The 2007

Libby Harricks
Memorial Oration

Libby Harricks Memorial Oration number 9

Honouring the Deafness Forum's first president & profoundly deaf achiever

Elisabeth Ann Harricks AM 1945 – 1998

deafness forum of australia

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Introduction to the 9th Libby Harricks Memorial Oration

Dr Jenny Rosen, Chairperson, Libby Harricks Memorial Oration Committee

Born and educated as a normally hearing person, Libby Harricks developed profound hearing impairment as a young wife and mother. Despite this, after learning skills to manage her own hearing difficulties she proceeded to become a passionate advocate for equal access for all hearing impaired people. Totally committed to raising awareness in the community regarding the issues relating to hearing disability, she was a founding member and long term President of SHHH Australia Inc (Self Help for Hard of Hearing People), and represented the needs of hearing impaired people on the Sydney 2000 Olympics Access Committee. Amongst her many activities, Libby was also the first President of Deafness Forum, the national peak body in deafness. In this role, she travelled widely throughout Australia, constantly lobbying on behalf of hearing impaired people, and raising awareness of their needs. In 1990, in recognition of her contributions on behalf of hearing impaired people, Libby was made a Member of the Order of Australia. After her death in 1998, the Libby Harricks Memorial Oration Series was established by Deafness Forum in her honour. The aim of the Oration Series is to continue her commitment to achieving appropriate recognition, awareness, and access, for hearing impaired people.

The Oration Series is published by Deafness Forum in monograph form. The inaugural Oration, *'Hearing Access Now!'* was presented in Sydney in 1999 by Emeritus Professor Di Yerbury. In 2000, at the International Federation of Hard of Hearing Conference, Professor Bill Gibson spoke on tinnitus and Meniere's Disease (also in Sydney). In Canberra in 2001 Senator Margaret Reid discussed *'The Politics of Deafness'*. At the XXVI International Congress of Audiology in Melbourne in 2002, Professor Paul Mitchell presented findings of the Blue Mountains Hearing Study. This important study examined the prevalence and impact of hearing loss in a representative older Australian community. In 2003, as the keynote address to a full day hearing access seminar at Macquarie University in Sydney, Donna Sorkin's address summarised progress in disability law and hearing loss from an international perspective. In 2004 Dr Peter Carter spoke at the 3rd National Deafness Sector Summit on the present status of Aboriginal ear health. For 2005, we moved to the Blue Mountains, and Alex Jones gave his excellent Oration, *'Deafness and Disability Transformed: An Empowering Personal Context'*. As the first Oration presented in Auslan, this was yet another new direction. In 2006, as a keynote address for the 4th National Deafness Sector Summit in Perth, Professor Harvey Dillon presented his paper entitled *'Hearing Loss: The Silent Epidemic'*.

The series speaks for itself in carrying forward Libby's passion, and the aims of Deafness Forum. We have been extremely fortunate with a series of outstanding Orators presenting on a wide range of relevant topics. Equally, we have managed to provide this opportunity across Australia, as well as providing continuing availability via the printed Monograph series. I must acknowledge the hard-working Libby Harricks Memorial Oration Committee, and the very supportive Deafness Forum national secretariat, whose assistance with this Oration series has been invaluable.

This year, we are delighted to have the opportunity to reach a new audience with a rural focus, at this 9th Rural Health Conference in Albury. I would like to acknowledge the Conference organisers for their help in enabling this to happen. At this point I would also like to acknowledge our sponsors for the 2007 oration: Australian Communication Exchange, Australian Hearing and Cochlear for their support and generosity.

It is now my pleasure and privilege to present to you the Orator for 2007, Mr Richard Osborn whose topic today, *'Hearing and Communication—A Primary Concern in Aged Care'*, impacts on us all, regardless of where we may live. Rick is a well-known audiologist in private practice in Melbourne. Over the years, he has contributed widely – from positions held at the HEAR Service, the Lincoln Institute of Health Sciences, the Royal Children's

Hospital, and innovatively, as an audiologist in various roles at Vision Australia Foundation. Rick has managed a number of national and international projects in education and consulting, and has written and presented many papers on the impact of late-onset sensory loss.

At age 65, 35% of Australians, rural or otherwise, can be expected to have a significant hearing problem. For those older folk in residential care, the prevalence rises to 85-95%. For many of these people, the effects of hearing loss will be compounded by fading vision. Rick has been a world leader in drawing attention to the interaction of such multiple disabilities, and how easily they can be (and frequently are) misdiagnosed as confusion or dementia. Clearly, unrecognised and unmanaged hearing and/or vision loss can thus disproportionately compromise all other management. During his Oration, I am sure that you will all gain considerable insight into just how this can happen.

Will you please welcome Mr Richard Osborn.

Hearing and Communication – A Primary Concern in Aged Care

Richard Osborn

Introduction and aims

It is indeed a great privilege to have been asked to present this address which honours the memory of Libby Harricks, who was tireless in her advocacy for people with hearing loss.

Hearing impairment has a potentially serious impact on people's lives, particularly on communication with others. Conversation may become strained and unsatisfying. This can impact on the quality of relationships and trigger social isolation as the person withdraws from shared activities. Hearing impairment also compounds other changes associated with the ageing process, such as vision loss and cognitive difficulties, forcing a loss of independence in a range of daily activities and reduction in life role participation.

Currently, hearing care tends to be seen as a separate and stand-alone specialist area. However, this paper will argue the importance of integrating hearing care and associated communication strategies into general aged care protocols. It is vital that all primary, aged care workers understand these issues and feel empowered to manage the day to day issues faced by older people with hearing loss.

Achieving this outcome requires a holistic approach that emphasises the development of practical skills in the training of aged care providers. Both initial training and continuing education programs are critical in addressing the hearing and communication needs, and consequent wellbeing, of older adults. Carers equipped with knowledge and practical strategies can draw on a positive approach and practical interventions to assist older people in their everyday communication, maintain their everyday living skills and continue their participation in valued social roles.

This paper has two primary aims, firstly, to provide the background theory that assists us to understand the complexities of the issues in this area, and secondly, to introduce some practical strategies designed to support older people with hearing and communication difficulties.

World Health Organisation Model

The International Classification of Functioning, Disability and Health (ICF) (World Health Organisation, 2001) provides a useful model to conceptualise the range of outcomes associated with hearing loss (see Table).

The ICF defines three levels of impact that flow from a health condition or disease:

(a) Body functions and structures, the anatomical parts of the body and physiological functions;

(b) Activities, the execution of tasks or actions; and

(c) Participation, the involvement in a life situation.

Health conditions negatively impact on each of these three levels, namely impairments, activity limitations and participation restrictions. For instance hearing loss represents the impact at the level of the impairment. At the activity level, hearing loss may result in a reduction in independence in the activity of telephoning. The effect of this may then flow to participation, in that the loss of telephone contact with friends may lead to a restricted participation in the valued social role of friendship. The usefulness of this model is to assist us to understand the range of ways a health condition may be expressed and to encourage a holistic approach in our management that I will elaborate on throughout this paper. Firstly however, I will provide some background as to the extent and nature of hearing loss in older people and discuss common conditions that compound its impact.

Table 1. World Health Organisation Model

ICF 1997	LEVEL OF IMPACT	DEFINITIONS	EXAMPLE
Health Condition/Disease		Alteration of health status	Presbycusis
Function/Impairment	Body	Loss or abnormality of a body part or function	Sensorineural Hearing Loss
Activity / Activity limitation (disability)	Person	Difficulty in the performance, accomplishment or completion of an activity of the person	Difficulty communicating on the telephone
Participation/ Participation restriction (handicap)	Society	Difficulty participating in life situations and roles concerned with the individual's relationships with society.	Loss of social contact with friends

Hearing Impairment

The extent

The prevalence of hearing impairment in people over 65 years of age is high. It is estimated that more than 80% of residents in nursing homes experience hearing difficulties (Worral, Hickson & Dodd, 1993).

In the 2006 Libby Harricks Memorial Oration, Professor Harvey Dillon delivered a paper, entitled "Hearing Loss: The Silent Epidemic", which described in detail recent Australian epidemiological research and outlined the extent and nature of hearing loss across various age cohorts. Some of the key statistics in this paper included:

- 2.8 million people in Australia currently have a hearing loss
- The prevalence and severity of loss increases with increasing age
- Over the next 25 years, with the ageing of the population, it is likely that 4.9 million Australians will experience hearing loss.

The nature

Presbycusis, or age-related hearing loss, is described as a sensorineural loss. That is, it is due to changes in the sense organ of hearing – the cochlea – and/or its neural pathways. Hearing loss due to presbycusis is permanent and is not treatable through surgery or medication. It has a number of characteristics which may include:

- Slow onset and commonly affecting both ears equally
- The hearing loss most often affects the perception of high-frequency sounds, and causes a reduction in the clarity of speech, particularly in noisy rooms or group conversations
- Commonly there is distortion of speech sounds, i.e. consonants, and an increased sensitivity to loud sounds
- Tinnitus, or a constant ringing sound in the ears, is also common.

Often there is a compounding noise-induced component to the hearing loss which is associated with the exposure to excessive levels of noise through war or military service and working with noisy machinery. This exacerbates the age-related loss, so adding to the overall extent and impact of the hearing impairment.

Compounding factors

In older people there are likely to be other changes that compound the impact of the hearing loss, such as cognitive impairment, vision loss and physical limitations. In considering ways to support independence and life role participation, we can't look at hearing loss in isolation and need to take the effects of these other changes into account.

Of the compounding factors, vision loss has the highest incidence and will be addressed in some detail.

Vision

Vision loss is a highly prevalent condition. Estimates vary between 10 % and 25 % in the older population (Klein, Klein & Lee, 1996; Kirchner & Peterson, 1980).

Many people experience severe vision difficulties due to the following conditions:

- Age Related Maculopathy (ARM) is the most common condition in the older age group. It produces a loss of central vision, causing difficulty seeing detail, which affects the person's ability to read, recognise faces and perceive colour.
- Diabetic Retinopathy produces a loss of parts of the visual field, causing a blurring and patchiness of vision, which affects safe movement, reading ability and the performance of many everyday activities.
- Glaucoma often produces a loss of peripheral vision, causing tunnel vision, which affects the person's ability to drive and move about safely.
- Cataracts produce a loss of contrast vision, causing blurring and increased glare sensitivity, which affects reading, face recognition and safe movement.

When surgical and medical options have been exhausted, the person with these conditions requires assistance in the form of low vision aids and devices, training in their most effective use, learning new ways of performing everyday tasks, and support from family and carers.

Vision impairment also has a significant impact on communication particularly as it reduce a person's capacity to detect non-verbal cues important for understanding meaning and emotional context of verbal messages.

The combination of vision and hearing loss is common in older people with each sensory impairment compounding the effects of the other. For instance, vision loss may affect one's ability to lip-read which those with hearing loss typically use to augment their communication. The combination of vision and hearing loss will be most apparent when communicating in environments with competing background noise (Erber & Osborn, 1994).

Cognition

Older people may experience both normal age-related changes in cognition, and specific changes associated with dementia or neurological conditions such as stroke. These changes may range from a mild slowing of information processing to more marked changes in language and memory function.
The presence of hearing loss exacerbates the impact of cognitive difficulties and in turn cognitive difficulties make it more difficult for the older person to adapt to and manage the effects of sensory loss. Certainly the presence of dementia states makes the clinical assessment of hearing more challenging and the person with significant memory difficulties is likely to have difficulty learning how to use their hearing aids effectively.

It is also important to be aware that hearing loss may even lead to misdiagnosis of cognitive and behavioural difficulties (McArdle,1997).

Physical

Loss of tactile sensitivity and conditions that restrict movement such as arthritis, hemiparesis following stroke, tremor associated with Parkinson's Disease adversely impact on the person's ability to physically manage aids and devices.

The Impact of Hearing Loss on Activity and Participation

Models of Human Occupation assist us to understand the importance of social roles in giving purpose and structure to our lives. This discussion relates to the third level of the WHO Model outlined in Table 1.

Humans innately seek activity and life role occupation to provide structure, routine and a sense of purpose and achievement. For older people, key life roles may include family, friendship, volunteer work and involvement in community organisations, such as the CWA and Legacy. Occupations assist people to organise their time into patterns and habits (Kielhofner, 2002), but when people withdraw from major life roles, the changes in routines and the resulting imbalance of occupation have a serious impact on their lives.

The experience of the older person with hearing loss is that they may have to strain to hear what is being said and may miss certain high-frequency speech sounds, particularly consonants, making it difficult to follow conversation. They may mishear people's comments, miss the punch line of jokes or commonplace asides, and not pick up nuance and other subtle aspects of conversation that enrich our interactions with others. The quality of conversation may become degraded causing a loss of enjoyment and they may feel "cut off" from people.

From the family's perspective, they may falsely assume that the older person has "tuned out", that they are disinterested, dementing or depressed. Such misattributions are common, particularly when the person with the hearing loss is unable or unwilling to acknowledge the degree of difficulty they experience in understanding what is being said. Sometimes friction within the household is caused when, for example, the television is turned to excessively loud levels or irritability results from ineffective communication, such as when information frequently has to be repeated. This impacts on how others may view the older person's personality and they may be perceived to be 'disengaged' or 'grumpy'.

As I have mentioned, strained relationships may snowball, leading to withdrawal from family, social and community roles, with a concomitant risk of loneliness, and social isolation as well as psychological sequelae such as frustration, anxiety and depression.

These impacts of hearing loss not only represent a loss to the individual but also to the community, as older people are a valuable resource in their roles as volunteers, grandparents and neighbours. They are the backbone of many community organisations such as the CWA, sports clubs and social groups.

Families may also be concerned about the safety of their older relative. For instance they may have difficulty using the telephone, hearing the doorbell, and moving about safely within the home and community. Families who observe such difficulties may question their older relative's capacity to live independently. However, by moving to an aged care environment, communication difficulties will hinder adjustment to change.

Having outlined the issues older people with hearing loss face I will now provide suggestions as to practical approaches and solutions to address the problems raised.

A Practical Approach to Understanding and Managing Hearing Loss

Assessment of hearing impairment

Due to gradual onset, many people with significant hearing loss may be unable to acknowledge the extent of their hearing difficulties. Whilst others may complain of having to speak loudly or repeat what they say, from the older person's perspective, they know that they can hear some sounds (e.g. knocking on the door, the car engine) and they may feel their hearing is "alright". However, this seeming inconsistency is quite typical of presbycusis, which causes a specific deterioration in the perception of high frequency sounds, including many of the consonant sounds of speech, whilst perception of low-frequency sounds, such as engine noise may be intact.

Their subjective experience therefore is one where the speaker has unclear speech. This may lead to typical comments such as: "People mumble" or "I can understand what they say on the news, but I miss what is being said in films". This problem is naturally exacerbated when competing background noise further masks the access to consonant sounds. Similarly sounding words may be confused e.g. "CATS" for "CATCH", "SUM" for "THUMB" and "CHEESE" for "PEAS", leading to misunderstandings and confusion in conversation.

Aged care providers and carers will observe behaviours that may indicate hearing difficulties including:

- Leaning forward, cupping of their ear as if straining to hear
- Responding to conversation inconsistently, with evidence of misunderstandings
- Requests for frequent repetitions
- The person speaking in a loud voice
- Complaining of "people mumbling"

- Startling to loud sounds
- Having the radio or television too loud.

Aged care providers who are aware of the likely underlying cause of these behaviours are encouraged to refer the person for a full hearing assessment.

Thorough audiological assessment measures the extent of any hearing loss and guides appropriate intervention strategies to ensure maximal use of the person's residual hearing function. Audiologists are able to prescribe appropriate technology including amplification through hearing aids, which I will expand on below. It is also critical to detect operable (e.g. Otosclerosis, Middle-ear effusion) or life-threatening conditions (e.g. Acoustic Neuroma, Cholesteatoma).

It is also important to provide follow-up to monitor the individual's hearing status as incremental changes can cause increasing difficulties, and aids and strategies that have worked effectively in the past may need to be updated to adjust to the new circumstances. In addition, new developments in technology may offer greater benefits to aid users.

Often an existing hearing loss can be exacerbated by the presence of wax occlusions in the ear canal. People who wear hearing aids are more prone to this problem. Wax occlusion not only increases the hearing difficulties experienced, but may also increase the likelihood of feedback (whistling) from the hearing aid. In my experience, examination for the presence of wax is infrequent in many aged-care facilities but it is a problem that is easily remedied and can substantially improve the communication ability of the older person.

Intervention

Amplification

The use of hearing aids is usually the most effective way of reducing the communication difficulties experienced by older people with hearing loss. Unfortunately, many people's concepts of hearing aids are negative. Their parents, friends or family members may have related experiences of poor outcomes from hearing aids fitted in the past. Some typical comments might include:

"They don't work", "They make all sounds too loud", "They whistle all the time", "They are uncomfortable to wear", "They don't work in background noise or when there is more than one person speaking".

Fortunately, there have been great advances in hearing aid technology and their performance has greatly improved in recent years. Feedback (whistling) is now easily controlled. Noise reduction digital amplification systems are routinely available. Most aids have directional microphones to enhance speech clarity in group conversations and noisy environments. Many hearing aids have multiple programs from which the wearer can select to maximise speech clarity and sound comfort in a wide range of listening situations. More sophisticated systems change between these programs automatically and the wearer is unaware of the complex signal processing and modification of amplification characteristics that are constantly in operation. So, no recently fitted hearing aid should amplify loud sounds above the level of the individual's loudness discomfort level. Thus, there are now many technical solutions to previously commonplace problems.

Additionally, there is a range of Assistive Listening Devices (ALDs) to address specific listening situations. These devices include: amplified telephones, cordless television headphones and FM microphones. Actively assisting people to use these aids effectively and with confidence is an important component of adapting to living with a hearing loss

Still, successful aid use requires the older person getting used to amplified sounds and learning to physically manage the hearing aids. Frequently the person has become accustomed to living in a pleasantly quiet world and so adapting to the different soundscapes provided by newly fitted hearing aids often requires considerable perseverance and flexibility. Unrealistic expectations of fully-restored hearing function may need to be moderated to avoid frustration for the new hearing aid wearer. An individual's motivation is a most important determinant of the benefit of wearing hearing aids.

It is very important that aged care providers have confidence in supporting their older clients with the everyday functioning of their hearing aids. Knowing when and how to assist with the changing of batteries, how to clean and maintain a hearing aid and how to prevent feedback from occurring are all easy skills to acquire and

put into practice. For example, the use of wax loops and isopropyl alcohol swabs makes cleaning of hearing aids a quick and effective procedure. It is important that carers overcome their initial reluctance or anxiety about handling hearing aids. In the unlikely event that a hearing aid is damaged, it is reassuring to know that repairing an aid is generally straightforward and inexpensive.

Communication skills training

Family, friends and carers need to be aware of communication strategies to support the person with a hearing loss to minimise communication breakdown and consequent social withdrawal.

Aged care workers who wish to expand their skills in this area can access a range of training programs either formally at TAFE level or through self-paced learning, for example, the 'SHHH' training package *Hearing Loss: The Invisible Handicap* (Rosen, 2006).

Strategies to enhance communication include:

- Avoid or reduce background noise
- Don't attempt to talk to the person from a different room
- Don't attempt to talk whilst engaged in activities that generate noise, such as running a tap, using a blender
- Ensure good lighting to maximise lip-reading opportunities
- Move closer to the person
- Attract the person's attention before speaking
- Use touch to focus the person's attention and provide reassurance
- Speak clearly and at louder volume (but not shouting)
- Use shorter sentences with pauses between them
- Patiently rephrase or repeat messages that have not been understood
- Confirm important information
- Cue the person into the topic of conversation and when topics change.

Specific programs for training core communication skills (Sloan, Mackey & Chamberlain, 2006) can be implemented to maintain or re-build skills and to integrate practice into community settings. Ideally, family members and others within the individual's social network will support their role participation and encourage the person to re-engage in community roles they may have withdrawn from.

The Built Environment

Features of the environment will have a significant impact on the ability of the person with hearing loss to communicate and function independently.

In the home, it is particularly important to reduce competing background noise such as:

- Create smaller more intimate spaces for conversation with seating arranged to facilitate face to face contact
- Turn off the air-conditioning, TV and radio prior to conversation
- Carpets and soft furnishings assist by absorbing sound and reducing reverberation, hence provide a friendlier listening environment
- Double glazing can assist in reducing outside noise e.g. traffic.

A range of technologies can be utilised within the home environment to maximise hearing and support communication including:

- Teletext captions for television provide subtitles for when the dialogue cannot be understood
- Fax or email facilities reduce the reliance on verbal communication, particularly for important details such as appointments
- Doorbells that sound within the audible range for the person
- Smoke alarms that provide a visual as well as auditory signal
- Cordless headphones for use when watching television to provide clarity of signal at the required sound levels, whilst the overall volume of the television is maintained at a normal level for others
- Amplified telephones increase the volume of the callers voice
- Effective levels of lighting to illuminate the faces of conversation partners as an aid to lip-reading.

Facilities such as day centres, social venues and aged care residences, must be designed to allow older people to maximise their participation in social activities. In addition to the design features mentioned above, the installation of simple acoustic features and installing group audio equipment (e.g. FM Sound System) enables most older people to participate in group conversation.

Case Example

The following case example illustrates the application of some aspects of the practical approach described throughout this paper.

Six months after the loss of his wife Howard, a 78 year old man, refuses to attend a family birthday gathering. His oldest daughter feels her father is just not interested in her or her family, as he doesn't appear to listen to her news and avoids visiting. His other daughter attributes his behaviour to depression, particularly as he has also withdrawn from a range of leisure interests and has stopped playing bowls. She wants to take him to the doctor to investigate medication. She calls the nurse from the Royal District Nursing Service who had developed a rapport with him whilst she had been providing nursing care to his wife during her illness.

The conversation with the nurse reveals that throughout the marriage Howard had relied on his wife for social communication. She was the central person who communicated with his daughters and over the past few years she had also interpreted and clarified for him when he had difficulty keeping up with conversation at bowls. The nurse felt that Howard's wife's death had unmasked an existing hearing loss, a belief consistent with his reported feelings of stress and discomfort when attending events where he knows he can't hear properly. He tells the nurse that he feels left out socially and he is afraid that the family will think he is "losing his marbles". Following the visit the nurse contacted the GP and gave the family information regarding local audiology services. The oldest daughter was somewhat sceptical of this hypothesis saying, "He can hear when he wants to hear" but agreed to take her dad to the audiology appointment.

Assessment and Intervention

Function / impairment:

At the audiology appointment a moderately severe sensorineural hearing loss, was diagnosed. Further, the apparent inconsistency in his ability to hear was explained, pointing to the impact of the environment. In the oldest daughter's household three young children create a good deal of background noise, and this magnifies the impact of his impairment. It is his hearing loss, not a lack of interest, which causes him to apparently 'tune out'.

The audiologist prescribed two digital hearing aids with directional microphones and adaptive noise reduction capability. The family were provided with information that assisted them to support and encourage Howard through the initial difficult period of adapting to the aid. Three months later he was using them confidently and with considerable success. The GP, concerned not only about the hearing loss but also Howard's psychological well-being, referred him to the local council to assess his support needs.

Activity / activity limitation:

In terms of activity limitation, the effects of the hearing loss were particularly apparent in conversation. However with commencement of hearing aid use and an awareness of the deleterious effects of background noise the family were able to more effectively compensate for this loss. Their understanding of the cause of his behaviour also triggered a more sympathetic attitude and they showed a greater level of patience when communicating with him. The aged care provider appointed by the council visited on a weekly basis and ensured he was managing the hearing aids well. On one visit she noted he was not wearing the aids. She checked the batteries and then found the ear moulds were blocked with wax. She cleaned the aids and arranged for his GP to syringe his ears.

Participation / participation restriction:

Howard initially presented with participation restrictions in his roles as father, grandfather and bowls club member. However, the improvement in his hearing and communication skills led to a greater confidence socially that enabled him to regain these roles.

The increased enjoyment and sense of competency he experienced led to him volunteering to go on the committee of the bowls club, so increasing his life role participation.

Summary

I would like to finish by stressing the key points of this paper. Hearing loss and associated communication difficulties are highly prevalent in the older population and they can have a substantial impact on the person's ability to participate in a wide range of societal roles. If left untreated these effects are likely to compound, with significant psychosocial consequences for the individual, their family and the community in general.

Communication cuts across all areas of health care and necessitates a holistic approach. I have outlined some of the practical strategies that can be incorporated into the daily practice of aged care providers. Supporting the communication of older people is a responsibility we all share and I hope you feel encouraged to implement the ideas outlined.

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About the Deafness Forum

Introduction

Deafness Forum is the peak body for deafness in Australia. Established in early 1993 at the instigation of the Federal government, the Deafness Forum now represents all interests and viewpoints of the Deaf and hearing impaired communities of Australia (including those people who have a chronic disorder of the ear and those who are DeafBlind).

Structure

Deafness Forum is divided into four classes.

Consumer means an adult who is Deaf or has a hearing impairment or has a chronic ear disorder; or a parent of such a person.

Chronic Ear Disorder refers to such disorders of the ear as tinnitus, Meniere's Disease, Acoustic Neuroma, hyperacusis and recruitment. People with some such ear disorders may also have a hearing impairment.

Deaf refers to people who see themselves as members of the Auslan using Deaf community by virtue of its language (Auslan) and culture.

Hearing Impairment refers to a hearing loss. People with a hearing impairment (or who are hard of hearing) may communicate orally (sometimes described as 'oral deaf') or may use a sign language or other communication methods.

All Consumers are entitled to describe themselves using whatever terminologies they prefer, and are asked to do so at the time of joining and each time they renew membership.

Consumer Association means an incorporated Association of, or for, consumers (as defined above).

Objectives

The Deafness Forum exists to improve the quality of life for Australians who are Deaf, have a hearing impairment or have a chronic disorder of the ear by:

- advocating for government policy change and development
- making input into policy and legislation
- generating public awareness
- providing a forum for information sharing and
- creating better understanding between all areas of deafness.

Community Involvement

The Deafness Forum is consumer driven and represents the interests and concerns of the entire deafness sector, including:

- the Deaf community
- people who have a hearing impairment
- people who have a chronic ear disorder
- the DeafBlind community
- parents who have Deaf or hearing impaired children in their families

Libby's Story

Libby's 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 the English winter soon after her marriage in 1969. Having returned to Australia in 1970 she began to find difficulty in understanding conversation and instructions, particularly on 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. The American founder, Rocky-Stone, was invited to Australia in 1982 and did a lecture tour entitled "The Hurt That Does Not Show" which cemented the bonds between the US and Australian groups and helped the local SHHH develop.

Libby, with others, then began SHHH News, a quarterly publication, and with Bill Taylor set up the first Hearing Information and Resource Centre at "Hillview", Turramurra with support from Hornsby/Kuringai Hospital. This centre provided reliable information on, and demonstrated, assistive listening devices for hearing impaired people. Through this interest, 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 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 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 of 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 hearing impaired at the highest level – the archetype of a successful achiever despite her profound hearing loss.

For her work on behalf of hearing impaired 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.

Unfortunately, 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 since I became hearing impaired 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 disabilities 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".

The Libby Harricks Memorial Oration

The Libby Harricks Memorial Oration program is supported by the Libby Harricks Memorial Fund of the Deafness Forum of Australia. Donations to this fund are tax deductible.
Please see enclosed donation form for full details.

Donations should be made payable to Deafness Forum. Additional donation forms and general information regarding deafness can be obtained from:

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