everything we do and everything we are is encompassed within this complex muscle. You can see the various areas of the brain and what those areas control within the body. You see some areas of overlap, such as the frontal and temporal lobes both involved with behavior and the frontal lobs and motor cortex are both associated with movement. The brain is not developing these processes in isolation inside of the various lobes and cortexes. Growth, learning, and development require full brain involvement through all stages of support or intervention, because the more we stimulate the whole brain, the better the results will be when we look at the more specific processes. The more we engage the whole brain of the child, the better the brain absorbs and retains information. Additionally each area that is stimulated encourages growth throughout the entire brain. Children must have opportunities during activities with parents and caregivers to move around, to touch, to see or hear, or to use their other senses, and to use balance and coordination. The stimulation to the whole brain is critical for infants and young children.
Whenever we talk about children who are DHH, we often talk about the potential for communication and language delays. In some cases, people use the words communication and language interchangeably, when in fact they are related but not exactly identical.

Communication and Language

- Communication is a successful way of conveying or sharing of ideas and feelings.
  - A child can communicate without formal language through gestures, facial expressions, showing, crying, laughing, etc
  - Communication can include formal language
- Languages are made up of words and rules that tell how these words are used
  - Words can be spoken, signed, or written
  - Rules or grammar are unique to each language (including American Sign Language)
- Speech is a verbal means of communicating, involving articulation, voice, and fluency
In the state of Texas, teachers working with deaf or hard of hearing children must be certified in deaf education. In birth to three services, the MOU with TEA and ECI again stipulates that teachers of the deaf must be certified in deaf education. This is because through their training, deaf ed teachers develop a knowledge of communication options for families, skills at presenting and using communication strategies with deaf children, strategies to increase both language and auditory skills, and experience with troubleshooting and using current listening technology for young children. Listening technology is a very important piece we bring to the family because deaf ed teachers can assist parents with information, support for use, troubleshooting, and even assist with changes in technology.
SLPs have a different skill set that they bring to the family. They, too, specialize in communication and language development, but they have global training in a wide variety of disorders while deaf ed teachers focus is on developmental issues stemming primarily from the hearing loss. SLPs can also diagnose disorders related to communication and language delays because their training includes a medical model of diagnosis and treatment. Speech therapists also work with people of all ages from birth through old age, giving them a very different global perspective on speech and language disorders. And as therapists, SLPs also can address and treat oral motor needs of a child including problems with feeding.

In some college programs, deaf education, audiology, and speech-language pathology are all part of the same department. Students often get exposure to some elements of the other professionals because these three professionals do see some crossover in skills; however, in-depth training is focused within that one degree. So as a deaf ed teacher, I received some basic audiology and speech pathology courses, and the reverse was true of students in the audiology or speech departments as well.
Under IDEA Part C, the Federal Special Education law for children birth to three, deaf and hard of hearing infants and toddlers are considered “at risk” for experiencing serious developmental delays without early intervention services. This is because children who are DHH are at risk for developing delayed communication and language skills. This is what makes DHH infants & toddlers “automatic qualifiers” for ECI services. They do not have to show any kind of delay to receive service coordination DHH services once Texas eligibility information has been received. Once the reports from an ENT doctor and audiologist have been received, the IFSP team can add DHH services to the service grid and the deaf ed teacher can begin working with the family.

Qualifying for services from the speech-language pathologist is not automatic, even if the child has a hearing loss. The child must show eligibility for speech services, and that eligibility can be determined through a variety of means, including assessment, parent report, and observation. Once the child has been determined to be eligible, then the IFSP team can add speech services to the service grid and the SLP can begin working with the family.

Both of these disciplines work with the parents and/or caregivers during home visit sessions. The purpose behind this, like other early intervention services, is so that the family can follow through on the strategies daily in order to help the child and
family achieve success. Because of the nature of speech, oral motor, and feeding, there may be more modeling with the child each session so that the parent can observe and then practice carefully. In deaf education, some of our strategies are handled through modeling with the child, and some are best explained through conversation with the family. It is not uncommon in deaf education for us to write both family and child outcomes, because the parents are our “students.”
When a family finds out their baby is deaf or hard of hearing, they are on the cusp of being asked to make a wide variety of decisions about their newborn. The family is wrapping their heads around the child’s hearing loss, and now we need to talk about hearing aids, cochlear implants, spoken language, sign language, total communication, bilingual communication, and on and on. All of us in early intervention are aware that families are dealing with many different emotions and concerns when we meet them, and we do our best to keep this in mind as we begin to share information. And in deaf education, parent choice is crucial as it relates to communication options and choices. How a parent communicates with her child is a very personal and individual choice, and it is a choice that can be changed at any time. Within these choices we see parents who choose to speak, then add sign later; who choose to sign without speech, who speak and never use sign, and everything in between, which means that the needs of the child and family change, too. Flexibility from us as the parents try to find their course through what is, for them, uncharted territory, will allow us to support them throughout while respecting the decisions they are making.
As we said before, children qualifying for services from the deaf ed teacher do not have to show any kind of delay because under federal law they are at risk for developing language delays. Under IDEA it was determined that these children cannot wait for a delay to appear because by then we have lost precious time we could have been keeping their development on target or as close to it as possible. Hearing loss can be in one ear or both ears and the severity can range from mild to profound and the child will qualify for services from a teacher of the deaf.

Speech language therapy services are different in that they do require that the child show a need or a delay. Often this can be determined through assessment of the child’s oral motor or spoken language, but the SLP will also take family concerns into consideration when determining eligibility. While assessments give us a certain amount of data, anyone who has worked with infants and toddlers can tell you that we cannot stop with assessment alone. We also need to consider what the parents see and hear, and any concerns they may have in addition to the assessment results. Parents know their children better than we ever will, and we always want to take their concerns and observations into account when determining service needs.
Clearly deaf education teachers receive specialized training in order to work DHH children, and we receive a teacher’s certification. Teachers are not required to have a master’s degree in order to teach, but many programs offer bachelor’s / master’s combined programs allowing students to graduate with both degrees simultaneously. Teachers of the deaf have considerable training to work with deaf or hard of hearing children of all ages, Pre-k through 12th grade. There is additional training that is recommended for teachers who are going to work in birth-3, and this training is usually provided through the district. By and large, teachers are trained to look at the whole child including language, physical, social emotional, self help, and educational developmental areas.

Most deaf education teachers certified after 2012 must renew their certification every 5 years and have continuing education hours that must be obtained before the renewal date. Teachers certified prior to 2012 are usually lifetime certified, meaning that continuing education is left to the discretion of the teacher.
Speech-language pathologists are required to have at least a master’s degree and they must have their certificate of clinical competence or their “Cs.” SLPs also receive considerable training in speech and language development and delays, but SLPs can work with people from birth through old age and therefore they have a broader perspective on speech and language. Additionally, SLPs are also trained to diagnose communication and language disorders in people of all ages, which can make the SLP a very valuable member of the IFSP team. Children who are deaf or hard of hearing can have other communication and language disorders, and the SLP can be of great help in identifying these if they arise. Speech-language pathology is a medical model of intervention, focused on the child’s oral motor and speech production capabilities in the forefront. Speech therapists also have a background in working with special devices for children who need augmentative communication such as boardmaker, iPads, or other technological options. For children who are deaf plus, the SLP can often bring additional support in the area of communication and language because of this specialized knowledge.
This slide is pretty self explanatory, but it also speaks to the heart of this discussion. Because of the young age of the children, services from the speech-language pathologist and the deaf teacher will often look similar. At times, they can look almost identical. BUT, and this is a big BUT . . . We are not a duplication of each other’s services. We are, in fact, both vital disciplines in the life of a child who is deaf or hard of hearing. Remember the brain? More input, different strategies, stimulating different areas of the brain is where progress is going to happen.
ASHA recognizes the importance of the speech-language pathologist and teacher for the deaf or hard of hearing working collaboratively to meet the needs of these children. Together we can often do more than we can alone.
There can be situations that can challenge the early intervention team in terms of determining services. Parents may want spoken language services for their child, even though the child’s audiogram and behavior indicates he cannot hear anything within the speech range. Other parents may request speech services but then endlessly delay obtaining or wearing hearing aids, which makes strategies for spoken language moot.

Technology can be a confounding factor. Cochlear implants are not new technology, but they convert the sound signal into a digital signal that the brain then has to learn how to interpret. Teachers of the Deaf usually understand how these implants work, the typical development of sounds and spoken language, and expected challenges, but this can be a big learning curve for the speech therapist if she is not familiar with CIs. Auditory Brainstem implants are such a new technology that many people in deaf education have not heard of them. However, they are being used under medical trials in the US, and countries abroad have been doing them for several years. Not only can the learning curve for ABIs be big for both the teacher of the deaf and the speech therapist, but with new technology comes the question of expected outcomes.

Teachers of the deaf will tell you that any young child working on spoken language as a form of communication should have speech services. This goes back to their
training and awareness of the at risk nature of hearing loss. However, there are some children who are developing spoken language at the expected developmental levels and so they do not qualify for speech services based on assessment. There are times that speech will stop services to these children because the child doesn’t show a need for the service, but the teacher for the deaf may well argue the point that speech services continue to be required. In cases such as these, the teacher for the deaf and the speech therapist can collaborate to ensure skills are not declining even if speech is not on the plan as a service. Situations such as these are the reason that we have teams working together in early intervention. There are so many different areas of development that none of us can be experts in them all. Working together will allow us to enhance our skills, and this will lead to the family and child getting what they need from early intervention.
Co-visits with the teacher of the deaf and any other discipline on the plan is permitted and encouraged. The teacher comes out of the school district and birth-3 services are part of FAPE or Free and Appropriate Public Education, which is part of IDEA. Deaf education services are provided at no cost to the family, so there are no funding conflicts about co-visits with the teacher of the deaf. However, co-visits must be documented on the service grid indicating which disciplines are providing the co-visits, the number of sessions, and the duration of the visits. An outcome will also need to be written for the co-visits identifying the area or areas of development that will be targeted. I cannot stress enough the importance of co-visits when working with a child who is D/HH. By working closely with each other and by participating in co-visits, each of us grow professionally and this, in turn, will give us even greater tools to use when working with families.
Can an SLP be used in place of D/HH or vice versa?

+ NEVER! Texas law states:
  + Teachers certified in the education of students with auditory impairments (D/HH) must be available to students who are deaf/hard of hearing; and,
  + Teachers assigned to instruction for children birth through 2 who are deaf shall be certified in education for students who are deaf/hard of hearing
  + If the child is D/HH, a certified teacher for the deaf or hard of hearing must be part of the IFSP team.
  + Because D/HH and SLP are different disciplines with different certification requirements, we cannot provide each other’s services
Teachers for the deaf will sometimes write family outcomes in addition to child outcomes. While the child’s skills are what we assess, the parents are the students, so to speak, because they are the ones who will be providing the day to day strategies for their child. To that end, there are times when it is prudent for a family outcome to be developed to clearly outline the expectations for the parent in terms of providing the strategies to guide their child’s growth. By developing a family outcome, we reinforce for the parents that they are their child’s teachers while also outlining the skills, strategies, and the purpose behind them. Many times a child outcome can also be developed based on the same goal so that the team can identify the child results of the family outcome. There may also be times when the family outcome is not accompanied by a child outcome, depending on individual needs and circumstances.

While this is a common outcome written by the teacher of the deaf, it could have just as easily been written by the speech therapist. The purpose behind this outcome is for the family to begin providing targeted sounds needed for speech while connecting them to daily routines. The sounds chosen are both visual and auditory, and sounds baba and mmm are also vibrotactile (meaning the child can feel them even if she cannot hear them). This strategy will allow the teacher to begin taking data on the child’s responses in order to help the parents see the child’s potential for developing spoken language.
This is another family outcome focused on getting the baby’s attention and getting eye contact from her. Eye contact plays an important role in the development of children who are DHH. Regardless of the kind of listening equipment the child has, the child is going to miss some information due to the hearing loss. Eye contact and the ability to read body language, facial expressions, and other non-verbal cues support the child’s comprehension of language, whether spoken or signed. So this is what the family will do daily to teach Nila, AND
...this is what Nila will do as a result of the parent’s teaching. Notice that the strategies are much the same between the two outcomes. However, in the parent outcome we have specified what the parents need to do and how often, and the mastery of the outcome is tied to the actions of the parent. The child outcome follows this up with what we expect to see from Nila when the family follows through. Language development in a child who is DHH requires ongoing planned activities, regardless of the communication choice the family has made. It is crucial that parents see themselves as the teacher and see us as guidance and support. Parent goals can help develop the parent skills necessary for daily communication and language with their child.
This is a very common deaf education strategy in early auditory training. The purpose of this is to encourage the child to listen carefully to sounds and attempt to match the sound with its source. It is usually developed as a game – think of hide-n-seek with sound. The initial sounds chosen are well within the child’s hearing range so that success is built in to the activity. As the child becomes more familiar with the game, the sounds are changed to make them more challenging to hear and identify. These listening activities also support spoken language development because the child is practicing listening intently.
This co-visit outcome could also be a speech outcome or a deaf ed outcome. But for a child who is learning to sign and speak, it can be very beneficial to provide some co-visits in order to get strategies and support from both disciplines. In this outcome, the teacher for the deaf will have the sign language background to support the family as they learn to sign, and the speech therapist will have the clinical background to support the child’s speech development. By working together the child gets the benefit of both providers and their specialized training, and the providers get the benefit of learning new techniques from each other.
This outcome looks similar to the one for Andrew that we saw a few minutes ago. Both outcomes are focused on using specific sounds to target spoken language development. But in Andrew’s case, the sounds were being connected to infant routines to encourage him to listen and to hopefully imitate. In this speech outcome, the sounds are targeted but the outcome involves using spoken words instead of single sounds. Unless the child has oral motor or feeding concerns, the speech therapist will usually begin services for eligible children as they are starting to say words. Due to their training, the SLP has a different skill set when teaching a child to speak including strategies for helping the child produce sounds at various positions within a word.
While this speech outcome does not have words in it specifically, the animal sounds are used both because they capture the interest of the child and because these sounds are also integrated into speech. Using animal sounds with books, in songs, or in games is a common strategy, and once this is mastered often the next step is to move from animal sounds to identifying the animal itself. The pairing of the object with the mouth is a good strategy to use with children who are deaf or hard of hearing so that they can both see and hear the sound you are producing. The introduction of the song “Old MacDonald” adds music, the animal sounds, and it brings the animal names into the picture for future outcomes.
The upshot of all of this information is this. Each of us on the IFSP team, be it the speech
therapist, teacher of the deaf, physical therapist, or service coordinator, have different training,
background, certification, and techniques for working with young children. When IDEA looked
at the disciplines needed to work with infants and toddlers, each of us (our jobs at least) were
on that list because we each bring something unique to the families. While we cannot serve
another’s purpose, early intervention is at its best when the team works collaboratively to meet
the needs of families and their children.
If you have any questions or would like additional information, please contact me:

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