

AUDIENS

**THE NEWSLETTER OF
THE BRITISH ASSOCIATION OF COMMUNITY DOCTORS IN
AUDIOLOGY**

OCTOBER 2000

NO 26 Dakota tribal wisdom says that when you discover you are riding a dead horse, the best strategy is to dismount. However, in the NHS we often try other strategies with dead horses, including but not limited to the following:

2. Changing riders.

From Awareness to Action - Protecting Deaf Children from Abuse

Anne McDowell

*Director of Family Services and Acting Deputy Chief Executive
NDCS*

The National Deaf Children's Society (NDCS) held a two-day conference in January 2000 on this subject. There were approximately 90 delegates, mainly from Social Services, the Police and Education. A key speaker, noting there were only two representatives from the NITS, asked "where is health?" It is hoped that the poor representation by NHS professionals does not indicate complacency or lack of interest in the subject. This conference empowered delegates to consider the knowledge, skills and attitudes which will assist them in working together to protect deaf children, children with other communication problems, or indeed all children. The conference was timely in view of the recent Department of Health documents on Working Together to Safeguard Children and Assessment of Children in Need. The triangle framework used in the latter document is worth study and indeed could be applied to any child with significant permanent childhood hearing impairment as it encourages us to consider the child in the context of the family and environment. The conference has been summarised by Anne McDowell, Director of Family Services & Acting Deputy Chief Executive NDCS.

Danny Lang

*Associate Specialist Child Health
Royal Cornwall hospitals Trust*

Summary

Deaf children are more likely to be abused - it's a fact. Reliable studies from the USA indicate that 'deaf and disabled children are two to three times more likely to suffer physical, sexual or emotional abuse, or to experience neglect.' The National Deaf Children's Society is the leading national UK organisation working on behalf of deaf children and their families. NDCS recently hosted a conference at Keele University, bringing together professionals from the fields of social work, education, the police, and health. "From Awareness to Action" was different from other conferences. Its aim was to ensure that each delegate left with an action plan to implement within his or her own organisation. Talking is not enough - professionals need to adapt and improve their practice. NDCS will follow up each delegate in six months time, to see how successful they have been in meeting their objectives.

So why are deaf children more vulnerable to all use?

Firstly, many deaf children do not develop fluent language skills — either spoken or signed — at the same rate as hearing children. Abusers see deaf children as an easy target because they may not have the language to disclose. Lack

of access to language means that they may not be aware that what is happening to them is wrong, or something that doesn't happen to everyone else. Deaf children may feel isolated, and may experience low self-esteem, especially if they do not have a strong peer group around them. They may feel that any attention is better than no attention, and so again are easy prey for calculating abusers. They may have learnt to be compliant and that keeping quiet pretending to understand and indicating that nothing is wrong is the only way to survive.

Society tends to have negative views of deafness. One of the effects is that deaf children are seen as unreliable witnesses. Another is that there is a number of myths about who gets abused (including the myth that only children seen as "sexually attractive" are abused), and who abuses. "The stranger in the mac" presents less of a real threat than the family member, care worker, teacher, taxi escort or playscheme volunteer. Most abuse is perpetrated by someone known to the child.

If there was one lesson to be learnt from the conference, it was that professionals need to work together. Deaf children will be more protected, and will get the support they need more effectively, when professionals start to work creatively across boundaries. This means social workers trained in child protection work building up vibrant, positive working relationships with social workers for deaf people, or (those) working in sensory impairment teams. Health professionals, such as paediatricians and audiologists, have a hugely important role to play, and need to be working more closely with social workers and teachers. Schools need to be more open and pro-active, and teachers need to *work* in real partnership with social workers and the police.

The police also play a crucial role. They need easy and ready access to support from care professionals and interpreters. The jealous guarding of professional territories aids abusers and makes deaf children more vulnerable.

The conference showed that there are many workers and managers who want to enhance the protection of deaf children. Over 90 people attended, and demonstrated that working together can be a reality, and not just a theory. Bringing people together from the range of disciplines helped

to build better understanding, mutual respect and trust. A number of myths were surely laid to rest during the course of the conference.

If we are to protect deaf children all of us need more fluent sign language skills, access to liaise who communicate best

with deaf children and the resources to do the work effectively. Communication is the key to ensuring that deaf children are kept safe and conversely, ineffective communication renders the child significantly more vulnerable. Val Leach, a social worker From the Deaf Child and Family Services at Springfield Hospital in south west London, showed graphically how even fluent sign language users may still misunderstand an abused child trying to disclose. She gave the example of the child who repeatedly signed what is usually thought of as the sign for apple". In this child's vocabulary, however, the "apple" sign meant "penis". Mary McCann. Communication Tutor al Royal School for the Deaf, Margate, explored the need role of deaf adults as advocates and aides to communication.

Children raised in the oral way who do not use sign language, are just as vulnerable. They may be able to read a greater range of English words, but will not necessarily understand the meaning. They *too will* miss out on much of the background information that hearing children and adults pick up informally, through radio, overhearing conversations, casual chat and so on.

Maddie Blackburn, a practising solicitor with Le Brasseur 'Tickle, showed how complex the legal system is to negotiate. There are startlingly few appropriately trained and practising lawyers, able to advocate on behalf of deaf children. In fact, very few cases involving *deaf* children and abuse ever reach the courts. Memorandum interviews are often delayed because of lack of interpreters, and vital evidence may be lost for the same reasons. Nevertheless, changes in legislation, including a greater acceptance of video interviews, special provisions for vulnerable witnesses, a greater focus on human rights and a revamped "Working Together" could all work in deaf children's interests.

Marcus Page, Co-Director of Triangle Services to Children Consultancy, talked about the importance of good witness support practice.' Good support, and ongoing explanation of the processes are vital for children and families. Continuity of personnel, and the accurate recording of information help

to build a sense of trust in the system. It follows that clear allocation of roles, support for non-abusing parents and other family members, and help in managing feelings are vital, both during the process and trial afterwards. A guilty verdict does not wipe away all the pain and anger. Even if a perpetrator is imprisoned, weekend leave, parole, and then release will be difficult events that the abused child and non abusing family may have to face.

Other sessions addressed the social, psychological and developmental effects of abuse, good practice in policing, making schools safe places, and listening to children. Dr. Peter Hindley, of National Deaf Services, Chris Lewis from RSD Margate. Anne Duffy, Head of Hamilton Lodge School, and Nick Cooper-Bland of the Metropolitan Police all contributed to a full and thought-provoking conference.

The NDCS will be producing papers from the conference, and will review the results of the follow-up of delegates in autumn 2000. Working closely with other national voluntary organisations, the NDCS will also be considering long term strategies for better protection of deaf children.

Anne McDowall

March 2000

References

- 1 *Working together to safeguard children. A guide to inter-agency working to safeguard and promote the welfare of children 1999. Dept. of health, Home Office. Dept. for Education and Employment. London. The Stationery Office*
- 2 *Framework for the Assessment of Children in Need and their families . 2000. Dept. of Health. London, The Stationery Office*
- 3 *Sullivan et al. in Hindley, P & Kitson, N. eds. Mental Health and Deafness 2000. pp149 - 184 London, Whurr*

hearing assessmmi

'I 'o ensure you are able to attend, would you please ring the Clinic 012(14698462_ when you will be given a choice of appointment day and time to see me.

Normal hearing is

An Attempt to Reduce Non-Attendance Rate in Paediatric Audiology Clinics

Dr. C.M. Varghese, FRCPCH, MSc, DCH, DMS,

Consultant Paediatrician (Audiology)

Abstract

Several studies have shown that non-attendance in clinics is a widespread problem resulting in wastage of NHS resources. Non-attendance can be *dna* (did not attend) or *cna* (cannot attend). In Bolton *dna* rate in paediatric audiology clinics was found to be 21% in Nov. 1996. The reasons for non-attendance are varied — illness, forgetting and lack of communication being important ones.

After a successful pilot study, we have initiated a scheme since September 1997 wherein patients participate in the process of appointment. In response to a letter from the clinic, the patient (the parent in our case) rings for an appointment, when they are offered a choice of dates and time. This initiative has successfully brought down the *dna* rate. A comparison of *dna* rate for a three month period before and after the initiative shows a reduction of *dna* from 16.6% to 5.2%.

Introduction

High non-attendance in clinics is common and several studies have been published showing the rate and causes of non-attendance. Table 1 shows a list of some selected studies showing the year of the study, the author, the place of study and the non-attendance rate. High non-attendance rate in clinics results in considerable waste of NHS resources. It can be argued that if there is 2% non-attendance rate in a clinic, 21% of the salary of the clinic staff is wasted. In addition, those who fail to attend will be added to the waiting list thus clogging the system.

Non-attendance can be classified into *dna* (did not attend) and *cna* (cannot attend). In the former group no contact is made with the clinic to intimate the intention of not attending. In the latter group belated

contact is made with the clinic to intimate the inability to attend the clinic but the clinic has not enough time to rearrange another patient in the vacant slot. An audit of non-attendance rate in paediatric audiology clinics was conducted in November 1996 in the North West involving fourteen districts by the North West Regional Audiology Clinical Audit group. This group is an association of heads of paediatric audiology services in the North West. It was found that the total non-attendance rate in paediatric audiology clinics in the North West varied from 22.1% to 45.2%. The *dna* rate varied from 7.5 to 29.2% and *cna* rate varied from 5.8% to 16.9%. Bolton came 7th in the league table with a total non-attendance rate of 30.8%, *dna* rate of 21.3% and *cna* rate of 9.6%. Several studies have attempted to investigate the causes of non-attendance by questionnaire studies. Potamitis T et al. (1994) from the Midlands conducted a postal questionnaire survey. The main reasons for non-attendance were clerical error - 27.3% and failure to remember - 17.9%

Bottomley W.W. et al. (1994) from Leeds noted that 17% of non-attendance was due to inadequate communication and 23% non-attendance was due to patients forgetting the appointment. Verbov J. (1992) from Liverpool found that 28% did not attend because of illness and 33% had problems related to appointment. Lloyd M. et al. (1993) studied non-attendance in out patient ENT and Gastroenterology clinics and found that patients are unlikely to attend unless they are able to discuss their problem with their G.P. Non-attendance was not related to severity, duration or nature of patient complaints. Hampal et al. (1992) from Middlesborough found that patients who fail to turn up for ENT operations were age group 16 or below,

Table I. Non-attendance rates

<i>year</i>	<i>author</i>	<i>place of study</i>	<i>clinic</i>	<i>non-attendance rate</i>
1995	Riordan et al	Liverpool	Audiology	27%
1995	King et al	Liverpool	Ophthalmology	12-60%
1995	Polamitis of al	Midlands	Ophthalmology	9-90%
1994	Bottomly et al	Leeds	Dermatology	19%
1993	Lloyed et al	London	ENT	26%
1993	Hayed of al	London	Gastroenterology	20%

male and had longer waiting time. 'Thorogood et al. (1993) studied the factors affecting non-attendance for health check in general practice. Non-attendance was higher among men, the unmarried, people in manual occupations, people living in rented accommodation, people without access to car, smokers and heavy drinkers.

In Bolton we conducted a postal survey of 100 patients to find out the causes of non-attendance. Only 39% returned the questionnaire. The reasons given for non-attendance were as follows:

1	Unable to travel	10%.
2	Did not feel the appointment necessary	10%.
3	Away from home	7%.
4	Illness	18%
5	Other reasons	23%
6	Not received appointment	7%.

We made several different pilot initiatives to reduce the non-attendance:

1. Arranging transport. We arranged transport for those in need on a trial basis for a few months. However this made no reduction in the total non-attendance.
2. Raffle scheme. We decided to play a lucky dip of £25 every month for those children who attended the clinic. But this made no difference in the total non-attendance rate.
3. We decided to offer patients a choice in the date and time of appointment. A letter was sent to patients

inviting them to ring the clinic and make an appointment for suitable date and time. In the pilot scheme only review cases were involved. This seemed to work and there was a drop of non-attendance by 6.4%. i.e. from 19.4% to 13.1%. Subsequently the management decided to extend this scheme to all patients attending audiology clinics-new referrals as well as reviews.

The purpose of this article is to describe the system we have adopted to reduce the non-attendance rate since September 1997 and to audit the outcome for a three month period before and after the introduction of the scheme.

Materials and Methods.

New referrals

All new referrals are logged and reference numbers are assigned. A letter (figure 1) is sent to the parents inviting them to ring for an appointment. Parents are offered an appointment suitable to them. There are a few who will not ring for an appointment. Two further reminders are sent to them and if there is no response then the patient is referred back to the referral source.

Reviews

In a paediatric audiology clinic all children with permanent hearing loss are regularly reviewed. In addition, children with glue ear and post-meningitic children are reviewed for a selected period. All review cases are sent the same letter (figure 1) inviting parents to contact for a review appointment.

Figure 1

96341

CMV/KH/APPI

Children's Hearing Assessment Centre
HORWICH CLINIC JONES STREET
Horwich Bolton BL6 7 AJ

Dear Parent

APPOINTMENT FOR HEARING ASSESSMENT

re

Your child has been referred to me for hearing assessment.

To ensure you are able to attend, would you please ring the Clinic 01204698462 when you will be given a choice of appointment day and time to see me.

Normal hearing is important to the educational development of your child.

Yours sincerely

Dr. C M Varghese
Consultant Community Paediatrician

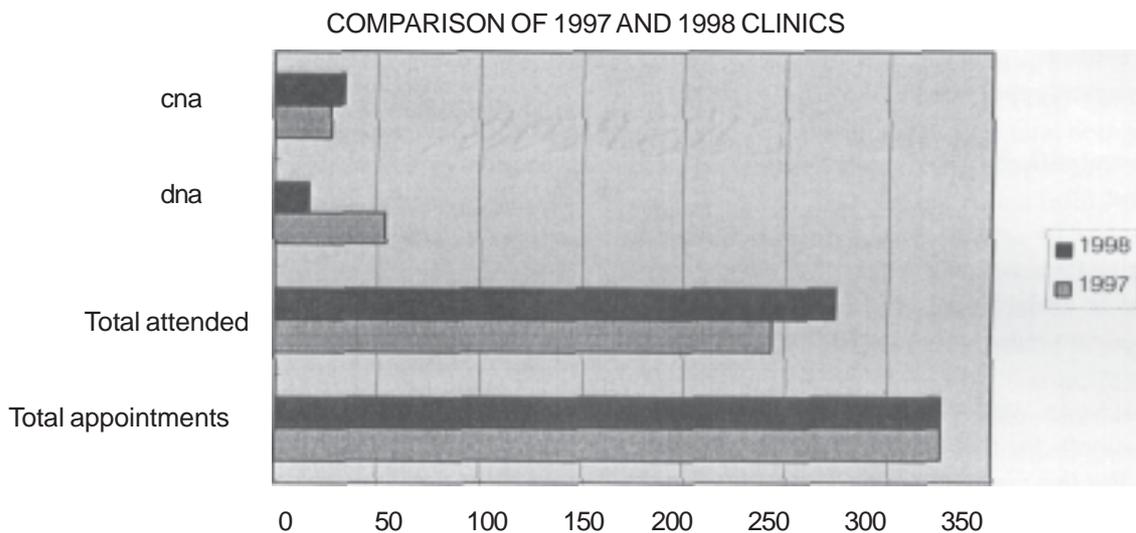
Table 2

Total appointments	Total attended	dna	cna
325	243	54	28
%	74.80%	16.60%	8.6%

Table 3

Total appointments	Total attended	dna	cna
325	274	17	34
%	84.30%	5.30%	10.40%

Figure 2



Audit.

Three months clinics from January 1997 to April 1997 were analysed using spreadsheet to show the total number appointed, total attended, total non-attendance, total dna and total cna. These three months represent the period prior to our innovative scheme. Another three months clinic from January 1998 to April 1998 were analysed using spreadsheet to show the total number appointed, total attended, total non-attendance, total dna and total cna. These second three months represent the post innovative period. Our objective was to reduce dna to 5%. It was expected that there will not be appreciable reduction in cna rate.

The results.

Table 2 shows the appointments and attendance pattern during the three-month period prior to our innovative scheme. Table 3 shows the same parameters for the three-month period after we introduced the innovative scheme.

Figure 2 shows a bar chart comparing the two sets of figures. The chi squared two-sample test was used to test the significance. "There is statistically significant reduction in dna rate. $X^2=21$, level significance (5%) 3.84, degree of freedom 1. There is no statistically significant difference between cna rate.

Discussion

Non-attendance in clinics is a ubiquitous and serious problem. By reducing dna, not only the time of the clinical staff is saved but also it prevents the clogging of the system by non-attenders.

Our dna rate improved from 16.6 % to 5.2% by our intervention programme i.e. letting the patients choose the time and date of their appointment. (This falls in line with Trust motto of giving patients choice.) Reducing dna can reduce the waiting list. Turner et al. from Stafford Hospital studied the causes of long waiting list in urology clinics and concluded that if non-attendance is reduced the waiting time can be reduced from 15 months to 9 months. We managed to see additional 31 patients in a three-month period by reducing the DNA rate. The draw back of the above system is increased workload of administrative staff.

Conclusion.

It is possible to reduce dna rate to around 5 % by giving patient the onus and the privilege of selecting the time and day of appointment from the available slots. It will reduce the waiting list. But a total non-attendance rate of around 10% (including cna and dna) is unavoidable in paediatric audiology clinics.

Acknowledgement

Many thanks to Kay Holdsworth and Susan Wilson for their hard work to make the change and to Valerie Walmsley for organising the patient survey.

Reference.

- Bottomley W W, Cotteril JA 1994. An audit of the factors involved in new patient non-attendance in Dermatology outpatient department 1994 Clin.-Exp-Dermatol 1994 Sept; 19(5): 399-400
- Hampal S, Flood LM 1992. Why Patients Fail to attend ENT Operations: A one year prospective Audit. Clin-Otolaryngol. 1992 June; 17(3):218-22.
- King A, David D, Jones-HS, O'Brien C 1995..J-R-SOC-MED. 1995 Feb 88; 88-90.
- Lloyd M, Bradford C Ebb S 1993. Non-attendance at out patient clinics: is it related to referral process? 1993. Fam-Pract 1993 .June; 10(2): 111-7.
- Riordan A, Thomson A, Hodgson .1 1995. Hearing assessment after meningitis and meningococcal disease. Arch-Div-Child 1995. May 72;441-42.
- Potamitis T, Orell PB, Jones HS, Murray PI 1994. Non-attendance at ophthalmology outpatient clinics. .J-R-SOC -med. 1994 Oct; 87(10):591-3.
- “Thorogood M, Coulter A, Jones L, Yudkin P, Muir J, Mant D 1993. Factors affecting response to an invitation to attend for health check. J-Epidemiol-Community health 1993. 47(3): 224-8.
- Turner AG, Cook H 1991. Are patients attitudes the cause of waiting lists? Br -J-Clin-Pract. 1991. 45(2):97-8.
- Verbov J. Why 100 patients failed to keep an appointment - an audit in Dermatology department. J-R-Soc-Med. 1992 May; 85(5): 277-8.

A CASE OF NON ORGANIC HEARING LOSS AIDED FOR EIGHT YEARS.
Annabel Dodds, Consultant Community Paediatrician in Audiology

East Lancashire Paediatric Audiology Service

Non-organic Hearing Loss (NOHL)

Non organic hearing loss is synonymous with pseudohypoacusis, psychogenic hearing loss and functional hearing loss. As early as 1966 it was noted that not all hearing losses were of organic origin. Goldstein (1966) wrote 'all non organic hearing losses in adults and school aged children are feigned and should be labelled pseudohypoacusis'. Brooks and Geoghegan (1992) reported that an apparent hearing loss was a cry for help and in a follow up 6 to 27 years after the diagnosis of non-organic hearing loss they found 5 out of the 26 had at some time received psychiatric help and 5 had communication disorders. Aplin and Rowson (1990) reported that 11 children (37%) had been fitted with hearing aids of whom only 3 required an aid on the basis of an organic loss. The diagnosis of non-organic losses can produce frequent confusion and frustration between patients, parents and children with professionals unable to confirm any hearing problem yet unable to offer any assistance (Musick and Geurkink 1980).

Case Study

In this case study I present a child of fifteen years of age who presented me with one of the most difficult management dilemmas in twenty years of paediatric audiology.

RJ was referred by the Advisory Teacher for Hearing Impaired Children. The letter of referral was as follows: "She wears a hearing aid in class when teacher is giving out information and then removes it as she moves around the school. I would hope an ITE hearing would be more cosmetically pleasing to her".

Past History:

RJ had been under the care of the ENT department hospital audiology department and community audiology department for over eight years. She failed the sweep test of hearing in school aged six years and, following assessment at the local clinic, was referred to ENT. At that point it is noted that she was a slow reader but speech was clear. There was a history of meningitis at 5 months of age. An audiogram in the hospital audiology department gave thresholds of 50-60 dBHL but the audiologist had queried the reliability of the responses. The ENT doctor arranged for a hearing aid fitting in one ear and RJ was fitted with a BE 10 series hearing aid to one ear. Following that she was under regular audiology review in ENT and community clinics producing similar audiograms at each visit although at some visits there had been queries about the reliability of her responses.

Clinic Consultation:

She presented in my Specialist school age clinic as a child who could easily hold a conversation. She told me she was taking GCSE's and good grades were expected (C and above). She was taking music GCSE and played the flute at Grade 3 level. She reported that she wore the hearing aid intermittently but found it helpful in certain situations and certain classes. She did appear to be quite quiet and dominated by her parents but there was no difficulty in holding a conversation without the hearing aid in clinic. An initial assessment in that clinic produced a pure tone audiogram, which gave a bilateral symmetrical sensorineural loss of 60-70 dBHL in the frequency range 500Hz to 4,000Hz. Speech tests did not correlate with this. At 45 dBA she was able to repeat 90% of the phonemes correctly in the free field without watching. Type A tympanograms were obtained in both ears using screening tympanometry and bilateral otoacoustic emissions were present using Echocheck.

Audiology Results:

She was referred to the Senior Audiologist for diagnostic audiology and results are as follows:

- PTA: Bilaterally 61) - 70 dBHL.
- Tympanometry: Type A bilaterally
- Stapedial Reflexes: Ipsilaterally present at normal levels
- Closed Speech Audiometry HPLE- 25 dBHL.
- Auditory Brainstem Response: 20 dBnHL bilaterally
- Cortical Evoked Response Audiometry, Bilateral results: 4000Hz-20dBnHL 2000Hz-20dBnHL, 500Hz - 20 dBnHLL.

The results of this diagnostic audiology assessment produced a dilemma for me. Her parents are very serious, intelligent people who in the initial stages had been very hostile towards me. After a long consultation they went through a stage of disbelief, questioning and eventually accepted the findings. They did however ask for a further consultation with an ENT Consultant for an explanation and on the day of the hospital visit the ENT Consultant asked for Pure Tone Audiometry and RJ produced the typical 60 to 70 dBHL levels as before.

The dilemma for me at this point was that RJ was due to sit her GCSE's and due to the hearing loss had been given concessions in certain subjects. Should these concessions be retained or removed was one dilemma. She was asking for a hearing aid and if concessions were being retained she should wear a hearing aid at

school. The decision was not to provide education with the final diagnostic results until after GCSE's. RJ was provided with a Starkey ITE hearing aid with a maximum amplification of 18 dB and asked to use as and when appropriate. GCSE concessions were retained. The plan is to arrange for central auditory processing assessment when available.

Why did this happen? The referral was initiated from the sweep test in school but it is important to note that RJ was not attaining as well at school as parents expected and that the presence of a hearing loss would explain this. The history of meningitis confused the situation because this was a risk factor for hearing loss. We do not know at this point what was said in that initial consultation between the ENT doctor and the parents and perhaps then hearing aid fitting was from parental pressure. At that time there was no Paediatric Audiology service for school age children. Children were seen in a Community Clinic and referred to ENT for follow up and management.

Could it happen again? We would like to think that this could not happen today as all children considered to need a hearing aid are referred to the Paediatric Audiology Service and undergo the following:

All hearing aid fittings under supervision of Consultant Community Paediatrician in Audiology.

All fittings by Paediatric Audiologist.

All fittings include free field warble tones, unaided and aided.

All fittings include free field speech tests unaided and aided.

Management of Non-organic hearing loss:

Future management of non-organic hearing loss may include the following:

1. Good history in all areas of life, looking at home based problems and school based problems. Frequently there is a history of bullying within school or possibly problems within the home. This may necessitate liaison with Community Paediatrician, school nurse or General Practitioner Counselling and reassurance for the child and parents. Pracy et al. (1996) suggest that once suspected the diagnosis should be confirmed and the children treated in a non-confrontational way with reassurance and regular follow-up.

2. Referral to clinical psychologist - Aplin and Rowson (1990) described a tendency for those demonstrating the greatest losses to be those with greatest psychological problems. Referral to educational psychologist - Aplin and Rowson (1990) showed in their study that 30% of the children were functioning 2 years or more below their chronological age in reading age.

3. Central Auditory Processing Disorder Assessment: I Hasbrouck (1999) states that patients who exhibit non-organic hearing disorder may have significant perceptual processing problems. The paucity of centres capable of assessing central auditory processing in children makes it difficult to provide the evidence for this. This is an area where more research is needed, as tests of central auditory processing become more available.

4. Suggestion Audiometry: when reviewing non organic hearing loss I came upon a report published in 1999 in the International Journal of Paediatric Otorhinolaryngology by Flosoi et al. In this paper 'Suggestion Audiometry' is described as a method of improving the pure tone thresholds. The equipment needed for suggestion audiometry is a standard audiometer and a typical behind the ear hearing aid. Before the test the examiner tells the patient that hearing will improve using a hearing aid. 'The hearing aid is described as an instrument that greatly improves hearing. Standard audiometry is performed 'pre-suggestion audiometry' then the hearing aid is applied behind the ear (no ear mould or tubing) and further audiometry carried out with hearing aid in place. This is called 'mid-suggestion audiometry'. The hearing aid is removed and audiometry is performed for a third time and is called 'post-suggestion audiometry'. The method can be repeated with suggestion speech audiometry using equipment as above but also a tape deck for speech. The results compare the pre-suggestion thresholds with corresponding mid and post levels. In 11 out of the 20 subjects the thresholds improved with the hearing aid but subsequently returned to same or worse levels with removal of the aid. The authors conclude that suggestion tonal audiometry should be regarded as a useful screening tool for detecting NOHL and that when a normal audiogram is suggestion audiometry no further screening is required as the loss can be assumed to be non-organic.

Personal Note:

Personally I use a range of management regimes for children with non-organic hearing loss and each depends on the individual child, family and type of problem. I am not recommending 'suggestion audiometry' but include it in this paper as a novel approach to the management of non-organic loss. It is my opinion that a number of these children will indeed have problems in central auditory processing and that central auditory processing assessments will in the future provide us with more information on how to help these children develop strategies for the problems that many of them experience. Where it is very difficult to demonstrate and in long standing cases as this child, I am of the opinion that Electrophysiological tests of hearing are most helpful and provide children and parents with more objective measurements. The use of the Echocheck is

extremely helpful in the battery of tests but should not be used in isolation.

References:

Aplin DY, Rowson VJ - Psychological characteristics of children with functional hearing loss. *Brit. J. Aud.* 1990. 24. 77-87

Brooks DN, Geoghegan PM - Non-organic hearing loss in young persons: Transient episode or indicator of deep-seated difficulty. *Brit. J. Aud* 1992 26.347-350

Hasbrouck JM - Auditory Perceptual problems in non-organic hearing Disorder. *Laryngoscope* 1989 99. 855-860

Hosoi H, Tsuta Y, Murata K, Levitt H - Suggestion audiometry for non-organic hearing loss (pseudohypoacusis) in children. *Int. J. Pediatr. Otorhinolaryngology*

Pracy JP, Walsh RM, Mephram GA, Rowdier DA - Childhood pseudohypoacusis. *Int. J. Pediatr. Otorhinolaryngology* 1996 37. 143-149

UK Council on Deafness: Who we are and what we do

What is the UK Council on Deafness?

The UK Council on Deafness (UKCoD) is a unique organisation, acting as an umbrella body providing valuable opportunities for large and small charities and professional associations working in the field of deafness to exchange ideas and learn from one another.

As readers know, deafness is complicated and no single action will overcome communication barriers for deaf people. Prior to the establishment of the Council on Deafness some 6 years ago, individual member organisations provided for their own constituents, leaving it to service providers to assess their assorted demands and come up with a coherent plan. UKCoD enables deaf organisations to pool their resources and deliver a united message to service providers, the Government and others.

Our Aim

"The UK Council on Deafness aims to improve and extend co-operation between member organisations in promoting and representing the diverse interests of deaf people, which includes D/deaf, deaf-blind, deafened and hard of hearing people, and those with additional disabilities."

Our Objectives

"The UK Council on Deafness provides a forum for debate and a focus for action. The Council promotes understanding and acceptance of the different perspectives on issues connected with deafness; Council members work together to achieve change on matters of shared concern."

What does UKCoD do?

Provides a forum for the discussion and exchange of information
Formulates and promotes policies in the field of deafness
Responds to consultative documents issued by various government departments, service providers and other charitable organisations
Promotes, fosters and develops initiatives for deaf, deafened, hard of hearing and deaf-blind children, adults and their families
Provides an opportunity for participating organisations to share resources and work constructively in areas of common concern
Aims to be a reference point for all organisations for deaf* people
Will be taking forward the Human Aids to Communication campaigning role
Administers and manages the Government's Opportunities for Volunteering Scheme on behalf of deaf organisations

Provides regular information to member organisations and deaf people via regular newsletters and information circulars

Develops Good Practice Guidelines for access and communication with Deaf people via our Deaf Action Project

Works in partnership with organisations to improve services, access and information provided to deaf people

Hosts conferences on issues of topical debate amongst deaf people and professionals e.g. Genetics, Telephone Helplines, Deafness and Ethnicity.

*deaf in this context refers to Deaf deafened, hard of hearing and deaf-blind people.

Membership of UKCOD

Our member organisations represent a broad range of Deaf experience and expertise from the hard of hearing through to Deafened and Deaf-blind people. Working within their separate fields they support many deaf communities, share professional expertise and campaign for improved access for deaf people. Our membership include the National Deaf Children's Society, the British Deaf Association, Sense, The Royal National Institute for the Deaf. Breakthrough (Deaf/ Hearing Integration), the Association of Lipspeakers and Hearing Dogs for the Deaf to name but a few. In total we have 37 member organisations with the aim of 50 members by the end of the year. The trustees are looking at various proposals at extending and enriching UKCoD's membership.

What are the Benefits of Membership?

Provision of networking opportunities to promote collaborative working and partnerships
Free attendance at 2 Open Council Meetings per year with topical debates
Priority access to additional conferences hosted by UKCOD on Deaf related issues
Free hi-monthly newsletter and free advertising space for members
Information on the development of project initiatives relating to the Deaf Community
Training in empowerment and management for deaf people via the Deaf Action Project
Training on the implications for deaf people on the implications of the Disability Discrimination Act
Affiliation to a national umbrella organisation, representing the views of the spectrum of deaf people with one voice
Reference point to encourage recognition of the range of services provided by and on the behalf of the deaf community

Projects Focus

UKCoD manages three projects at the moment with several more coming on-stream.

I. Deaf Action Project

'Improving Deaf People's access to the Public Sector'
The Deaf Action Project, managed by the UK Council on Deafness, has been established to facilitate integration between the following groups of people and bodies with the primary aim of improving the level of access for the widespread deaf community to the public sector:

- Grassroots members of the deaf community
- Organisations representing the interests and needs of the deaf community
- Public/statutory sector organisations who have a duty to provide equal services to all sectors of the community
- Organisations operating a public service where contact is frequently made with individual members of the deaf community.

If you or your organisation fit into one of the above categories then it is likely that the Deaf Action Project can help you improve equality of service provision for deaf people by the Public Sector in your region.

How will the Deaf Action Project achieve this?

The Deaf Action Project (DAP) is establishing regionalised forums across the United Kingdom where representatives from the deaf community and the public sector are invited to discuss minimum access requirements for deaf people to the public sector in their region.

2. Opportunities for Volunteering Scheme

The UK Council on Deafness allocated grants to voluntary organisations that work for or with deaf people, on behalf of the Department of Health. Any voluntary organisation wanting to set up a project for the benefit of deaf, deafened, deaf-blind or hard of hearing people can apply for a grant to help their work.

The purpose of the scheme is to encourage people, especially unemployed people, to become volunteers. The Council on Deafness considers applications for projects that will use volunteers to benefit deaf people — it is even better if the volunteers are also deaf.

Examples of projects

The projects must be connected with health or with social Services. These are the kinds of projects that are acceptable: Setting up a self help group for deaf people

Using volunteers to staff a community support service

Training volunteers to provide support for deaf-blind people

..... even renovating premises for a deaf club

What are the rules?

- The project must be connected with health or social services
- The application must be for a new project using volunteers
- Over half the volunteers that are expected to be used should be unemployed
- The project must be in England and must be at a local level
- Continuation funding must be found once the OFV funding (maximum 3 years) comes to an end.

3. Disability Discrimination Act Project

The Disability Discrimination Act (DDA) research project started in March 2000. The aims of the project are to:

- Collect information that is up to date following legislation changes from October 1999 and the setting up of the Disability Rights Commission
- Enable UKCoD to become a rich source of information concerning the DDA

Part of the research required was to look into the provision of DDA training courses/workshops. This was found to be difficult because there are few courses being advertised, although there are a great number of freelance disability equality trainers.

The project is also conducting a survey involving UK Council on Deafness member organisations, which focuses on the provision of DDA training within member organisations, whether for their staff or clients. A report will be distributed to the members at the end of the project showing UKCoD's findings.

3b. Training

UKCoD is now offering DDA training to organisations or the public sector which works for or with Deaf people. The training is unique in the sense that the focus is on the implications and effects of the DDA on deaf people — where the real disabling factor is communication and not physical access, which is the barrier for many disabilities.

Should you have any questions about UK Council on Deafness, the work it does or any of the projects running please contact UKCoD at:

UK Council on Deafness, 59 Banner Street,
Clerkenwell, London, EC1Y 8PX
Tel 020 7689 2080 Text 020 7689
2081 Fax 020 7689 2082

Dakota tribal wisdom says that when you discover you are riding a dead horse, the best strategy is to dismount. However, in the NHS we often try other strategies with dead horses, including but not limited to the following:

1. Buying a stronger whip.
2. Changing riders.
3. Saying things like:” This is the way we always have ridden this horse”.
4. Appointing a committee to study the horse.
5. Arranging to visit other sites to see how they ride dead horses.
6. Increasing the standards to ride dead horses.
7. Appointing a tiger team to revive the dead horse.
8. Creating a training session to increase our riding ability.
9. Pass legislation/resolutions declaring that” This horse is not dead “.
10. Blaming the horse’s parents.
11. Harnessing several dead horses together for increased speed.
12. Declaring that “No horse is too dead to beat”.
13. Providing additional funding to increase the horse’s performance.
14. Do a thorough study to see if contractors can ride it cheaper.
15. Declare the horse is “better, faster, and cheaper” dead and start clinical governance.
16. Form a quality circle to find users for dead horses.
17. Revisit the performance requirements for horses.
18. Burn the horse farm on which it was born.
19. Promote the dead horse to a supervisory position!
20. Change patient habits.

