

Overview of Challenges Facing DHH Young Adults

It seems that almost weekly, if not daily, there are news clips and blogs about new entrepreneurs with disabilities opening businesses. Many are owned and staffed by deaf¹ people with careers such as financial advisors, clothing designers, tour operators, researchers, doctors, and veterinarians. These enterprises are not limited to just a few countries either, but represent employment opportunities opening up around the world—in Indonesia, Slovakia, Hungary, Egypt, and India, and the list keeps growing.

In many parts of the world today deaf people are much more frequently considered a regular part of community events and employment activities. Clearly, in a number of respects they have made tremendous gains over several hundred years through their involvement and activism. In a variety of countries they also have taken active roles as leaders and visionaries with remarkable new insights and ideas. In many cases, the struggles, perseverance, and hard work that led to their achievements have been more challenging than those typically faced by many similarly accomplished individuals—and they have overcome significant obstacles in some cases. We can be grateful for, and appreciative of, these contributions that allow deaf and hard of hearing (DHH) children born today to expect to have far more access to, and more equitable, opportunities than ever before and life options that now are much more varied than in the past. These opportunities will continue to expand in new ways that one can only imagine at this point.

But this book does not just celebrate these and other accomplishments, it also addresses the challenges that remain in order to minimize obstacles. Not all DHH children will be able to access all of the opportunities that are open to their more typical peers. Limitations, barriers, and discriminatory attitudes remain among those with whom they will interact in the community, at school, and at work. We also need to prepare them to successfully deal with situations in which these barriers cannot easily be addressed. Some DHH children will face issues that cannot be resolved within the developmental

1. I use the term “deaf” to include a range of individuals who are deaf or hard of hearing or to refer activities for this range of students or adults to include deaf education, deaf services, deaf resources, and such. When known that these individuals consider themselves to subscribe to values associated with Deaf culture, they will be referred to as Deaf individuals.

timelines that would most enhance their potential for later success, and these issues will change in response to evolving societal circumstances and values: Each era presents its own particular challenges of equity and access.

This and the next chapter provide a historical review of educational and employment achievements of DHH people. This sets the stage for appreciating the many advancements that have occurred, sometimes with substantial improvements in only a few years, and others whose accomplishment has required much longer to bring about. The various historical-through-contemporary legislative and programmatic achievements are important, primarily when viewed in the context of societal circumstances within which they occurred. The longitudinal perspective these challenging situations presented, as well as the strategies that led to their attenuation, provide insights for current and future issues. In many areas of adult living, DHH individuals have not yet achieved the equal access and opportunity to pursue their goals. The fact that increasing numbers of DHH individuals are becoming successful entrepreneurs is notable only because, as a community, they have persevered through periods of significant restriction. The history of their accomplishments can reveal insights into the complexities of the challenges that remain, including the factors that prolong their existence and those that can result in their diminution. Beliefs about “difference” and “deviance” in society and the valuing or devaluing of DHH individuals tend to be deeply embedded in the core hierarchical structures that organize society; behaviors may be modified or superficially eliminated during certain eras, but deep-seated societal beliefs are difficult to change and require long-term efforts.

For DHH young adults approaching the age of transition, their preparation for adult roles and responsibilities should address the myriad activities involved in education and training, career, leisure and recreation, daily living skills, decision making, self-determination, and the additional skills essential to leading satisfying adult lives. This should be our goal regardless of local or societal limitations. In investigating the past in order to build a more positive future, few studies have examined areas beyond education and employment. The improvement in these areas represent significant achievements. More recent progress includes greater participation in the various community and other activities of adulthood, also broadening research efforts in these topics. Legislation and programming that more fully address these areas also are creating systematic means for evaluating students’ current status and planning outcomes.

This chapter reviews the key elements of transition services, describes the major educational developments, first in K–12 and then in postsecondary education, and discusses developments in the Deaf community that have created opportunities made possible by transition services today. The DHH leaders and innovators across this history have made substantial contributions to the positive conditions of today, with several periods of quite substantial change and development that have led to the opportunities available DHH adolescents and adults.

Overview of Transition Services Definitions

Transition services are authorized and regulated by the Individuals with Disabilities Education Act, which was most recently revised in 2004 (IDEA, P.L. 108-446). These services are comprehensive across the full range of adult needs beyond academic preparation

to include vocational education, functional academics, independent living, and community participation.

The term “transition services” means a coordinated set of activities for a child with a disability that:

- (A) is designed to be within a results-oriented process that is focused on improving the academic and functional achievement of the child with a disability to facilitate the child’s movement from school to post-school activities, including post-secondary education, vocational education, integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation;
- (B) is based upon the individual child’s needs, taking into account the child’s strengths, preferences and interests; and
- (C) includes instruction, related services, community experiences, the development of employment and other post-school adult living objectives, and, when appropriate, acquisition of daily living skills and functional vocational evaluation. (Section 602[a] [20 U.S.C. 1401[a])

Transition planning occurs during high school and is mandated to begin at age 16 or earlier, depending upon student needs, with several states requiring that it begin at age 14. Planning typically occurs at an annual individualized education program (IEP) meeting, which must include the student’s teacher, a general education teacher, and an administrator with contractual authority, as well as the parents and the student, when age 16 or older. The team identifies goals that cover further and/or postsecondary education, employment, and independent living, the listing of which varies somewhat from state to state. Transition services should be linked to academic instruction by identifying courses of study that support each transition goal area (Flexer & Baer, 2013; Sitlington & Clark, 2006; Wehman, 2006). All of these services and goals must be based on the student’s interests, strengths, preferences, and needs.

Another important element of transition legislation is that it comprises a coordinated set of activities, including a number of services that typically are beyond the scope of K–12 academic programs. Transition planning meetings therefore should include community and other agencies that provide related services. The primary adult services provider for DHH students is through each state’s vocational rehabilitation (VR) office with designated rehabilitation counselors of the deaf (RCDs), who have specialty training in, and knowledge of, the impacts of hearing loss on employment and living outcomes. Community developmental disabilities services or mental health agencies also may be invited to IEP meetings, particularly for students with these disabilities. One key purpose of transition legislation is to ensure that service agencies working with these students after their graduation from high school attend early planning meetings. This ensures that high school and post-school services are available and coordinated in preparing students to achieve their adult goals.

The breadth of transition planning and the identification of nonschool services, which are provided in conjunction with school-based services, is the focus of this book. Central to DHH students’ success is the quality of services provided and how the relationships among the key stakeholders can be leveraged and optimized in order to improve young adult and lifelong outcomes for these individuals. This chapter now examines some of the factors that have influenced the variety and quality of services available both

historically and currently to DHH adolescents and young adults, focusing particularly on educational opportunities and community participation. Chapter 2 focuses on vocational and employment patterns and opportunities.

Perspectives on Disability and Hearing Loss

In general, many aspects of society have exhibited significant progress in more consistently expecting DHH students and adults to be capable of comparable achievements as a result of having equal access and opportunities. Technology has provided much-improved access to spoken communication by providing devices that assist in listening or reading captioned/text-based communication. Although Alexander Graham Bell developed the telephone to assist people with hearing losses, it became a substantial work and personal barrier until digital communication allowed for a range of inputs and outputs, including email, paging, and texting. Video relay services and remote interpreting now allow sign language users to make appointments or order pizza over the phone. New hearing aids and cochlear implants provide much greater access to sound and speech, and sign language interpreting now occurs regularly in remote locations through video relay interpreting.

Nonetheless, negative societal perspectives persist, some of which have been claimed to originate with a pronouncement attributed to Aristotle: “[T]hose who are born deaf all become senseless and incapable of reason” (Garretson, 1981, p. xix). Other reports suggest instead that DHH individuals were more broadly accepted by Greek society and used a form of sign language (Moores, 1996). This ancient and negative characterization appears periodically in historical and modern belief systems, but with more positive elements as well. For example, the Justinian Code, which was developed in the sixth century AD under the reign of Emperor Justinian, integrated Roman law and became the foundation of much of later European law. It gave full rights to those who were deaf but literate, deaf and able to speak, or late deafened (Moores, 1996). This indicates that even ancient societies recognized the existence of a range of communication preferences and abilities among those with hearing losses and the rights associated with these capabilities.

In Europe, the Middle Ages were less positive in their treatment of DHH individuals, who were restricted by both civil and religious codes. In general, they were deprived of the right to inherit property, to celebrate Mass, or to marry without dispensation from the pope (Moores, 1996). There also were no systematic efforts at education during this time although a few individuals learned to speak or write. Not until the 1500s did some individuals in Europe consider the education of DHH children to be a worthwhile enterprise and subsequently established schools and programs. In that literacy was a path to equality according to the Justinian Code, deaf people without educational opportunities to acquire these skills were denied equal rights.

The influence of these negative perceptions and beliefs can be seen today as well. For example, a series of recent news items indicates that some still believe that DHH individuals are incapable of driving a motor vehicle (Hearing Solutions, 2014). Such limiting perspectives can have long-term impacts on DHH children and the lives they imagine for themselves. For instance, childhood disability is associated with a diminished likelihood of completing high school and obtaining employment (Loprest & Maag, 2007). This occurs as a result of daily experiences that reinforce beliefs that they are less desirable and less valued than their more typical peers, often despite the best efforts of their

family. Other societal difficulties result from those who show excessive sympathy or expect stereotypic “goodness” leading to feelings of inadequacy. Some people assume that children with disabilities require continual help or behave like much younger children; they also may harbor demeaning perspectives that diminish self-sufficiency. Behaviors that limit eye contact or create physical distance, as well as displays of avoidance, can cause feelings of social isolation and contemptibility. Perceptions of social isolation can lead to longer-term issues, such as higher rates of school absenteeism and deficits in interpersonal skills (Moore, Konrad, Yang, Ng, & Doherty, 2011). Peer rejection also has been linked to depression and dysfunctional behavior, while stigmatization leads to feelings of shame, inferiority, and low self-esteem, all of which can produce self-imposed limits to life opportunities and adult aspirations. Although these studies address effects across the range of disabilities, employment data on job titles and aspirations indicate that these same issues have influenced the lives and careers of DHH individuals for quite some time. Rather than ignoring their presence, we need to address what we can in order to provide maximally positive opportunities for DHH adolescents and young adults and to equip them with the skills to manage these situations successfully on their own.

One important and affirming development in the past 125 years has been the narration and publication of life stories by DHH individuals. These accounts have helped shape societal perceptions in more realistic and constructive directions. It is essential to recognize the contributions that deaf individuals have made to society as innovators, states persons, philosophers, writers, artists, politicians, and reformers (White, 1981). This singular and rich history testifying to their success and empowerment is often insufficiently acknowledged by the larger community, including those of us working in education, adult, and community services. Yet these accounts of successful self-determination serve as models for every DHH adolescent and young adult as they create their own futures. As technology, legal supports, and access to programs continue to improve, we also need to recognize that what is not imaginable for the futures of children who are now age 10 or 15 may be quite achievable by the time they reach 25. Our own conceptualizations of what is possible must continue to expand along with these developments.

Historical Developments in U.S. Education

Transition services are the responsibility of K–12 schools with reports on plan quality submitted annually to the federal government (National Secondary Transition Technical Assistance Center, 2012a, 2012b). Access to comprehensive education services has been foundational to many of the achievements of DHH adults with regard not only to academics but in providing the skills they need for assuming the roles and responsibilities of adulthood to include employment and community participation. Educational efforts focused on DHH children began approximately 200 years ago, primarily in wealthy families who sought services that would enable their children to participate in society (Leakey, 1993). At that time, the United States was still quite a young country, and society recognized just a few of the disabilities identified today (e.g., hearing loss, vision loss, significant intellectual disabilities, and mental or behavioral disabilities; Osgood, 2008). For those whose families were not wealthy, children and adults with these disabilities were kept at home and tolerated rather than educated. Some individuals were supported by the community when their families were unable to do so, but others were treated much less charitably and were sometimes ostracized, prosecuted, or condemned.

Social services were quite limited: Some individuals were housed in almshouses, which also cared for poor and elderly people and those with disabilities (Winzer, 1993). During this time, most people lived in rural areas; thus communities were rather isolated from each other. Population ethnicities varied across the United States, but individual communities were predominantly homogeneous (Osgood, 2008). Formal schooling, which was available to very few children, also varied according to geographic location. Most boys received only minimal schooling; girls received even less. Children typically were involved in some form of work at the family farm or trade or perhaps worked as an apprentice in a shop. They typically assumed increasingly adult roles once they matured beyond early childhood.

Educational efforts for DHH individuals began with a census in 1800 carried out by Francis Greene, the father of a deaf boy who attended school in Edinburgh with Thomas Braidwood (Gannon, 1981; Moores, 1996). Greene's census of deaf persons in Massachusetts found approximately 70, a figure he used to estimate that approximately 500 deaf people lived in the United States at that time. He also published a book of the methods used to educate his son, much to the displeasure of the Braidwoods, who sought to keep their methods secret and therefore economically sustaining for the family (Moores, 1996). Between 1812 and 1817, Colonel Bowling of Virginia hired John Braidwood, the grandson of Thomas Braidwood, to teach his own deaf children. Deafness apparently was common in the family: Bowling had two deaf brothers and a deaf sister, who also attended the Braidwood school. John Braidwood established a school in New York and one in Baltimore, in addition to the Virginia school, all of which failed within a few years (Gannon, 1981; Moores, 1996).

At that time, most of the population and many educators believed that education for individuals with disabilities had little value. Moreover, most instruction was primarily religious (Giordano, 2007). However, a series of social and economic developments, including new patterns of immigration, led to several changes in the country and an evolution toward a more urban and industrial economy (Osgood, 2008). The resulting urbanization led to the concentration of populations, while industrialization created conditions of low wages, work competition, overcrowding, and poor living conditions. Increasing poverty and crime, as well as inferior living situations, began to be recognized by some constituents of society as requiring reform. This led to the Progressive Era, which had its greatest impact between 1880 and 1920 in targeting the societal concerns of sick and elderly individuals, poor people, and those with disabilities (Osgood, 2008; Winzer, 1993). Reformers advocated for services that would be organized and supported by federal and state governments, which subsequently led to substantial growth in publicly funded programs and facilities. Most of these programs were more charitable than educational in quality; one exception, however, was the schools established for deaf and blind individuals (Osgood, 2008; Winzer, 1993).

By 1900, "disability" had become an important construct as well as a target for reformers (Osgood, 2008). Interestingly however, where rural communities had been flexible in managing their own schools and populations, urban districts had far more children than could be administered with this same adaptability. Increased demands on school districts to enroll large numbers of new students resulted in increased structure, stratification, and standardization across classrooms and programs. The consequence was that urban schools became more rigid, and, to this end, those children with disabilities, or who were not performing at expected levels became more noticeable.

The earliest special school founded during this period was the Asylum for the Deaf in Hartford, Connecticut, established in 1817 (later renamed the American School for the Deaf). Subsequently, the Asylum for the Blind was founded in 1832, and a school for children with intellectual disabilities was established in 1848 (Gannon, 1991; Osgood, 2008; Winzer, 1993). These were followed by the founding of the New York Institution for the Instruction of the Deaf and Dumb in New York City in 1818, which the state began funding in 1821 (Moores, 1996). In 1820, the Pennsylvania Institution for the Deaf and Dumb opened in Philadelphia, with state support approved in 1821. Laurent Clerc, a Deaf educator, was brought from France by Thomas H. Gallaudet to the American School for the Deaf because of his sign language and curricular expertise. This had a long-lasting educational impact as the three early schools relied on his leadership and sharing of curricula, educational philosophies, and teacher-training methodologies (Moores, 1996). In turn, these schools provided leadership and educational leaders during much of the 1800s. All of these early schools had a strong focus on vocational preparation and instruction in the manual trades to ensure later employment for their graduates (Leakey, 1993).

Between 1850 and 1900 the overall number of special educational institutions in the United States increased substantially, primarily for the purpose of identifying, segregating, and treating individuals with disabilities. Many of these institutions initially aspired to educate and even cure their enrollees; however, these ideals later turned to skepticism and even contempt when these standards often were not met (Osgood, 2008). After struggling to achieve student integration through academic instruction, many superintendents of institutions for those with cognitive disabilities began implementing more of a custodial type of care in the early 1890s. Despite some public concern regarding conditions in these institutions, growing populations continued to result in overcrowded institutions.

Consistent with increasing state and national efforts to care for children with disabilities, institutions for DHH children continued to be established throughout the 1800s and into the early 1900s. By 1940, because of their small size, only four states had not sponsored institutions, although each had a formal contract with other states to provide residential instruction (Osgood, 2008). In general, institutions for deaf and blind children were more positively viewed by society and regarded as maintaining an educational, rather than a custodial, focus. These children were believed to be more intelligent, capable of learning, and better able to integrate into society. However, these institutions were not entirely free from the criticism or suspicion that targeted other institutions. Growth in the establishment of day schools for DHH children also challenged residential approaches to instruction and socialization (Osgood, 2008).

During the early 20th century, much of the previous professional optimism for integration of individuals with cognitive and behavioral disabilities began to wane, a view that was consistent with the attitudes and beliefs in the broader U.S. society. Greater public recognition and government involvement in disability issues and an interest in eugenics led to concerns about the transmission of disability to future generations. A national eugenics records office was established and conducted numerous studies of families with disabilities (Osgood, 2008). Disability was viewed more negatively, and children with disabilities were separated into increasingly specialized categories (Osgood, 2008). More positively, large urban schools that had benefited from their experience with these children began experimenting with new methods. They developed curricula

and other program activities that targeted specific disabilities. Many believed that the use of standardized intelligence tests was quite important in identifying those with intellectual disabilities. Concurrent with these developments, compulsory education laws resulted in more children attending school who may previously have been kept at home or placed in residential institutions.

For DHH students, the number of day programs grew considerably at this time, and by the early 1900s, more than 100 cities and 20 states had established such programs (Osgood, 2008). However, DHH students remained segregated from standard public school classrooms due to the highly specialized curriculum that was used and the unique training and skills of their teachers. Integrated instruction was limited to advanced industrial or vocational training and to those students who could rely on their oral skills for communication. These programs followed the regular school curriculum as much as possible and made accommodations and adjustments as needed, although students remained segregated.

The Great Depression of the 1930s affected disability services in that it strained local resources. Most special education programs suffered from inadequate resources, low status, and poor morale (Osgood, 2008). Schools in general struggled to accommodate large increases in students identified as eligible for special education. As a result, districts began focusing on practical and vocational preparation. During this period and after World War II, residential schools were very popular because they offered students personal care and education, which some families were no longer able to provide (Gannon, 1981). After World War II, many still believed that residential schools offered superior training.

The general perspective on special education services during this time was that specialized instruction and segregated placement for students with disabilities benefited *all* students (Osgood, 2008). The normal curriculum and classroom pace was not to be altered or slowed, and teachers were not to be overly burdened by learners who demanded more time and attention. Yet, during the 1940s and 1950s the most specialized and segregated programs, residential institutions, also experienced increasing attention and criticism as they grew in size. Several photographic and narrative essays were published that made the general public aware of the occasionally brutal living conditions at these institutions, which was particularly true for facilities enrolling individuals with cognitive or behavioral disabilities (Osgood, 2008). These and other investigations showed that the actual educational, social, and vocational goals of many of these institutions often amounted to warehousing. In response to these disclosures, several parental and informal groups were formed in various states, a number of which became formal associations to support improved lives for children with disabilities. In general, many parents became more knowledgeable about disability concerns and more activist in their approach, although medical and professional opinions still typically garnered greater weight in decision making (Osgood, 2008).

Despite public concerns at that time, many institutions continued to provide little more than custodial care, a pattern that continued throughout the 1960s and 1970s, with most of the enrolled children exhibiting substantial levels of mental retardation. Concerns about quality combined with the high financial costs of these institutions spawned an increasing number of institutional closures during the 1970s and 1980s (Osgood, 2008). The deinstitutionalization of the children in these facilities, however, did not have the same impact on residential institutions for deaf or blind students in that these facilities, which were never as overcrowded, had retained a primarily educational focus. Specially trained teachers had typically provided more actively instructional services than did

staff members in the facilities for children with cognitive disabilities (Osgood, 2008). Although the segregated practices of the schools for deaf and blind students were sometimes criticized, many of these institutions continued to exist for quite some time.

The history of educational developments for DHH students is particularly noteworthy in that the first facility in the United States began with the American School for the Deaf and utilized the expertise of a Deaf man, Laurent Clerc, in developing a model for services used in many of the early schools. Another important element of deaf education is that the custodial and sometimes brutal conditions in institutions for those with cognitive or behavioral disabilities were not generally true among the schools for deaf children. Most of these specialty schools maintained an educational focus and were perceived as providing positive educational and vocational training. Day schools offered alternative curricula and educational philosophies, but few schools during this early period offered integrated educational services or facilities. Most importantly, the treatment concerns that led to the deinstitutionalization of many other children with disabilities were not typical of institutions serving DHH children. The solution to poor facility quality was to deinstitutionalize students with disabilities and close residential facilities, concurrent with enrolling these students in general education schools and classrooms. And although deaf education did not share significantly in this problem, they were part of these larger “solutions” and ever since, have been required to meet the same mandates of P.L. 94-142

The earlier history of deaf education reveals how DHH individuals themselves assumed important instructional and administrative roles that perhaps helped to maintain standards higher than those in other educational institutions. They are unique in that, where other disability groups have relied on parents and family members, deaf education has benefited from the direct input of its own graduates. Residential schools also remained the primary educational environment for DHH students, although this began to change after World War II (Moores, 1996). Enrollment in segregated and residential schools was at a high point in 1910, during the Great Depression, and in response to the 1964–1965 rubella epidemic, which resulted in more DHH students than local schools could accommodate (Moores, 1996). After WWII, far more children were served in local public schools, often with one or more classes specifically for DHH students. Large urban areas often were able to establish public day schools that could provide disability-specific services for DHH students who lived within commuting distance (Moores, 1996). Also unique to deaf residential and specialized schools is their function as cultural centers of the Deaf community (Padden, 1998b). Their roles and contributions were therefore, quite different from those of residential schools for individuals with cognitive or behavioral disabilities.

Historical and Current Influences on Educational Services

One of the important implications of P.L. 94-142 was its requirement that education occur in a child's least restrictive environment within local public schools and in general education classrooms whenever possible (Turnbull & Turnbull, 2000). The population of DHH students, consisting of approximately 1.2% of the special education population (U.S. Department of Education, 1993, 2005, 2013) became just a very small part of this larger legislation. Where deaf education had been administered as a separate entity, often with the strong involvement of DHH individuals themselves, it now was increasingly

overseen by special education supervisors in public school systems. The result has been a substantial change in governance that allocates resources to resolving DHH-specific needs.

P.L. 94-142 was passed in 1975 and guaranteed parents the right to participate in program decision-making and for due process when disagreements arose (Turnbull & Turnbull, 2000). Parents of children with cognitive and behavioral issues were no longer limited to institutions that provided largely custodial care. The effects of these rights on deaf education were different in that residential facilities were staffed by specially trained staff and utilized unique curricula. Another important factor is that 90 to 95% of DHH children do not have deaf parents and for these families, the child's access to language and communication with family members often is substantially diminished (Gallaudet Research Institute, 2013; Mitchell & Karchmer, 2004). Reduced abilities to interact with their DHH children and therefore, understand the nature and extent of their learning needs greatly complicates parents' decision-making. Parents' early decisions affect their children's adult capabilities, with many individual skills and needs often obscured until DHH children develop the foundations of language. The results are seen in the long-term poor achievement of DHH students, which has changed little over four decades (Qi & Mitchell, 2012; Traxler, 2000).

The long-term effects of this legislated deinstitutionalization remain today, in every parent's choice between segregated or inclusive placements for their DHH child. This becomes important when planning for high-quality transition services and finding the needed expertise in providing these services. For the 85% and more of DHH students who attend public school programs (U.S. Department of Education, 2013), many of these services are generic and designed to meet the needs of all high school students who are preparing for work or postsecondary training (Luft, 2013b, 2014a). Even among students with disabilities, approximately 1.2% of whom are DHH students (U.S. Department of Education, 2013). The result of these standard and nonspecific services is that many DHH students fail to acquire key transition competencies in comparison to their peers with disabilities (Luft & Huff, 2011; Newman et al., 2011). This evidence suggests that most secondary-level school services are not meeting these students' needs. In contrast, several investigations have found that residential schools for DHH children provide higher quality transition services and yield better outcomes (Bullis, Bull, Johnson, & Peters, 1995; Luft, 2013b, 2014a; Stinson & Kluwin, 2003).

These legislative and educational trends away from disability-specific service provision led the professionals serving visually impaired and blind students to design an "expanded core curriculum" to address essential areas unique to these individuals. It is taught in addition to, or is integrated into, the academic core curriculum (Lohmeier, Blankenship, & Hatlen, 2009). Similar efforts have been undertaken by several states (Iowa, Georgia, Florida, and Wisconsin) to focus on critical skills for DHH students that are not part of the standard curriculum. Many of these disability-specific skills are critical for adolescents to acquire prior to assuming adult roles and responsibilities. Educational planning must maintain a balance between meeting the required, standardized expectations while also addressing unique needs that allow our students to succeed. However, these curriculum guides provide transition teams with important resources, particularly for DHH students attending schools without extensive deafness-specific expertise or programming.

Although present-day deaf education has much less involvement of deaf professionals than in the past, the perspectives of DHH individuals in society are being more widely

recognized with greater respect for the values and traditions of the Deaf culture and community (Gannon, 1981; Osgood, 2008). Yet, the organization of deaf education within special education programming and legislation, and the decision-making rights of parents, often means that these d/Deaf perspectives typically are not represented in programmatic decisions. The increased achievement for students with other disabilities when placed in inclusion classrooms can lead parents and educators to conclude that this also applies to DHH students. However, this has not been shown to be true; instead, the factors that are the most predictive of their academic success for DHH students are their individual developmental and demographic characteristics (Kluwin & Stinson, 1993; Stinson & Kluwin, 2003). Even recently, this presumption—that inclusion was the best placement for ensuring high academic outcomes of DHH students—was a common position of professionals attending a national focus group meeting organized by the Office of Special Education Programs (Office of Special Education Programs, 2012).

Perhaps due to these misunderstood benefits of inclusion, the perspectives of DHH adults and students who have been in these classrooms are given less weight and therefore have much less impact. Many have described frequently feeling isolated and misunderstood in inclusive settings. Some have expressed significant relief and benefit from attending residential or specialty schools, where they retain the ability to communicate with everyone using ASL (Gannon, 1981; Osgood, 2008).

This is the mix of intended and unintended consequences that faces professionals and parents today. Changes from the educational structures of the past with a separate, disability-specific administration and curriculum and significant involvement on the part of DHH professionals has resulted in far more standardized and generic educational services provided to DHH students. Management by general and special education and instruction based on state curriculum standards, with academic progress measured by grade-level tests limits resources for resolving disability-specific needs (No Child Left Behind, 2001; Individuals with Disabilities Education Act Amendments, 2004). As a low-incidence disability, many public schools do not have access to a range of deafness-specific experts nor can they afford to provide a range of specialty program options; this is the reality facing many transition planning teams in public school deaf education programs today.

The Deaf Community's Contributions to Education

In contrast to today's standard and generic educational services provided through general and special education structures, only 50 years ago there was strong activism addressing deaf-specific issues. The Babbidge report (Babbidge, 1965) and the Commission on Education of the Deaf (Bowe, 1988; Bowe was a Deaf educator and researcher) both examined the status of education and DHH individuals that resulted in an important expansion of educational and postsecondary opportunities to DHH young adults. In 1965, Congress authorized the National Technical Institute for the Deaf to support technical education. In 1968, Congress established regional programs at Delgado Community College in New Orleans, Seattle Community College, and the Technical Vocational Institute in Saint Paul, Minnesota, to provide technical training to deaf individuals in integrated educational settings (Gannon, 1981; Walter, 1992).

The involvement of the Deaf community in the education of, and service provision to, DHH children perhaps contributed to the stronger educational focus of residential

schools at a time when institutions for those with cognitive and behavioral disabilities were primarily custodial. In general, the involvement of DHH individuals in their own history has been underappreciated (Garretson, 1981; White, 1981). This includes Laurent Clerc as providing instructional and communication expertise and guidance that were utilized by the early schools in New York and Pennsylvania, and beyond as their curricula and training methods became models for many of the subsequent schools.

As described earlier in this chapter, DHH individuals were highly involved in the deaf education enterprise. Schools offered a favorable career path, and DHH faculty often were in demand. In 1850, 36.6% of teachers of DHH students were themselves deaf (Gannon, 1981). A high point was reached in 1858, when 40.8% of teachers were deaf although this percentage fell to 30.9% in the next decade. Somewhat different figures have also been reported; for instance, Jones (1918, cited in Moores, 1978) stated that 36% of teaching staff were DHH in 1851 and 42.5% in 1870. This percentage dropped to 22% in 1895 and to 14.5% in 1917 due to rapid growth in speech-based instructional methods and a belief that these were best provided by instructors with normal hearing. Despite some differences, both data sets show a relatively high involvement of DHH individuals as school faculty members in the mid-to-late 19th century and much lower levels in the early 20th century. In addition to their involvement as faculty members, DHH individuals were founders of 24 schools for DHH children, a pattern that continued into the early 1900s. Eight DHH individuals were principals or superintendents in the 1890s (Gannon, 1981). These schools perhaps provided an otherwise unusual opportunity for professional-level employment as well as administrative and management roles. In comparison, the Babbidge report (Babbidge, 1965) noted that five out of six DHH individuals had manual-labor jobs, compared to only half of the general population.

This high level of involvement was subsequently affected by several factors, such as the growing international movements that supported oral and speech-based communication. An important determinant in this was the Congress of Milan in 1880. The Italians had become increasingly convinced of the desirability of spoken-language methods, in part because of the influence of the Austro-Hungarian Empire and widespread admiration for German accomplishments in science and linguistics (Radutsky, 1993). The final vote at the Congress of Milan indicated that a majority of delegates favored the oral method, although the United States and Britain voted in opposition. The American delegates offered a compromise that included sign language with speech and objected to the decision to use only speech (Gannon, 1981). As a result of this vote, schools in the United States gradually became more oral in their communication methods and sometimes combined speech and sign methods. This had an important impact on DHH faculty in that they were no longer considered to be qualified or appropriate to teach speech-based skills. Their numbers fell substantially, and as of 1927, only 14% of teachers were themselves DHH (Gannon, 1981). Interestingly, although these teachers were no longer considered competent to teach DHH children, most early schools were segregated by race and considered the hiring of black deaf teachers to be a positive step in supporting the students' self-respect and self-confidence.

In the 1880s, the National Association of the Deaf (NAD) became concerned about the impact of oral education on DHH children and on the employment prospects of DHH teachers. The result of increasing industrialization during the early 1800s also had affected employment, and NAD realized that DHH individuals needed improved training for existing industrial work. It believed that this also would address not only

workplace and community discrimination, which restricted employment, but also increase the independence and well-being of most DHH workers (Gannon, 1981). Its members understood that they must be their own most effective advocates because the general public did not understand the impact of hearing loss or the capabilities of DHH individuals.

The eugenics movement, which led to a negative public perspective on disability, also affected the Deaf community. In the 1880s, Alexander Graham Bell, who believed that social contact among DHH people would result in a “deaf race,” published several documents detailing his concerns. He used data from schools for deaf children to support his belief that intermarriage and interaction led to an increased number of births of DHH children, and he strongly discouraged deaf residential schools, deaf newsletters and newspapers, reunions and clubs, and related activities (Gannon, 1981). The data he used, however, showed that very few marriages between DHH individuals resulted in children with hearing loss, while several subsequent analyses indicated that less than 2% of DHH children had deaf parents.

More positively for the Deaf community was a series of developments regarding American Sign Language (ASL). Until the 1960s, ASL often had remained a hidden language in schools and even among many elements of Deaf society. During the 1960s, William Stokoe (1960) engaged in academic investigations that identified the linguistic parameters of American Sign Language. His findings described parameters that were equivalent to those of spoken languages. Linguists subsequently recognized ASL as a full-fledged language (Parasnis, 1998). This promoted greater recognition and understanding of language-acquisition processes and the fact that many DHH individuals acquired ASL, as well as knowledge of Deaf cultural norms and values, from peers at residential schools for DHH children. This was unique to Deaf culture in that the majority of DHH children had hearing parents; therefore, their linguistic and cultural learning occurred outside the typical family structures. The recognition of ASL as a genuine language subsequently led to greater general acceptance. Colleges, high schools, and other agencies began offering classes on Deaf culture and ASL (Gannon, 1981).

At this time an increasing number of professionals recognized that limiting DHH children to oral and spoken-language methods did not guarantee their success with speech and speechreading skills. Several studies demonstrated that sign language does not impede the development of speech, as previously thought, and that DHH children did better academically and socially and with written language when they used sign language (Gannon, 1981). Other studies (Vernon & Koh, 1970, 1971) compared DHH students who used sign language (and had Deaf parents) with those who attended an oral preschool or had no preschool training. The 1970 study compared students attending an oral preschool with those who signed and were genetically deaf in order to rule out additional disabilities. Results showed better overall academic achievement as well as significantly greater written language and reading skills in those children who grew up using ASL. No differences were found between these two groups of children for speech intelligibility or speechreading skills, despite little or no training for the signing group compared to extensive training for the other group, and no differences were found in psychological adjustment. Interestingly, those who attended preschool did not have better academic outcomes than those who did not attend preschool. The 1970 study also summarized eight prior investigations that showed more positive outcomes for students exposed to ASL or fingerspelling. The 1971 study compared three groups: those attending

oral preschool, those who were oral without preschool, and those who grew up using ASL. Results again showed significantly higher academic achievement by those using ASL, with no differences in oral skills. Of students 16 years and older, those using ASL had significantly more positive academic outcomes: 68% passed college entrance exams, whereas only 47% of the oral preschool group and 34% of the oral/no preschool group did so. These developments further supported the growing positive recognition of the Deaf community, including the impact of ASL, and the potential to achieve better academic outcomes.

Although the increasing use of ASL was perceived as a positive educational option, concerns remained about continuing to develop each DHH child's oral language skills. A number of sign language systems were devised to bridge the differences between ASL and English. In 1969 Roy Holcomb, a deaf educator and administrator, began using the term "total communication" for one such system and publicized its benefits as incorporating both sign language and oral skills. By 1976, two-thirds of the schools for DHH children were using total communication although many teachers were originally orally trained and often struggled with the sign language components (Gannon, 1981). Several other forms of English-based sign language were developed during this time, including manually coded English (MCE), which used ASL signs in English word order, Seeing Essential English (SEE1), which signed each English morpheme separately, often using initialized ASL signs, and Signing Exact English (SEE2), which was similar to SEE1 but signed compound words using the corresponding ASL sign (Gannon, 1981). The overall impact of these English-based sign systems was that, more ASL signs began including fingerspelled, initialized English letters. Although English-based sign systems have created some controversy, linguists typically do not see these artificial languages as threats to natural languages, such as ASL, if they are not imposed on people and communities (Gannon, 1981). Several such systems were developed by DHH individuals, again evidence of their professional involvement in educational endeavors.

A significant medical development in this era that affected population demographics was the advent of penicillin-based drugs, the use of which dramatically reduced the severity of many childhood illnesses. The result on the DHH child population was a substantial reduction in the number of students whose hearing losses occurred later in childhood. Penicillin minimized the severity of children's illness and fever and left their hearing intact. This was important for deaf education in that these childhood-deafened students had fluent spoken-language skills before their hearing loss occurred. Education using spoken-language communication methods could focus on maintaining these existing skills, rather than developing new skills. With fewer children deafened later in childhood, the DHH population now included far more children deafened at birth or prior to learning language (Babbidge, 1965). Many of these children otherwise might not have survived their illnesses. Yet not having first acquired speech and language skills prior to their hearing loss meant that the new population had little or no prior exposure to, or memory of, these skills. Whereas programs using oral methodologies could depend on a significant population who were already competent in spoken language and therefore needed primarily maintenance skills, this new population had few or no linguistic skills upon which to build. These students needed clear and unambiguous language exposure, perhaps provided through ASL, in order to acquire what the previous populations primarily needed only to preserve.

Despite these developments and the involvement of DHH individuals in many educational venues, significant concerns remained about ensuring proficiency with oral skills that might otherwise not be developed using signed language-based approaches. Hiring patterns continued to evidence these concerns: In the United States in 1961, only 11.7% of teachers were DHH, and they were employed primarily at public residential schools. Less than 2% of DHH teachers worked in local public schools (Doctor, 1962, as cited in Moores, 1978). By 1974, 12% of teachers were DHH, although 30% were employed in local public schools. In 1991 and despite being a decade-plus beyond P.L. 94-142 and the 1973 Rehabilitation Act guarantees of employment access, only 15.6% of teachers and 13.0% of administrators were DHH (Andrews & Jordan, 1993). These employment figures improved slightly by 2004 when 22.0% of teachers and 14.5% of administrators were DHH (Simms, Rusher, Andrews, & Coryell, 2008). From 1993 to 2004, the rate of DHH teachers working in public school programs more than doubled, increasing from 7.3% to 15.4%, but still a noticeable minority.

These are conspicuously low figures, particularly compared to those of the 1850s and despite employment rights in the 1973 Rehabilitation Act Amendments and the Americans with Disabilities Act of 1990. A more positive perspective is that, because education is no longer a primary source of employment, DHH individuals today have a far greater variety of occupational opportunities. However, the much reduced employment figures also indicate much lower DHH involvement and governance of educational enterprises. The earlier residential and segregated schools typically were administered separately from local public schools; in addition to having high ratios of DHH faculty and administrators, these programs utilized their own academic curricula, which focused specifically on the needs of DHH students. That is no longer the case today because of the much reduced involvement of DHH professionals and local school programs administered by special education services. Curricula now must adhere to state standards with academic success measured by grade-level tests (No Child Left Behind, 2001; IDEA, 2004). Overall, the early and substantial influence of DHH adults on educational programming and administration has been considerably diluted, and despite the increasing inclusion of DHH students in general education classrooms, a corresponding high level of inclusion of DHH professionals and administrators in educational programs has not occurred.

Efforts to Achieve Equity for DHH Individuals

One of the particularly unique aspects of Deaf culture is that acquisition and transmission of ASL rarely occur in families; 90–95% of DHH children do not have deaf adults in their homes to serve as language and cultural models (Gallaudet Research Institute, 2013; Mitchell & Karchmer, 2004). DHH children who sign share neither the language nor the culture of their parents, unless they also sign. Cultural transmission for these children tends to be lateral and between peers, resulting in a tendency to develop stronger peer networks than family relationships (Parasnis, 1998). Some of these alliances include social and professional organizations and clubs for DHH individuals and educators. Several of these organizations were founded at least 125 years ago and often focused specifically on the promotion of access and equity. One example is the National Fraternal Society of the Deaf (“The Frat”; Gannon, 1981), which was established in 1898 and formally organized in 1901, initially founded to provide burial benefits to deaf male adults.

However, it added life insurance, as well as illness and accident coverage, for deaf individuals when hearing companies would not. The organization also addressed the need for better training in order to secure industrial employment positions and the discrimination that DHH adults encountered.

Because of the many DHH adults who wanted to drive, this organization also dealt with the use of automobiles in the early 1900s. Increasing numbers of automobile accidents and fatalities led many states to enact motor vehicle codes in the 1920s. Many of them restricted privileges for those with physical or other disabilities, and at least four states refused to allow DHH individuals to have a driver's license (Gannon, 1981). These restrictions were passed despite the fact that DHH people generally had safe driving records. The rationale was based on a practice that was prevalent prior to the implementation of stop signs and traffic lights. To alert other motorists, drivers would honk their horns when approaching an intersection. With assistance from friends and superintendents of state schools, DHH individuals eventually won the right to drive in all states. Some states still retained some level of restriction, however; for example, Maryland law required DHH drivers to be accompanied by a person with normal hearing who sat in the front seat (Gannon, 1981). The Frat also was instrumental in providing DHH drivers the insurance they needed in many states.

Other equity issues that influenced the Deaf community were the result of the civil rights movement of the 1960s in its impact on other minority groups. Professional recognition of ASL led to increasing general interest in sign language and Deaf culture. Although advocacy and Deaf community involvement increased, during the 1970s only three superintendents of state schools were deaf, although the number of deaf administrators throughout the country and deaf people serving on school boards also rose. Twenty DHH students attended law schools around the country, and television networks began trials of captioning services (Gannon, 1981). The National Association of the Deaf held its first convention in 1972. The National Center for Law and the Deaf was established in October 1975 and within two years had handled more than 300 cases.

Today, DHH adolescents who are setting goals and mapping their futures have many more options than ever before, some as a direct result of efforts of the Deaf community and related organizations. Although even now there are sometimes questions about DHH individuals' ability to drive, by the mid-1900s these rights generally had been acquired throughout the United States. Even though schools were a reliable early source of professional employment opportunities, DHH individuals have a far greater variety of options today. Unfortunately, the rates of hiring DHH individuals as faculty members and administrators of educational programs remain low despite legal guarantees of employment access and accommodation. Students' educational and communication methods also are more varied and include a number of sign language systems developed by DHH individuals, although some of these remain controversial with regard to how well they promote complete access to a natural language. ASL is more widely recognized and is frequently offered in K-12 and postsecondary schools, as well as in the community. Many of the Deaf community organizations established 150 years ago remain strong today and continue to advocate for equity and access for all DHH individuals. The importance of these advocacy efforts in improving equity is that today's students have far more diverse opportunities to participate fully in society, to assume an equal range of adult roles, and to be recognized more for what they can contribute than for their

hearing loss. The Deaf community and the many DHH individuals who contributed to these efforts also function as role models. And although the issues facing today's young adults are somewhat different, the strategies of these individuals can inspire the leaders and innovators of tomorrow.

Summary of Current Issues and Challenges

This chapter's review of the educational opportunities of DHH individuals indicates that significant progress toward equity has been made. A number of efforts were undertaken in the mid-to-late 1900s to improve the educational opportunities of DHH individuals. However, many of the concerns identified by the Babbidge report (1965) and the Commission on Education of the Deaf (Bowe, 1988) remain of nearly equal concern today. The field still struggles with poor academic outcomes, language-learning issues of young children, the needs of those born with disabilities, the quality of pre-K–16 educational programs, and the generally unsatisfactory status of deaf education. Positive outcomes include the establishing of postsecondary programs that specialize in training DHH individuals with the goal of achieving equitable academic and employment outcomes.

Recognition of the Deaf community's educational and societal contributions has led to research efforts that have recognized ASL as linguistically equivalent, indicated potential advantages to early sign language use (formerly viewed only as disadvantageous), examined and identified the role of Deaf culture within society, and identified new visual language paradigms in bilingual-bicultural or bimodal communication and instruction. As we will see in the following chapters, although DHH individuals no longer have the same impact as they did as educators in the 1850s, they now have far greater career choices, including research and entrepreneurship in a wide range of endeavors that would have been hard to imagine 50 years ago, when equal access was just beginning to enter the social discourse.

One of the changes that has significantly affected deaf education is the movement away from separate and disability-specific curricula and the reduced involvement of DHH professionals. Education now is provided through general and special education services, with curriculum content, standards, and testing based on the expectations for general education students. Political and legislative developments have increasingly placed deaf education under the purview of broader special education requirements and programming. Compared with the patterns prevalent 150 and more years ago, the participation of DHH individuals as teaching faculty, managers, and administrators of schools has been substantially reduced, thus affecting the presence of positive role models, and their roles in governance and curriculum. Despite the guarantees of access delineated in the 1973 Rehabilitation Act Amendments and the Americans with Disabilities Act (1990), the number of DHH faculty members remains below the levels of the 1850s. The result is that education, including transition services, is prescribed by broader service sectors that often have little, if any, knowledge of how to provide appropriate services for DHH adolescents or young adults.

The tension between ensuring disability-specific services and generic, socially sanctioned services often is seen in the negotiation of educational placement decisions for DHH students. As described earlier, presumptions that DHH students function similarly to other populations in that they have typical cognitive abilities should not be

the basis of such determinations. Maintaining a balance between involvement in generic services and separate specialty services often is difficult. Rarely are such determinations based primarily on students' abilities; instead, typical practices, politics, and desired or presumed (rather than student-centered) placements and programs often predominate. A concern is that like P.L. 94-142, deaf education easily can be included in solutions to problems faced by larger populations, to address issues that never have been ours. And those that we do face are represented by numbers too small to garner sufficient attention or resources. This is the situation that we as professionals and parents face in trying to develop and implement a comprehensive set of transition services that will best prepare DHH adolescents and young adults for an optimal future.