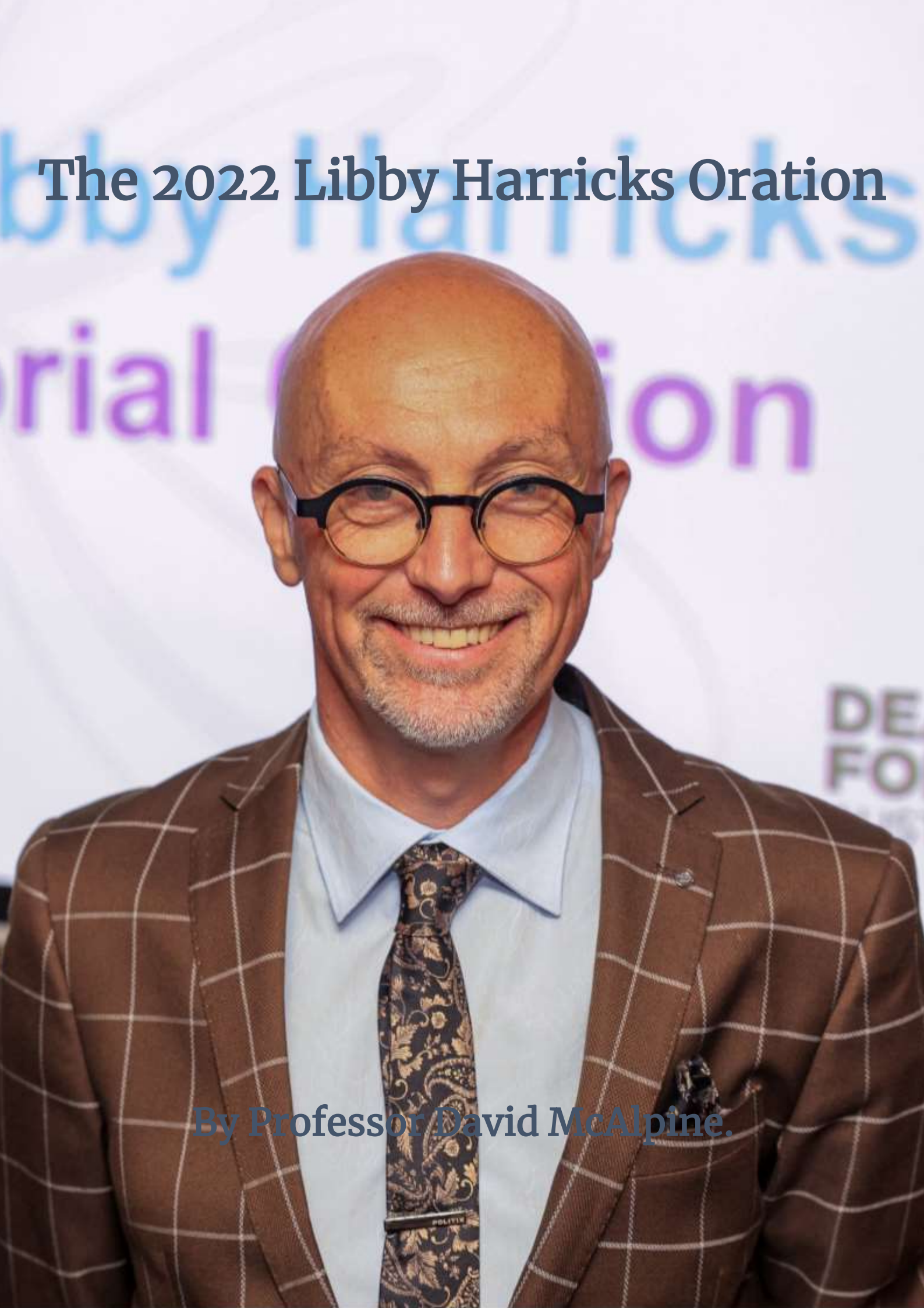
The 2022 Libby Harricks Oration



By Professor David McAlpine.

Introduction to the 23rd Libby Harricks Memorial Oration in 2022.

From the chair of the Libby Harricks Memorial Oration organising committee on behalf of the Deafness Forum Australia, Catherine McMahon, Professor of Audiology at Macquarie University and the Director of H:EAR.

The Oration series is presented each year by Deafness Forum.

In 2022, the Oration was held at an event in Sydney organised by Hearing Australia.

The Oration series honours one of the outstanding advocates for Deaf and hearing impaired people in Australia, Mrs Libby Harricks, OAM. Libby was the inaugural chairperson of Deafness Forum Australia and she worked tirelessly to raise awareness of the need for equality of inclusion in life activities for Deaf and hearing impaired people.

In recognition of her advocacy work, Libby was made a Member of the Order of Australia in 1990. Following her untimely death in 1998, Deafness Forum of Australia established the annual Libby Harricks Memorial Oration Series to honour her achievements.

The Series aims to continue her vision of working towards gaining appropriate recognition, awareness, and access, for hearing impaired people.

Over the past 23 years, the Oration series has developed a well-deserved reputation for carrying forward Libby's commitment to raising awareness of issues relating to hearing impairment.

The reputation of the oration series is undoubtedly due to the great contributions of our outstanding Orators who have presented on a wide range of relevant topics.

Dr David McAlpine presents the 23rd Libby Harricks Memorial Oration. His topic – Is Prevention Better than Cure?

David McAlpine is Distinguished Professor of Hearing, Language & The Brain, Dept of Linguistics, and Academic Director of Macquarie University Hearing.

Trained as a neuroscientist, his leadership roles supporting the development of research into hearing and deafness and the translation of research into benefits for those with hearing problems informs his view that engaging with individuals and communities through all sorts of avenues – conversations, media, and the arts, is key to securing hearing health and positive listening futures for all.

Listening to the Future – is Prevention Better than Cure?

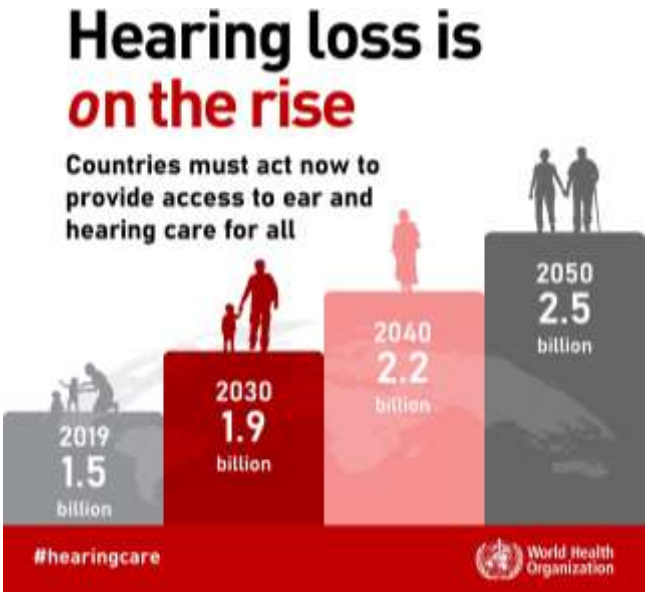
Thankyou to Deafness Forum Australia and the Oration committee for honouring me with the 2022 Libby Harricks Oration. I would also like to acknowledge Hearing Australia for supporting this event and congratulate them on their 75th anniversary. They are an integral part of the Australian Hearing Hub here in Sydney, along with National Acoustic Laboratories, Cochlear, The Shepherd Centre, and Next Sense. Australia has a world-leading research program into hearing and deafness, and in developing treatments and interventions for hearing loss. This is recognised globally and continues to attract talented people to our shores.

On such occasions, it is customary to reflect upon where we have come from and to understand what helped make us the people we are today. As an undergraduate at the University of Western Australia, I was fortunate enough to come under the mentorship of the famous Brian Johnson and 'Lab 10', where my interest in hearing and deafness research was sparked. Now I probably had some clues as to where I was headed—I was often in a record store (remember those!)—78 Records on Hay St in Perth—starting out on my own tinnitus journey! And so, it proved. Cut to 35 years later, how has our ability to prevent hearing impairment changed, it at all? If we look, or perhaps listen, to the future—is the future for hearing health 'bright'—I hesitate to say 'loud'? Will hearing health improve over time? Will hearing healthcare become 'mainstream'? Can we deliver a national agenda for preventing hearing loss. Could we scale that up globally? Or are we on the path to declining hearing health? Is preventing hearing loss beyond us and do we simply have to accept the inevitable? What does our future sound like?

Listening to the future of hearing health

To help us on that one, we can look to the World Health Organisation's 2021 World Report on Hearing. It confirms what we knew—hearing loss is a chronic health condition that manifests right across the life course *in utero* to late age. And it's increasing globally at a time when vi ion loss is declining. It affects 1 in 6 of us, rising to 1

in 4 by 2050, a product of our ageing societies, yes, but also our life-style choices.



The WHO also estimates the annual cost of untreated hearing loss is close to 1 trillion dollars—lost productivity and the like. And despite it being the most common sensory deficit—comorbid with other health issues in later life—hearing loss still has the status of an orphan disease in terms of ring-fenced research funding, public-health profile, and other initiatives. To date, its known consequences on speech and language, life-chances, cognition, mental health—have failed to shake the nation, and indeed the globe, out of its torpor when it comes to preventing hearing loss and protecting our listening abilities over the life course. Why is this the case? Are we not cutting through when it comes to messaging the dangers of hearing loss? Is anyone else listening—communities, governments, healthcare systems, businesses, regulators? And what is our message on prevention? Are we trying to prevent hearing loss per se, or are we more focussed on preventing the consequences of hearing loss? More radically, might we better seek a cure for hearing loss—should we be trying to reverse it, say, through biological means? Are those lifestyle choices contributing to hearing loss 'hardwired', and therefore the only way forward is for us to develop 'a pill for deafness'? And how does the concept of prevention work in the charge towards over the-counter, or OTC, hearing aids? Hearing loss is increasingly part of the business model for major tech companies. Will cheaper hearing aids—if they even are cheaper—get them off the hook for their negative behaviours when it comes to our hearing health? Before heading down that path, it is useful to reflect a little bit more on what a purely preventative approach to hearing loss would require and for this, I think it's helpful to take a life-course perspective.

We know that preventing hearing loss starts before conception, and genetic counselling can alert prospective parents to the potential of congenital hearing loss. This is a prevention issue globally, particularly in the global south where consanguineous relationships are common. And it doesn't matter whether you live in multicultural Australia or the upmarket suburbs of Riyadh, or if you're part of the Bangladeshi community in east London, consanguineous relationships increase the risk of congenital hearing loss by three to fourfold. What differs of course across socioeconomic groups is access to interventions. I remember from my days as Director of the Ear Institute at University College London watching well-to-do Hasidic families from the northwest of the City walking up Grays Inn Road to the Royal National Ear Nose and Throat Hospital for hearing aid and cochlear implant fitting for their kids, but I didn't see so many coming from east London from the Bangladeshi community, which was poorly served, partly due to language barriers and health literacy issues. So just on this issue alone if we were considering preventing hearing loss in the first place how do we overcome the issue of congenital hearing loss in consanguineous relationships. This isn't a medical or health related issue, it's a cultural and societal issue at a global level. Who tackles this issue—its impact on health certainly extends beyond hearing loss—do we simply let it pass?

We also know that disease and infection in utero can damage hearing, as can common

therapeutics administered at birth and indeed across the life-course. This again is a global challenge because we know that some of these treatments—aminoglycoside antibiotics for instance—are common in developing economies where more costly but safer treatments are out of reach. Preventing hearing loss from therapeutics that target other, often life-threatening, health conditions is an economic problem, not a hearing health problem. Answers on a postcard, please, for these issues one.

Early screening—constant vigilance

Now, of course, in Australia we have universal newborn hearing screening—a major element in preventing the consequences of hearing loss. A gold star for that one. So, what's the problem? Well, the problem is the world moves on—funding, political priorities—and our gold standard program has no central repository or database to capture a national profile of hearing impairment. This is a missed opportunity. The lack of a central repository can downplay the status of health conditions at a time when the' big data' message is all-encompassing in health. A timely warning about this comes from the UK which and its universal screening program. This was long championed by Adrian Davis for Public Health England, but it never developed a national database—the data are sequestered in individual NHS Hospital Trusts with little to no ability to explore or combine the data across jurisdictions, and therefore no ability to employ the data for a broader purpose—vigilance in managing the high incidence and life-time consequences of hearing loss at birth. So, following the Global Financial Crisis in 2008 which hit the UK especially hard, 'efficiencies' in the health service bundled hearing screening into the broader newborn health screen, which included the heel-prick test for PKU (phenylketonuria) and sickle cell anaemia (demographically important in the UK). But, compared to the high 1 in 900 or so live births with hearing impairment, the rate of PKU is about 1 in 10,000 births, and of course is entirely reversible at that point. One in 79 births have the sickle cell trait, but only about 15,000 people in the UK have the disorder, about 1 in 5000, compared to the 1 in 6—and rising—with hearing loss. This merging of hearing screening into the broader screening agenda carries risks. Like the rest of screening in the NHS it's now considered optional—look it up on their website—you are now 'offered' it in the hospital, though the guidelines suggest it can take place at any time up to 3 months after birth. No prizes for guessing which communities are most likely to miss hearing screening because of this downgrade—those most at risk. Preventing the consequences of hearing loss in childhood requires early diagnosis and timely intervention. And it's good to know that on the issue of public-health messaging and cultural and linguistic diversity, or CALD, it's worth noting that Piers Dawes—previously of Manchester but now at the University of Queensland—was recently awarded a significant NHMRC grant to explore this issue in an Australian context. He's doing this with colleagues from Macquarie University Linguistics department—it's an issue of language and health literacy, not simply hearing health.

Hearing screening can also be a victim of its own success. Programs like 'SWISH' here in NSW have entirely replaced school screening, yet we know twice as many kids lose their hearing after they leave hospital then are diagnosed **in** hospital. This leads to underdiagnosis and underfitting of hearing devices. Indeed, diagnosis in the early years relies on parental intuition—guesswork; three-quarters of mild-

to-moderate hearing loss—requiring the use of a hearing aid—is not identified by parents/carers at all, and subsequent visits to the GP may or may not lead to referral. Educating parents and carers as to the signs of hearing loss during the early years could help prevent or reduce the consequences but are we confident that parents should or can be the front-line for diagnosing hearing loss in nursery, kindergarten, and early school years? My wife and I missed it in our oldest son, now 6. He eventually had grommets inserted for glue ear, and along with some speech therapy improved, though he still has some language issues. As Professor of Hearing, Language, and the Brain, and my wife a hearing scientist, shouldn't we have known? And friends in his birth cohort were also missed. One, in particular—thankfully now engaged with Hearing Australia—was late diagnosed with a moderate hearing loss and now wears hearing aids. And his dad is an emergency doctor and his mum a Physical Therapist. Preventing or reducing the consequences of hearing loss in the early years requires expert diagnosis, but we're a long way from reaching most children who pass their hearing screening at birth but lose their hearing later.

The most invidious example of entirely preventable hearing loss is in Australia's First Nations people, where middle-ear disease is an international scandal. It contributes to reduced education and employment outcomes and greater contact with the criminal justice system. And coming back to parental diagnosis, Kelvin Kong—the pioneering surgeon and a Woromi man—has spoken passionately about this issue and is dedicated to solving it. But you may also have heard him talk about missing the signs of glue ear in his own daughter. Even for parents with the right knowledge and skills, knowing your child has a hearing problem during the early ears is hit or miss—so many other things are going on. Preventing chronic ear disease in Aboriginal children and avoiding its many adverse consequences—is rightly a priority of Australia's national roadmap for hearing health, but it clearly requires that we also Close the Gap right across the life-course in all sorts of ways if we are to achieve this. How do we prevent hearing loss and its consequences in the early years when diagnosis is simply left to chance?

Procreation, prevention, and noise at play

And when we talk about preventing hearing loss, we must talk about sex—no, really! And we must go back to Charles Darwin's seminal works to find out why. Darwin is a strange choice when we think about preventing hearing loss in early adulthood in the 21st century, but when it comes to this demographic, it's critical to understand what drives behaviour and whether we really can change those behaviours. When you think of Charles Darwin you normally think of finches and the evolution of their beaks he so elegantly described, an observational foundational to the theory of evolution well before the discovery of DNA. But birds, particularly some native Australian birds, get top billing in hearing simply because they generate very loud sounds. Budgerigars—native to Australia—are in the list of 10 noisiest birds globally, peaking at about 105 decibels. Now, birds of a feather flock together, and we know that budgerigars gather in the thousands. And these birds sing, Loudly, for their supper, and much else besides, including mating. With all this constant noise about, why do they not go deaf? Simply put, it's evolution. To survive as a species, you need to be successful at the four Fs—feeding, fight-or-flight (literally, in the case of birds), and 'fornicating'. For the latter, many birds sing to attract a mate, and they pass on that song to their offspring in the nest. Propagation of the species depends on hearing that song across the life course and teaching that song. Birds must do this against 100-decibel background noise day in day out. As such, they have evolved the ability to repair the inner ear. If birds didn't need to hear to procreate, they wouldn't have an inner ear that regenerates itself. It's simply evolution. Humans don't regenerate their hearing because there is no evolutionary pressure to do so—

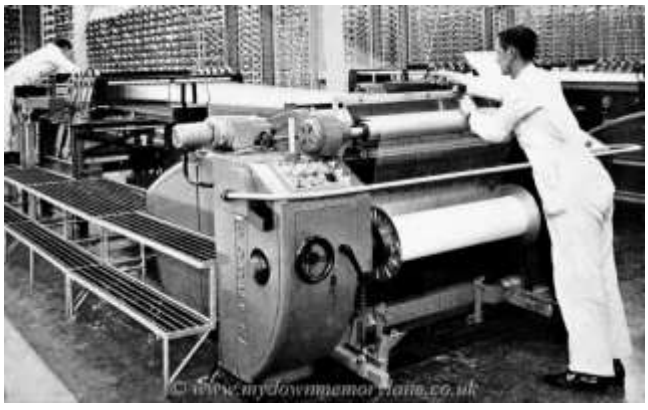
humans tend to procreate well before they go deaf (though, with a 3-year-old son at the age of 55, I'm not the best evidence for my own hypothesis).

Nevertheless, although they don't have robust hearing, like birds, teenagers and young adults do tend to flock in together in noisy groups, and they tend to do so with the four Fs in mind. This commonly occurs at venues with elevated levels of completely unregulated social noise. Teenagers and young adults are at risk of developing levels of hearing impairment previously observed in older adults.

A recent study of Japanese millennials reported an alarming decline in hearing function—equivalent to 20 years accelerated ageing—compared to the previous generation, due to noise from clubs and gigs, and headphone use. This hearing loss is entirely preventable. But to do so needs more than a stern warning. It requires a combination of personal action and regulation just at a time in life when this is not easily going to happen. You are taking on evolution. Who is going to challenge punters at a nightclub to protect their hearing, or demand club owners take notice and make their venues less attractive. In fact, permanent hearing loss is entirely permitted at music venues and festivals in the way that *visual* impairment is not. Worse, hearing loss has become a badge of honour. You go to a gig, you get deafened, you go out and boast about it. This wouldn't happen if a club were allowed to beam dangerous laser lights into your eyes for four hours straight. Imagine the conversation on the street. 'G'day mate, how was the gig?'. 'Great, couldn't see for a week'. It's not going to happen. What is our prevention campaign to 'tackle the consequences of evolution on hearing loss'?

Noise at work—not gone, but forgotten?

Moving from play to work, we sometimes suggest that social noise is replacing noise at work, but it is often augmenting it. Preventable hearing loss from 'noise at work' remains a blight across Australia. Noise regulations differ across states and are weakly enforced regardless of other regulatory norms (e.g., farming, mining, military, restaurant & service industries). And the consequences of unregulated noise at work are still working their way through the system simply due to demographics. This is the age cohort for whom prevention of the consequences of hearing loss is most acute. My own father worked in those industries most damaging to your hearing and he was indicative of many individuals at the time. He was employed in the shipyards in Belfast, Northern Ireland, the linen trade, and at the printing press—industries known to be bad for your hearing. It's no surprise he had major hearing problems by his 50s—Given the times, preventable, but not prevented.



What was preventable, but remains largely unprevented, were the consequences of his hearing loss, especially at the end of his life. My father died of Lewy body dementia at the age of 74, in a nursing home in Perth. Of course, I don't consider his dementia to be a consequence of his hearing loss—Lewy Body dementia is idiopathic. When I visited him in 2016 just after moving from the UK, he did not remember who I was and couldn't hear anyone telling him. I like to think he thought I was my identical twin brother who was living in Perth and had been one of care team, but it didn't help that he was sitting in his room wearing somebody else's hearing aids—with no batteries. Given the circumstances of his life, a working-class man from Northern Ireland employed in noisy industries at a time when going deaf in Belfast was the least of that society's problems, his hearing loss was almost given. But the response to his hearing loss in Australia in the late 'twenty tens' should not have been. If care staff at the nursing home had administered a drug error, they would have been reprimanded or dismissed. But hearing aids that connected a bedridden, deafened man to his family, his friends, and his beloved Johnny Cash CDs. This is where we are today!

Now, his complement of 74 is no age these days, and it is our increased longevity that means we will be living with a significant communication disorder for a greater proportion of their lives than ever before unless we do something about it. And again, preventable hearing loss in older life is exacerbated by otherwise positive trends — the democratisation of social spaces, music venues, bars etc., provides 'opportunities' for noise exposure well into later life; the boom of the baby boomer generation is the sound of amplified music. Mick Jagger is 78, and so are his fans. And this demographic is also the one in which the incidence of skin cancers is peaking—their early-life exposure to the sun predates the SLIP SLOP SLAP campaign of the 1980s—'Slip on a shirt, slop on some sunscreen, and slap on a hat'. Public health campaigns can change behaviour, but SLIP SLOP SLAP worked because we only had 3 television channels back in the day and everyone watched Test Match cricket. Getting to one generation can influence the next generation—parents cover their kids in 'rashies' on the beach. But what would a modern campaign for preventing hearing loss even look like. And where? Facebook? Twitter? Tik Tok? We simply can't keep up. Do we simply have to accept hearing loss as a lifestyle choice?

And lifestyle choice inevitably leads to marketing, where hearing aids are already well embedded. And it's no bad thing—people need to know their options. And it really is lifestyle; adverts for hearing aids often comprise a bloke with more hair than he should have at his age, with a woman much younger than he should have his age, driving a car that he can't afford because he's bought a very expensive pair of hearing aids!

Someone exactly like me in fact, except that I don't wear hearing aids, I've never had a driving licence, and I haven't seen a barber in decades. Well, you can guess the rest. In fact, it's the subtlety of marketing that often gets important messages across, while submerging a lot of stuff you don't want people to know or that's irrelevant. People 'buy' messaging. But if the solutions don't match the messaging, particularly in terms of performance, what then? Are we stuck in the advertising rut?

'Big-brand' sounds—don't be Phillip Morris

Many marketing campaigns today really are about messaging who we think we are or want to be, regardless of the actualities, and hearing loss

is no different. Even Phillip Morris, the major cigarette manufacturer, with 5 of the top cigarette brands globally is at it. Their website suggests they are moving into the private health space. Think about that—a cigarette manufacturer taking care of your health! They discuss responsibility, ethics, support for diversity of people and corporate culture. Nice irony there. And, of course, Phillip Morris haven't seen the light—they're not actually moving out of cigarette manufacturing. They still make most of their 31 billion US dollars in revenue from selling cigarettes, but not here in Australia. As with most advanced economies, we've offshored our lung cancer, and our noisy industries, to China and other developing economies, which is also where Phillip Morris is making most of its money. Knowing this, are you happy for Phillip Morris to provide your healthcare?

Which brings me neatly to over-the-counter, or OTC, hearing aids. This approach—largely in the United States—to rectify what is perceived as a lack of affordability of hearing aids may provide many benefits—we shall see—but in the move to OTC we must take care not to allow 'big tech' to monetize the solution to a problem they may well be generating in the first place. Apple are currently moving into the hearing aid space and many others will too. But, bluntly, if you're going to deafen people with your technologies when they are young you can't really be monetising the solution to that problem when they're older. And it's not one way traffic regarding consumer technologies moving into hearing aids. A recent professional trade-magazine review about a product from a major electronics manufacturer states

"*I was a bit worried with the earlier headphones—about their output level. With these* new headphones*, that's not the slightest problem. Stacks of gain. You can play anything to any level you like....The company rates the maximum output level of the headphones at 108dB and mid-band total harmonic distortion at less than 0.3% at 100dB. They're quite impressive figures.'*

They are impressive figures. They're the type of figures which if you were listening at work, would be highly regulated—about 5-10 minutes of listening at most. It's therefore interesting to note that the holding group that recently purchased this company is a long-standing manufacturer of hearing aids and other listening devices. Now I'm not putting this company in the same space as Phillip Morris. I think there's great opportunity for cradle-to-grave communication solutions—and messaging. However, if you specifically design a product to generate high intensity, undistorted sound, the onus is on you to make listeners aware of the risk and to mitigate those risks, not to provide later life solutions to the hearing problems you cause in earlier life. In the rush to OTC, we need to avoid being Phillip Morris. Monetising a potential cause of hearing loss allows you to profit by restoring hearing function. Is that ethical and should we be calling it out? Given the close-knit hearing technologies community we have, and the desire to enhance communication abilities over the life course, we could be working together to maintain healthy hearing and communication over the life course. Let's see if that happens. Board room decisions may hinge on whether prevent hearing loss in the first place is profitable. What's your public health campaign going to do about that?

Therapeutics—the case for a cure

So, if prevention is a difficult problem, we then need to approach the elephant in the room—a cure for hearing loss. Do we need a cure or is what we have enough to solve the problem. I'm going to say that the answer is – we need a cure, and the reason is because there is much of hearing loss we can't prevent—even preventable hearing loss. But finding, and funding, a cure won't be easy. Therapies for hearing loss are a hard problem. We don't have the diagnostic toolbox, or an effective delivery system for bringing drugs to the inner ear, though cochlear implants are an idea choice in my view.

Importantly, we don't understand the patient populations—their genetics or their phenotype—required to make effective therapies and make therapies effective. We also know that the money invested into the science of hearing and deafness is much less than is invested into other health conditions including vision loss. This all plays out in the stock market, where the currently listed start-up companies in hearing therapeutics have tanked their share price by around 95% in the last two or three years due to badly designed and poorly executed clinical trials. We need to understand what a true translational pipeline for hearing therapy looks like. These are well established in other disease models, and they work.

To finish, I'm going to back this up with what I hope is not too flippant an argument. We know that Libby Harricks—whom this oration honours—was a pioneering advocate for people with hearing loss, but we also know she died of breast cancer at the terribly young age of 52 in the late 1990s. At that time survival rates for breast cancer were not as good as they are today. What changed. First, prevention. You can't easily prevent the **onset** of breast cancer, but you can prevent its progression through timely diagnosis—a combination of personal knowledge and behaviour and better diagnostic tools. Sound familiar. Second, you need a cure. You can't manage breast cancer, you must get rid of it—new drug therapies, new combination therapies, augmented by radio- and surgical interventions. People survive breast cancer now because their breast cancer is eradicated, not because it is managed.

The broader point I want to make is that once you have evidence of an effective therapy, money pours into that disease model. This kickstarts new diagnostics, changes behaviours, engages public health agendas, gets commercial, government, and clinical partners talking. And it doesn't matter what the therapeutic intervention is going to be: it could still be hearing aids, it could still be a cochlear implant, it could be a combination of all these things—therapies, hearing aids, implants.

Success in finding a potential cure for hearing loss raises all boats. People take effective drugs for breast cancer **and** have radiotherapy **and** have surgery.

Australia is one of a handful of countries that could achieve the unity of purpose required to deliver a cure for hearing loss. So, I believe we should be working together to deliver the next generation of hearing therapies—genetic, biological, pharmaceutical. These will become effective tools in our armoury not just for curing hearing loss but informing the public, empowering them to take charge of their hearing health, driving prevention campaigns, and showing that prevention and cure, together, will transform the hearing health and the wealth of our nation and the globe.

David McAlpine is Distinguished Professor of Hearing, Language & The Brain, Dept of Linguistics, and Academic Director of Macquarie University

The Oration series

Since 1999, Orations have been presented annually throughout Australia by a series of outstanding Orators.

1999: 'Hearing Access Now!' Emeritus Prof Di Yerbury AM (Sydney)

2000: 'Recent Advances in the Understanding of Meniere's Disease and Tinnitus' Prof William Gibson AM (International Federation of Hard of Hearing Conference, Sydney)

2001: 'The Politics of Deafness'Senator Margaret Reid (National Press Club, Canberra)

2002: 'The Prevalence, Risk Factors and Impacts of Hearing Impairment in an Older Australian Community: The Blue Mountains Study' Prof Paul Mitchell (XXVI International Conference of Audiology, Melbourne)

2003: 'Disability Law and People with Hearing Loss: We've come a long way (but we're not there yet)' Ms Donna Sorkin MCP BA (Macquarie University, Sydney)

2004: 'A Sorry Business: Lack of Progress in Aboriginal Hearing Health' Dr Peter Carter (3rd National Deafness Summit, Brisbane)

2005: 'Deafness and Disability Transformed: An Empowering Personal Context' Alex Jones (Blue Mountains NSW)

2006: 'Hearing Loss: The Silent Epidemic: Who, why, and what can we do about it?' Prof Harvey Dillon (4th National Deafness Summit, Perth)

2007: 'Hearing and Communication – A Primary Concern in Aged Care' Richard Osborn (9th Rural Health Conference, Albury)

2008: 'Access, Equity and Hearing Loss in Australia in 2008' Prof Robert Cowan (5th National Deafness Sector Summit, Canberra)

2009: 'The Bionic Ear: From an Idea to Reality' Prof Graeme Clark AC (GP Continuing Education, Sydney)

2010: 'Early Identification of Hearing Loss in Australia: Well Begun is not All Done' Prof Greg Leigh (6th National Deafness Summit, Sydney)

2011: 'Molecules, Managers or Mentors: How Can We Minimise Noise Damage in the Worksite?' Dr Robert Patuzzi (11th National Rural Health Conference, Perth)

2012: 'A Report Card on the Social Wellbeing of Deaf and Hearing Impaired People in Australia' Dr Anthony Hogan (7th National Deafness Summit, Melbourne)

2013: 'The Consequences of Being Born Deaf in the 21st Century' Dr Laurie Eisenberg (Australian Hearing Hub Inaugural Conference, Macquarie University)

2014: 'Making Connections' Prof Susan Brumby (8th National Deafness Summit/ XXXII World Audiology Congress, Brisbane)

2015: 'Towards a new model for the Deaf Inclusion of Leadership in early hearing detection and intervention services' Dr Christine Yoshinago-Itano (8th Aust. Newborn Hearing Screening Conference, Sydney)

2016: 'The Oration' Hon John Howard OM AC, 25th Prime Minister of Australia (9th National Deafness Sector Summit, Sydney)

2017: 'Hearing and Mind: What should we do about hearing loss to promote cognitive wellbeing in older age' Dr Piers Dawes (17th Alzheimer's Australia Biennial National Dementia Conference, Melbourne)

2018: 'Sisters are doin' it for themselves' Dr Graeme Innes AM (23rd Audiology Australia National Conference, Sydney)

2019: 'Global hearing health: Challenges and opportunities' Prof Andrew Smith (Indigenous Hearing Health Symposium, Hearing Hub, Sydney)

The COVID health pandemic caused a break in the series in 2020.

2021: 'Indigenous Ear and Hearing Health — Tackling the Silent Epidemic' Prof Harvey Coates AO presented the 2021 (An international webcast from Perth in Western Australia)

DEAFNESS FORUM AUSTRALIA

https://www.deafnessforum.org.au/events/libby-harricks-memorial-oration/

Libby Harricks' story is one of courage and triumph over adversity by utilising the knowledge of her own severe hearing loss to help others.

Libby started to lose her hearing following a bad dose of flu in 1969 and she began to find difficulty using the telephone which was very important in her profession of pharmacy. In spite of advice to the contrary, Libby tried hearing aids and found they helped. Had she heeded the negative advice, Libby believed she might never have embarked on the road to self help, which so enriched her own life and that of many others.

She thought her two boys quickly learnt to sleep through the night and her friends remarked they had loud voices, which was the boys' mechanism for coping with a deaf mother!. The more the doctors said nothing could be done to help, the more Libby looked towards self help and so she learnt to lip read, a tool she relied on heavily in her quest to help others.

Libby's will to win led her, with the help of others, to get involved with the setting up of a support group, which became SHHH – Self Help for Hard of Hearing people. They set up the first Hearing Information and Resource Centre In Turramurra NSW.

Libby became an enthusiastic user of technology and with her handbag full of electronic aids was enabled to join in a full social life with family and public. Libby became President of SHHH (renamed Hearing Matters Australia in 2019) in 1986 and began to develop her role as an advocate for hearing impaired people generally. She became involved in ACCESS 2000, under the Australian Deafness Council, and was a member of the Disability Council of NSW. Her horizons broadened further as Vice President of the Australian Deafness Council and then as the first, and two terms, President of the newly formed national peak body in deafness, the Deafness Forum Australia. In this latter role Libby made a huge contribution to bring together all the different organisations into a central body, and actively lobbied on behalf of Deaf and hard of hearing people.

Libby was made a Member of the Order of Australia in 1990. Later she was appointed by the Government to the Board of Australian Hearing Services and was asked to represent the needs of hearing impaired on the Olympic Access Committee.

Libby faced another hurdle when she was diagnosed with breast cancer in 1995. Following surgery, she continued her family and volunteer work with undiminished vigour. She would wickedly show off her wig at public functions after her chemotherapy, and talked openly of her "mean disease". She died peacefully on 1 August 1998 and was honoured by hundreds who attended her Thanksgiving Service on 6 August.

In her own words, Libby related her outlook:

"I look back over these years and realise that any efforts that I have made have been returned to me threefold.

"I have found talents I never knew I had.

"I have gained so much from the many people I have met and worked with to improve life for people with disability and through self-help I have turned the potential negative of a profound hearing loss into a positive sense of purpose and direction in my life".