Understanding Barriers to Effective and Affirming Care for Deaf and Neurodivergent Clients, in partnership with RIT/National Technical Institute for the Deaf

Presenter: Haley Boring, MS, CCC-SLP

At this time, it's my pleasure to introduce our presenter. Haley Boring is a practicing speech language pathologist at National Technical Institute for the Deaf. She focuses on neurodiversity and is passionate about working with students to create supports to help them succeed. Haley studied at Nazareth University where she completed the deafness specialty program. As mentioned, today's course is in partnership with RIT National Technical Institute for the Deaf.

And at this time, I'll turn it over to Haley. Thank you so much. And thank you so much everyone for coming. This is a topic that I'm really passionate about, so I'm really happy you're here today. So to begin with, whoops, sorry.

Here are my disclosures and limitations or risk and our learning outcomes for today.

So to begin with, I want to tell you a little bit about the people that we see here at ntid because I think it helps a little bit to paint a picture of who we're talking about. So NTID is was created by Congress to create more higher education opportunities for deaf and hard of hearing students.

This shows you a little bit of the diversity of communication and listening technology used by our students. So some students use listening technology such as hearing aids or cochlear implants. Some don't choose to use none. There's really a wide variety of how much that's used or what situations. Similarly, our students vary in their communication modality.

So some of our students use exclusively ASL and others use exclusively spoken language, and still others use a mix of both.

Our communication department offers both audiology services for the NTID community as well as speech and language services. And all of our audiologists and speech language pathologists are ASHA certified. We all sign. So when you saw that slide that showed that diversity of communication

modalities, we match the communication preferences of our clients. So if especially related to this topic, if one of my students is looking for support in something like executive functioning or self advocacy through social skills, then pretty often I might have a session where I'm not using my voice at all.

And we're working through ASL only, so we really just match communication needs for the student.

So moving into our topic today, I want to start by making sure everybody has this, a little bit of basic terminology. So if you haven't learned much about the neurodiversity movement yet, it's important to know that neurodivergent doesn't. It's not a replacement word for any of these terms. It just is a word that it's an umbrella term that means any brain that's different from most people in that society. So most often you're going to see it referring to people who have neurodevelopmental disorders.

So you'll see autism, adhd, dyslexia. Part of that being that someone who has a neurodevelopmental disorder has always had this as part of their identity, a part of who they are. They can't really separate from that. You might see other people also using this, people with mood disorders or even folks who something like a stroke or a TBI happen later in life. But most of the time, what you'll see it referring to and what we're primarily talking about today is neurodevelopmental disorders, but it certainly applies to those, those other identities as well.

So then why is it important to talk about neurodevelopmental disorders and neurodivergent clients and deaf and hard of hearing clients? The reality is, and if you're working with this population frequently, you probably are seeing that there's a higher rate of occurrence for deaf and hard of hearing individuals. So if we look at things that are more likely to occur with deaf and hard of hearing kids, things like prematuRITy, time in the nicu, those things are also factors for things like autism and ADHD too. So we see specifically, autism has a 7 to 9% occurrence for deaf and hard of hearing kids, while it's only a 1.7 to 2% for hearing children. Then on top of that, some features of deaf communication or behavior or sensory needs, it can kind of get a little bit murky to piece out what comes from where.

So when somebody has that dual diagnosis, you kind of have to do a little bit of, of investigative work to see where is the root of this surface level observation. And we'll talk a little bit about that more specifically.

So I've separated out some of the barriers that are impacting these students with dual identities from receiving appropriate services. First of all, we all, if I wanted to get speech therapy today, there would be barriers for me to receive care. Or if I wanted, for me, it would potentially be a little bit easier to receive audiological care because I work here at NTID and I have co workers available potentially to help me. But for most people there are long wait lists. Right.

We have to worry about if insurance is going to support it, if they qualify. Those things obviously apply to this group as well.

Next, what specifically impacts more heavily will be the fact that finding research that looks at both specialized areas and that overlap is going to be harder to find so it's harder to find research that shows what communication traits look like for someone who signs. And is adhd, what is stimming like, what is linguistic development like? There's less research there that shows that overlap and how they kind of interact with each other. We also have at times a lack of trust between the communities we're working with and communication providers. And finally, I already mentioned that there's an issue with having limited providers available in general.

But that gets even more intense when we're looking at somebody who is available to provide services and has all the necessary tools, skills, knowledge needed to work with both of these specialized areas.

So we'll start by talking about the research. First of all, there is some research that looks very specifically at deaf and neurodivergent language development. So specifically deaf autistic language

development. There is a researcher currently at the University of Miami and Ohio who does a lot of research about signers who are also autistic and how they develop language, which is really cool and interesting. So that we take out that piece of what happens when a child isn't exposed to language.

And so that we can really see how does develop for autistic kids. Even if they develop, they are exposed to language naturally. And we, we know that language deprivation isn't a piece of the puzzle for that child. So we have some research that's like that, that unicorn research that fits maybe perfectly for the people you're seeing. We also have research about a typically developing, a neurotypical deaf and hard of hearing child.

We have research for that. We know how development happens, we know a bit about behavior, about language. And then we also have research about these neurodevelopmental disorders. We have research about a hearing autistic child and how they gain language. We have research about behavior and ADHD or what supports help children with learning disorders.

We have research about that. So when we can't find that exact match, we have our best option. We can move forward with evidence based practice by using some of our clinical expertise to take the research that we do have and then apply it. So if you have a 15 year old with ADHD who is also deaf, you might have to kind of pick from those different areas of research and use your clinical judgment to determine best ways of moving forward and what supports you think will best support that child.

So then discussing the lack of trust, just as a basic idea, if a community doesn't trust us, they might not be referring to us or adults might not be choosing to come to us. And when we're talking about the community, we're not really talking about the clients themselves. In some cases it may be especially for audiologists because you may have adults who make the decision to come into your office offices. If you're working with a three year old, it's not really them that we need to win their trust. Sure, once we're working with them, we, we do, but it's the community around them to even get them into the door to

seek services from us.

So on top of if we don't even get them in our door, they might turn somewhere else.

I, I don't know if you have social media, but if you do do I am frequently seeing influencers who will say buy my program and I'll help you get in control of your child's behavior or take this program, take this, this course for parents to learn how to make your child talk. And some of the time those programs and those courses are developed by speech language pathologists or occupational therapists are people that really do have, they themselves have the knowledge. I think moving forward we have a little bit of a question at the field to how much can the general community DIY these services. But the reality is parents are desperate to help their kids and it is something that's happening and we should be aware of. In addition, we might have professionals that have less experience or expertise or research backed knowledge who are taking on communication supports.

So for speech language pathology it might look like there's not a speech therapist available or choosing to see a sped educator looking at speech and language goals in early intervention because there's not an SLP available or they're choosing to use the SPED educator instead. For audiology it might look like people choosing to go to a hearing aid dispenser and circumvent audiologists or take their AirPods and use those or use other technology to support rather than going in to get support from us.

So this is a little bit from my speech perspective because that's my comfort zone. I think it's really important when we're talking about this distrust to kind of acknowledge and address why does this exist? Because what's on this slide is essentially what I was taught and the ideology I approached and entered the field with. And I believe that if you approached most audiologists and speech language pathologists, their beliefs would align with these. We know that it doesn't make sense to try to force things on people.

If I try to put my goals on even a child and they don't know why it's relevant, they're not going to be as motivated to work. So we know that working with our clients is both evidence based and it's ethically better. So it would be easy to look at this and say, well, why would there possibly. Why would you distrust this? The reality is this hasn't been everyone's experience.

And I hope truly that most people today do have that first slide of experience. But I also, especially working here at ntid, have colleagues, especially who had speech therapy years and years and years ago, had experiences with audiologists years and years and years ago, and this slide matches more with what they believe in general, speech therapy and audiology, their approaches. Now, I don't have a separate slide for those in the neurodivergent community, and I do think it's a little bit less of a common experience there. But you could make a very similar case for some folks who have had negative experiences with helping professionals who are also, especially those who are autistic.

So now moving forward, we really just have to add, I know we already have a lot on our shoulders, but part of working with these communities is doing what we can to repair this relationship and make sure that we're not adding more harm accidentally.

All right, so our last barrier that we have today is providers themselves, their knowledge, their skills and the tools they have matching the community that they're working with. So again, there's such a need in general for related allied health professionals in general. In my area. I live in a rural area of New York and my county has kids that enter the early intervention system and they graduate and move into CPSE before ever seeing a provider because there's just not, not enough providers available in general. So then if we took the pool of providers available to offer services and then we filtered down and found those left who are available, who can offer services and have knowledge about deaf and hard of hearing development, or can offer services and are able to sign if this child uses ASL to communicate or their family uses ASL to communicate that that little pool of providers gets smaller and

smaller and smaller.

Then if we add in one more filter of somebody who has the necessary tools and knowledge to work with neurodivergent and deaf kids, our pool is getting even more limited. So our providers realistically to work with both populations, we want to make sure that we know in general what tools should I have if I want to make sure that my center is accessible to neurodivergent kids? What tools could I have readily available to make sure that this is a positive experience for them? We want to make sure we know in general what does the community generally prefer, what language is being used? Are there any things that we should probably try to avoid?

Realistically, that's true for any community you work with, knowing for these individuals how behavior, communication, development, how that generally occurs, and then just the basics of being able to communicate with that person. So if someone is signing and you're going to have an ongoing relationship with them, that's going to be a really difficult relationship. Especially for those SLPs who are supposed to be modeling language, that's going to be really challenging even with an interpreter.

If it's your first experience with high tech or even low tech AAC and using augmentative and alternative communication is new to you, that might be a little bit difficult too. At least in on the audiology side, you're probably less likely to be modeling for the child. But as an slp, if I were to go back and be working again with kids who are learning to use high tech devices for communication, I would need to be piling on additional continuing education for myself and taking time to improve my speed and fluency in finding vocabulary there so that I can be a good model. So these are some of the basics we need when we think about diagnosis. We also kind of have to have a little bit of of an ability to analyze all this for the child in front of us especially because there really isn't normed options for evaluations that standardized options that look at especially deaf kids.

So figuring out how do you assess this child in a different language and the norm hasn't looked at them, you really have to have a little bit of that skill, of an analytical skill to be able to see all through all that and see how these characteristics are interacting with each other.

So to kind of describe this. So we're going to talk about this a little bit more because the takeaway here isn't going to be that you're going to walk away. I understand and know how to differentially diagnose between these two things. For one thing it's an ongoing question, but for another thing, it's just too big of a topic that could be covered today within this topic. But I do want to show you how communication traits can look similar between deaf and hard of hearing, typical neurotypical children and neurodivergent children.

So some ways that hearing status can impact communication. You might see a child who has is it has listening fatigue. They've been listening all day and on top of the listening they're also trying to lip read and take in visual information. From the environment, While also, I mean, a current school day is a long time for any child. So it's draining for any child.

But that might start to look like inattention, executive dysfunction, or even some behavioral outbursts when this child is just drained. Similarly, language deprivation. This can impact behavior again, because when children can't communicate their needs, they're going to find a way to communicate that with you. And it might not be the pro social way you would like them to do it. An example of this might be.

So looking at a child who really is just stuck on one topic, they always come back to the same topic. They. I had. I had one child who every single day would ask me, what's your favoRITe color? And after a couple weeks of this, I finally asked her because I was trying to kind of analyze, where is this coming from?

I finally asked her, what's my favoRITe color? And she remembered and told me green. And I was like, great. So, you know, and then I thought about the bigger puzzle piece of her. She wasn't in general.

I mean, she, she. She generally liked bright, colorful things, but not in a way that this was specifically a high interest subject for her.

So I realized for her, the really motivating piece was she wanted to communicate. She wanted that social interaction. And this was a phrase that was an easy script that she could turn to, and probably a script as a young child that was frequently asked to her. Adults especially, we ask kids, what's your favoRITe color? So she knew how to communicate that with me, but didn't so much know how to communicate about topics that she would be more interested in.

So if it had been the first thing, if it had been colors are her high interest, then I would have approached it moving forward by bringing in more color, by bringing in color activities. Maybe we would paint, we would talk about color, we would find ways to talk about other language functions with color. But since it wasn't, I realized what she really needed was supports for how she can ask other questions. So for her, it might have looked like a high interest topic, but really it was a lack of language there. It was a gap in vocabulary.

We also can see where many children who have a neurodevelopmental disorder also have a concurrent language disorder or just differences in language in general. So we might see somebody that has impaired syntax, but then the flip side is if that child is their first language, is asl, did. Do they truly have impaired syntax, or are they omitting grammatical and syntactical features that don't exist in asl? Because English is their second language. And finally, thinking about deaf culture and how that impacts social norms and expectations.

So if we are looking at a child trying to analyze and determine is this child presenting with limited understanding of implied social expectations or is this child following common cultural norms within their community? So if their community is deaf culture, they might follow different common cultural norms. So we need to kind of piece that out because things like sharing information are really highly valued within deaf culture, which sometimes looks like subjects that are taboo, not just being open, fair game and discussing anything or giving an extensive amount of detail about something because information is so highly valued.

Okay, this is a way too complicated looking for both the last slide and this one. There is a handout that you'll have. Don't sweat this too much. I'm going to break it down for a second. This was me trying to put out from my brain into onto paper, more or less, an approach for moving forward and deciding if you should work with a certain client.

So all you really need from this is first of all, do you have the knowledge and tools and skills readily available to support this child with their current diagnoses? If the answer is yes, great, then we're going to move on and say, can I communicate with this child? This would be true whether or not you're looking at a deaf and hard of hearing child or I've worked in settings. If I'm working with a Spanish speaking. If there's a clinic and there is a Spanish speaking client coming in, if somebody's readily available who is fluent in Spanish, then that person makes sense to take on that caseload if they have space and they can't.

So in a similar way, do you already have these skills? If yes, go ahead and move on, then it's wondering, do you have cultural knowledge? So all of that last slide of what's important for us to kind of know about these cultures, if you already have that knowledge, we're great. That's you're in good shape to be working with this client. Go ahead and proceed with treatment and also remember that you're here.

So I know that you know this, but education is not going to be stagnant. We're going to need to keep up on all of the changes that happen and make sure that we're aware of all that. So continue to educate yourself, but go ahead. If the answer to any of those things was no, then we're just going to move on to is somebody else available? If they are, that might be a good fit.

If no one's available so my county situation where we have tons and tons and tons of children who are waiting and looking for services, no one's available. Either a speech therapist is going to see that child or they're not going to see that they're not going to get services. Similarly, our local audiology centers, I'm not sure how many have set supports for neurodivergent kids. Either they're going to go to one of the the two ish main centers or they're not going to get audiology services.

So at that point, our next question is, do you have the resources to gain those things? Do you have time, do you have the money to go pay for workshops? You have everybody here, at least most people I assume here have subscription to audiology online or speech therapy online, speech pathology online. So both options. Do you have the resources and the time to do that?

It might look like if you have somebody in the area that maybe doesn't have space to take on a new client, but they would be willing to consult with you or to mentor you, that might be an option. Use of. I know this is a much harder thing, especially if you don't work at a university, but peer reviewed research that's currently available or articles from reputable sources. So things that are coming from asha, not necessarily things that are coming from Facebook. Right.

Similarly, if we are looking at language and culture, we want to make sure that we're able to gain those things as best as we can, especially if we're going to be working with these populations more happily and we want to make sure as much as possible, we are learning from people within the community.

So that was a very complicated graph. Just for that really. Just essentially the reason I have that refer to a different provider if your answer is no for all of those things. And sometimes that's fine. We cannot specialize in everything.

So if you do not have the bandwidth or the finances to get appropriate tools and you don't think you're a good fit. I do think that we have to remember that we can cause harm even outside of for speech therapy. I think that speech therapists are pretty good at seeing those medical cases and realizing, ooh, I am not qualified for working with somebody with a trach or I am not qualified, I do not have the clinical skills to work on dysphagia anymore. Right. In a similar way, if we're working with something that we don't have knowledge and we don't have the ability to gain that knowledge, even for language, we can cause harm.

So if we truly can't at this time, then best would be to find somebody who can for that child.

So then let's talk about how these things do impact assessment and treatment. So for people in these communities, kids who are deaf and hard of hearing are generally diagnosed later with autism versus autistic hearing children. I can tell you, working currently with college age students, I've had students get diagnoses now in their 20s. I've had many students who either are aware and have a diagnosis, are aware that their characteristics match with a certain diagnosis, or have no idea, but characteristics do match with those diagnoses. And these students often assume those ones who don't have the diagnosis and don't aren't already on that path to figuring that diagnosis out.

Those students often just assume that these traits are common for all deaf and hard of hearing kids. And some of the people around them, like parents, sometimes assume things like stimming that must be a deaf thing is something that we've heard here. So we might take characteristics of one and apply them to the next one. And like you saw in that other slide, sometimes they do get a little bit blurry and gray.

Then we also have to consider in the cases that the person evaluating isn't fluent in the person's first language. So if that's ASL and they are not fluent in asl, how much nuance must be missed there? I mean, how can you assess for things like figurative language if you don't have a shared culture and a shared language? It would be really challenging. So any of these things that we're seeing, and I know that audiologists and speech language pathologists, we're not necessarily in the room for those initial evaluations, but we are doing our own evaluations of this person and how to support them moving forward.

So our initial assessments and our ongoing evaluation, when we're making these inaccurate assumptions, we're. That's kind of snowballing into later a plan of care that's already on this, this rickety foundation.

So our practice, so we already mentioned, if we have the wrong idea about what the baseline, what the root of these surface level observations is, then we're already treating the wrong thing potentially. So first of all, we're already potentially looking at the wrong thing when we get to our plan of care. We also know that some of those students, like the ones I mentioned in my county, are stuck waiting and waiting and waiting on a waiting list for a provider, and they're just not receiving services. Some students might receive services, somebody might go ahead and say, you know what Any services are better than no services and move forward with working with somebody when they don't actually have all of those skills needed to work with that, that person.

And yes, we already addressed plan of care doesn't necessarily target those underlying needs. So then the most important piece here, this impacts our students. So if the appropriate skills, the underlying skills are not being supported, what we're going to see is those gaps and abilities continue to widen and get bigger and bigger and bigger. When that happens, as the gaps get bigger, you're going to see more challenging behaviors because again, if somebody cannot communicate, if somebody is constantly

stuck in this loop of frustration, they need to communicate and express that in some way. So while we're building on skills and while other same age peers are building on skills, the gap's continuing to widen and later providers are going to have more to catch up with.

Mental health also suffers. So there have been studies looking especially at autistic kids, but even studies about like ADHD kids and how many corrections they receive in a day. Mental health suffers for these, these kids and they start to internalize that. And I'm saying kids, but also I do mean adults as well, especially as the people that I see every day are adults. And this is a big piece here.

If we reach that point, we've missed a lot of opportunities for self advocacy. So if we haven't gotten services this entire time and then we're entering school and we're finally getting services, these children don't know, they haven't had those opportunities to self advocate for listening technology, for practicing. How do you tell a teacher that the FM system isn't working, that her mic isn't on? How do you tell somebody, my body doesn't feel okay, I need to go for a walk. We're missing these opportunities.

Often the children don't even know either that they can ask for those things, they don't necessarily have the language to do it, or they just don't even know what to ask for. They don't know how to identify, I need this right now. So when we miss these things, we also miss giving them opportunities to practice doing that so that hopefully when they arrive at college or at a job as an adult, they know how to say, oh, actually I'm sorry, I really need access to these tools to help myself succeed. Or I need you to turn on your speech to text so that I can understand what you're saying, or advocate for interpreters or whatever that looks like for that child. As an adult, they have to practice the skill as children so that as an adult they're ready and then finding community.

So I do work with deaf kids every day. Kids, adults, my students regularly, those who have those concurrent diagnoses, they have approached me and said, I don't understand because I grew up in this community or I'm here now and I have access to the deaf community. And even when I'm in these

groups that are supposed to be my people, they're supposed to be my peers, I'm supposed to feel so loved and supported. It doesn't quite fit. I still don't fit here.

So remembering that giving clear these it's that piece of. You might have seen the analogy of am I a weird horse or am I a zebra? And there's benefit to just knowing yourself and knowing how to find community that have shared experiences.

Okay, so I don't want to have this presentation be doom and gloom. Everything is bad because it isn't. And there are ways that we can move forward and things that you can do to support these individuals tomorrow so we can close this gap. First of all, we have to start with ourselves, right? We have to make sure that we deserve the trust.

We are asking parents and community members, we're asking them to trust us when they send their children to us. So we need to start by making sure that we're educated and we're doing the right things so that we deserve that trust.

Step one to how we're going to do that is make sure that we have those professional skills. So audiologists might look like gaining some knowledge about like, okay, how can we support neurodivergent kids in our clinic? It might look like attending trainings and webinars about neurodivergent kids like this. Or it might look like requesting consultation or mentorship from. If you have a local occupational therapist who's really good with sensory and they focus on that, maybe they can consult with you to see how you can make the sensory environment more supportive for your clients who have sensory processing needs.

Similarly, we can gain new tools, new approaches and remembering to make sure that the sources we use are experts within their scope of practice, that this is a reputable source, that it is coming from the right place. So I mention OT when I'm talking about sensory because they're the best people that we

can get sensory processing information from. It's their field of process, field of expertise. So we want to be going to the people within their fields and getting evidence based practice from reputable sources.

I just mentioned this. This more applies to the slps, but this is a website that my department maintains. It's a free online resource and it goes through some of the basics. And our goal is to keep it something that I know that some folks who are working out there, a lot of SLPs don't necessarily interact every day with deaf community like we do here and might only have a deaf or hard of hearing client once in a while. And so it might not be realistic for every provider out there to go learn everything and become a specialist in this.

It's, it's not. So we do have this as a resource available so that hopefully it's something that you can apply. Even if this is an area that you are less knowledgeable about, you can gain knowledge hopefully relatively quickly.

All right. And then continuing to expand your toolbox. So all of that stuff about professional development is obviously important because what we do is, you know, the professional development piece. We want to make sure that we are providing appropriate services, but then we also want to make sure that we are knowledgeable about the culture we're working with. We want to know how do people within this community want to be referred to, what language is used, what things are generally triggering.

And then we want to make sure that that stuff comes from the community. So honestly, in some ways this can be the. It's not necessarily easy, but it can be because it can fold into your everyday life. There are deaf and neurodivergent stand up comics and influencers and authors and artists like you can find those people and just learn from them within your day to day life. Similarly, if you are like me and you live in an area with a big deaf community, there may be community events, there's theater, there are deaf night out.

You might be able to find community events to meet people within your own community and then your communication development. So I mentioned before, if I were to walk into a school where I would be working with autistic kids especially, I would absolutely be prioRITizing myself to gain fluency and speed and knowledge about the most common high tech AAC options out there. I would be taking courses and dedicating time in my schedule to improve my own fluency. Similarly, similar thing applies for ASL communication development, especially if it's a situation where you have that ongoing relationship or audiologists, something like oral rehabilitation for speech language pathologists. If you're treating, then you're going to have an ongoing relationship with this person.

So making sure that you have a plan for how am I going to communicate with them and what can you do to build your communication skills?

All right. And then we can educate our teams. So first of all, I've worked in so many different settings where people do not really know what a speech therapist does. And I will be fully honest, I myself forgot that an audiologist could work with oral or, I'm sorry, with auditory processing. So we all could use those reminders sometimes.

When do you want people to refer to you in a similar way? I think that this creates an opportunity for good collaboration in your setting. So audiologists, when should we be referring? When is audiology's turn to be referring? I'm sorry, refer to audiology.

And when should we referring to ent? Or when do we want to make sure that occupational therapy is getting clued in? When we can build those professional relationships, we can further support our kids because we have more eyes that can say, hey, actually I'm wondering if this behavior we're seeing is coming from this, this child is getting poor. Like the, the signal to noise ratio in here is awful. And like, maybe we need to talk to audiology about getting an FM system so they can access the classroom

better because it always happens in this room.

Or maybe it's this child's behavior always happens around this time and there's this sensory experience. So we get OT in or speech and OT collaborate together to help them learn the language they need to advocate in that situation. When we collaborate, we have more eyes on the picture and we have fewer gaps and fewer spaces for these people to fall through. It's also helpful if I think a lot of times people know, they know the most basic. They know what push in therapy looks like, maybe, or they just know pull out.

We know direct services, and that's all we know. Sometimes your school, if you work in a school setting or your clinic might have other options like a lunch bunch or a social group or a parent group, or schools might have an RTI system or a consult. Especially if you work in a school setting that has that three to one, three weeks and then one week of consult, paperwork, makeup, those things. If you have that, that's a good thing to make sure your teens know about so that they know how they can utilize your resources in house. I also try to be aware of what resources are available in the community.

So when I meet families who have been waiting and waiting and waiting and waiting on that wait list for early intervention, I am telling them, go to the library. Because in our area, our libraries do these wonderful toddler story hours that are targeting a lot of early language skills and they're not going to be specialized language care, but they are going to be supportive and they are going to get that family support, that child support, maybe be able to get them connected to more resources. So knowing what resources are in your area can also help to give additional resources, especially when we have these, these students or these adults who are falling further behind.

And then finally we want to advocate. So we want to ensure that our caseloads have the appropriate services and that that goes beyond our services. If you feel this child truly needs a one on one aid, and this is something that can be supported, advocating that an appropriate person is hired for that,

advocating that it's added to an IEP or a 504, making sure that these students, when you notice the person in front of you, really has some high sensory needs, is there something that you have readily available that could support them? Is there more supportive seating that you could request for your clinic? Is there, is there consults with ot?

What can you do to support this child? And then in our communities we also, we want these people to have access not only in school, we want them to be able to access everywhere that we do in our communities. So there's many different features that public spaces can implement to support both deaf and hard of hearing and neurodivergent patrons. This, there's a hyperlink here to the Guggenheim for all toolkit which is a really nice. It's the art museum created this website that lists a whole bunch of different accessibility features that can support autistic, especially kids and not only kids, but adults as well.

Many supports, if you look at them, you're going to realize you'll see that like so many supports are realistically supportive for anyone. Access really helps us all. There's a lot of things that are maybe intended as a support for a neurodivergent person that might support me as a parent or might make life easier as a deaf person. Things like being like sound related things and sensory needs and having visuals, all of those things support both communities. So this is a really great resource if you are, especially if you're trying to advocate in your community for more supports.

And so this is just a little bit more specifically what some of that can look like sensory supports that give the whole group access. So these would be things that if you have an RTI program in place and things that can be accessible to all kids or if you want just accessible in your clinics, in your communities, these can be options that can support everyone. So having access to be like allowing someone to use music if it's not interrupting or disrupting Their ability to do the task, having access to weighted laugh pads or adaptive seating. Then also things that can decrease sensory input. So a lot of places will

choose to have like scent free spaces, things that again reduce that reverberation or that background noise.

Like those things are going to benefit our deaf individuals and they're also going to benefit our neurodivergent folks as well. And again, I put down here, if you have an ot, refer to them. So if you work in a school, you may already have an ot. If you don't, there's one in your community, refer to them if you're not sure because they are the ones that this is their, their scope, their area.

All right. And some supports that can help executive functioning. So there are strategies you can incorporate into your everyday, like using routines, setting clear indirect expectations and boundaries, reducing visual and auditory distractions. And again, this is something that's going to affect both your, your average deaf child and your average neurodivergent child. And honestly, just any child or adult, if you're in an environment with lots of visual distractions, it's just going to be harder to, to be successful in that environment.

And then you can also use tools like visual timers, social stories, that's a really great easy thing that you can add into your clinic so that especially autistic kids, but also kids with adhd, having structure and expectation can help a new environment and a new situation feel a lot less scary. So you can create a social story that goes out with your intake paperwork or is it readily available on your website that has pictures and walks through what to expect during their appointment. You can do that.

And then we can also consider at baseline how do we talk about these things? Because it's really easy and I see it frequently happen where people are intending to be affirming, but it's spoken of as well. People listen by doing this or people have a good communicator does this. Oh, and sometimes people also do that, that's fine too. But we, we are automatically othering all of these other ways and styles of communicating or all these other ways of engaging with information as other different, worse.

So we can think about how we approach that in the first place. We can talk about communication styles and how we can work together to fit with people who don't match our communication style. And this also kind of goes along with the conversations about identity, first language or person first language and matching what your client sitting in front of you prefers.

Okay, so then we talked before about some of the mental health ways that all of this can impact our clients. So when possible, we want our clients to build communities, to find belonging. We want them to be proud of their identity and who they are. For some people, that might not include their neurodivergent status, it might not include that for them, it might not include their hearing status, but we want to build opportunities for that when possible, for people to identify that way, if they choose to, for that to be validated and for them to be able to find community that shares their experiences. So it might look like peer mentor programs.

Either you can, within your clinic or your school, create something that way or look in your community to see what exists. I regularly refer, tell my students we look together and we will pull up. Since I am fortunate enough to work in a college, there is a club for everything here. So I will let my students know, we'll pull it up. And I mean there's a beekeeping club and a model train club and a, there's, there's even a skydiving club which is wild.

So if you have a high interest topic, it's going to be easier to communicate and to connect based on that. So join those interest based groups because you're more likely to find somebody who shares that high interest and connect in that way. There's also support groups and clubs that might exist in your area. So at our clinics, I lead two groups that are identity neurodivergent focused. We have an executive functioning group that really kind of works together to troubleshoot executive dysfunction and find strategies and supports that work for students.

And we also have a neurodivergent group that will sometimes also look at executive dysfunction because it's something that many neurodivergent people struggle with. But we also work to build social connections between each other and navigate some of the things that come up when you're a college student with a neurodivergent identity. And it's also important to highlight adults in the community. These might be adults who, you know, maybe my students graduate and I ask, will you come back and talk to my students and will you just like tell them what things you're doing now? Like you're, you've, you've been successful, what worked for you?

Come talk to my students. And so they can have this role model of somebody who identifies in the same way as they do.

If that's not something you have access to, you can find adults who are really cool role models, who are artists and comedians and we can highlight those people and when we do, we can show that I Mean these people being this is part of their identity and they're cool or this is part of their identity and look how smart they are. Can you believe this? TED Talk or whatever that looks like. But highlighting people so that we have role models and we see that people with both of these identities can be really great role models. And again, when we're talking about who scope, while we all can support these things, looking to see, especially if you are in an academic setting, you probably have school counselors and social workers.

Those people can help you to build these things. Either collaborate together or look to see what do they have already set up.

And I want to kind of highlight one of my favoRITe places because I think that while nothing is going to be perfect, I think that this is a place that's really doing their best to do it well. So the science museum here in Rochester, you can go in and when you enter you can request a sensory bag. It has some noise canceling headphones. It has like a small emotion communication card. It has some fidgets and there's

one more, I think, I think like an ID tag that while I wish this wasn't necessary, request other people to be a little bit more patient if that person wants to use that.

They also have sensory friendly hours intermittently so that you can go in at a time that there's, you know, not a whole horde of third graders all coming in at the same time screaming. So you can enter during sensory friendly hours. They also have some calm down spaces and low stimulation spaces. And what I love about this is not only do they have them, in some cases they have. Well, in all cases there's one nearby in those, those really loud high movement areas.

There's one close by that you can go to and they make it very normal. So there's this, their big climbing structure area where kids are running around and screaming and playing. They have a little quiet nook hidden just around that's incorporated into the space that has some sensory tools, that has some books. The light is dimmable. It's really great.

They also have. You can. If you're not sure what a social story is, if it's, if it's new to you, you can see they have an example of a social story there online. So they do have that as an option that you can access the next one, this field trip forecast. I love that they do.

It's not specifically marketed as a access support for neurodivergent people, but it absolutely helps my own sensory overwhelm. They will let you know which days of the week online. They post each week, like Tuesday morning there is going to be so many third graders here. And then me and my kids will absolutely not go that day because it's going to be a meltdown for all of us. It's not going to be a good time.

So that's a support that can help anyone and it's readily available. And they also do have interpreters available for events. When they do events this coming weekend, their nature center has a pancake breakfast for Maple Weekend and they'll have interpreters there for that as well. So the finding

advocating for more places to do these things. A lot of these steps are pretty simple and they give more access to more kids and adults.

So more of our places having these things is something that we as communication providers can be helping to advocate for.

So I have this slide here shows a survey. This is separate from your, your final the quiz that will go along with this course for asture credit. And if you have time and don't mind adding to it, this just helps us to know things that you're looking for, how you feel about the courses during this partnership. And thank you so much. This is something I'm really passionate about and I hope that it was helpful today.

Thank you so much, Hayley. I learned so much. I really appreciate all of your expertise on this topic. We don't, we definitely don't get enough of this in graduate school or in other CE programs. So this has been really special.

So we'll leave the Q and A open for a few minutes if anyone has comments, questions, anything to share. I also wanted to just note, Haley, after we talked about your PowerPoint and you talked about the museum there, I started looking into my area. So I'm in New Jersey and then Newark Museum of Art does some of the same things. So they have like sensory days for families where the museum's closed and they just take families through separately and they have different supports and things. So.

So I think this is out there. We just have to maybe look for it and find it. Yes. I actually had a situation where somebody in my life was describing that for their child. They were supporting their child by before they went to a new place, they were looking up online and finding pict and talking about, okay, we're going to find this is where we would go if we had to go to the bathroom.

And this is where this would happen and like doing. And this wasn't somebody who was an allied health professional. And I finally was like, you recreated a social story. Like you're just doing all of the work. And as soon as she learned that word, you can just look.

There was a social story for we use social stories for my toddler, when we had a big plane trip and helped him, there was one available, the airline that we flew, we were able to at it and he could see what to expect and it really helped to support him because he knew what to expect and when he had to wait in line, he knew that that was something that would probably happen. That specific RMSC that's by us is certified by its Culture City, but with a K. They have like a sensory certification from them. Our zoo here in Rochester has the same. But I mention it because you can actually look on Culture City's website and they will show you where near you has that certification. So you can find it that way too.

But there are other examples that don't have that too. So definitely look for those kinds of things in your area. Great. And advocate for them. Right.

If a place that you love or you want to enjoy with your family doesn't have it so perfect. Well, we are at the end of time and I don't see any questions coming in. So I just again want to extend our help, our heartfelt thanks to you and all the faculty at NTID for the other folks here, our participants. If you'd like to find other courses by the faculty at NTID, you can search the course library on speechpathology.com or audiology online by that topic. So we have created a special topic for RIT ntid and we have all their courses there.

So look for more great CE activities. So thanks everyone. Hope to see you again in another webinar soon.