Hearing Happenings In the Hill

The official newsletter of the
Broken Hill & District Hearing Resource Centre Inc.
Edition 5
December 2011

Merry Christmas & a Happy New Year

AGM November 2011

End of an Era........

2011 has been a year of change for the Hearing Resource Centre, with the appointment of a new Chairperson and CEO. The Centre's Founder and Voluntary Coordinator Cath Bonnes AM, retired at the Centre's recent AGM, after 26 years of service to the Centre and the Community of Broken Hill. This meeting not only saw the retirement of Cath but our long standing Chairperson, Joan Hirschausen. Joan leaves us after twenty years of service. To Cath and Joan, wishing you a long, healthy and enjoyable retirement.

Neville Gasmier, Chairperson, presenting Cath Bonnes AM with a "Life membership" Award

As Cath's successor, I would like to personally thank Cath, for her assistance, guidance and leadership which she has provided with for so many years. It has always been a pleasure to work with you, Congratulations you on your well deserved retirement. Mr. Neville Gasmier has been nominated and appointed by the Committee to replace Mrs. Joan Hirschausen as chairperson. On behalf of our staff and volunteers, I would like to welcome Neville as our newly elected Chairperson. ***Anne Woods***

From the Chair: Neville Gasmier

It is a great honor and pleasure to be elected President/Chairperson of this long serving and valued organization. I look forward to working with the new Committee to ensure that the organization maintains its services to the community and continues the growth that has been seen over recent times.

I take the opportunity to thank Ms Cath Bonnes for her dedication and hard work in realizing her dream for the establishment of such a service for this community and wish her well in her retirement. I would also thank Mrs. Joan Hirschausen for her commitment to the organization over the last twenty years and wish her the best as she takes a well earned rest before undertaking her next challenge.
This is a time of great change, however together we can ensure the work of others before us continues through this new team of committed people. This is a challenge I look forward to but it will be a team effort that maximizes the best outcomes for our clients.

Richard Osborn B.Sc. Dip.Aud. B.Ed. (HI) M.Ed.

Rick studied Science, Economics and Education at LaTrobe University, Audiology and Special Education at the University of Melbourne. He has been active in developing Collaborative programs between Ageing & Disability Agencies, both in Australia and neighboring countries .He is currently a Director of Osborn, Sloan & Associates, a practice providing neuropsychology, occupational therapy, audiology and health education services.

Hearing and Communication - A primary concern in aged care

The following information is small excerpt from Rick Osborn's presentation at the "Hearing in the Hill" Silver Jubilee Seminar, Oct 2010.

Part 2.

I am going to concentrate a little bit on the common conditions of vision loss amongst older people. Many of you will be familiar with these but I am going to first look at macular degeneration, which is where people lose their central vision. Again it is something that comes on over a period of time, generally speaking. The good thing about macular degeneration is that people rarely go completely blind but it does affect the clarity of vision. So people can quite easily move around the room, but reading and recognizing people's faces and lip-reading can be a very much greater challenge.

Unfortunately, it's the major cause of vision impairment amongst older Australians and it can have a very big impact, particularly if the person also has a hearing loss so their communication function is really affected by the lack of lip-reading and the lack of being able to hear consonants clearly. Glaucoma is exactly the opposite. In glaucoma people lose their peripheral vision but their central vision can remain quite good to the point where they can read, they can recognize colours and that sort of thing. That is generally treated with eye drops, but the damage that has been done in the loss of the peripheral vision unfortunately can't be restored.

Cataracts are very common and fortunately can be remediated. Cataract is this general blurring of vision. It's a bit like looking through a shower screen rather than through a windscreen. In Australia the operation is routinely done but around the world it's the leading cause of blindness. So there is fantastic intervention for that, but the person has to recognize that they have a cataract and they can have something done about it. Unfortunately, in a lot of aged care areas, they are not necessarily diagnosed so people may be living with cataracts and living with poorer vision than what they need to.

Diabetic retinopathy is associated with diabetes and is a patchiness of vision. This affects how people get about but also affects how they see the world around them, so things come in and out of view quite a bit. How that affects communication is that's what a face would look like. It's very hard to pick up those lip movements that we rely on for conversation, particularly in background noise. Older people that have a vision loss of marked degree, even if their hearing is perfectly normal, will not enjoy conversation in a social environment because there's just too much noise going on. Even if their hearing is terrific, they can't rely on lip-reading to help us understand.

The effects of vision loss on communication:
The obvious one is the facial cues and lip-reading that you miss out on. But also there are those very subtle aspects of communication, the eye contact, the nods, the smiles, and the wink if a person is saying something a bit sarcastic or ironic and even turn taking is largely indicated in conversation by small visual cues. It's the eye contact, the looking away and all sorts of subtle things like that. Vision impairment has a big impact on the enjoyment of conversation, particularly if there's also hearing difficulty.

Cognitive changes are also very common in the ageing process. There can be just normal age-related changes. Just think about how some older people take a little longer to learn to use an ATM or to use the Internet or in our particular field take a little longer to learn how the remote control for their hearing aid works or knowing just when to change the battery. There can be some very subtle aspects of technology things that may take a little bit longer to bed down - these are normal age related changes.

Then for many people an aspect of cognitive change can be the early onset of dementia or confusion about information. There can also be cognitive changes as a result of stroke and that can have a very big impact. And in the audiology field where it comes in is how easily a person can adapt to the use of amplification and how easily they can get on top of managing the hearing aids.

Often sensory impairments, vision and hearing loss can mimic some of the behaviors that are associated with dementia. We know from very simple studies that when mini mental tests are done in the aged care field, the results are much stronger when people are using usual simple amplification devices like the Tandy amplifier. The reason for that is if you are asking a person a question, they are much more likely to get it right if they have heard it right. Changes in people's behavior in older age are assumed to be because they are not coping as well, they are not thinking as well as they have in the past, but often it can be due to the fact that they have a significant sensory loss of either vision and/or hearing. So hearing and cognition interact in a person's everyday communication functioning.
We have got vision changes, cognitive changes and the other thing that impacts on how well a person adapts to hearing aid use is physical changes. What is the sensitivity in the fingertips for changing batteries, for feeling for the small volume control? If there is arthritis then hand movement is going to be affected. If there is a tremor, early onset of Parkinson's or hemiparesis as a result of stroke, it is going to make the management of the hearing aid much more difficult. These impacts on a person's ability to physically manage their hearing aids can all be overcome, but the requirement is time and training. It may be that the person themselves can't manage the particular aid or device and they do need support of a carer.

My experience has been that, if enough time is spent in finding out what the person can do, there is often the internal motivation that the person has to remain independent that often will overcome the difficulty. Even a person with a massive hand tremor, if you teach them to anchor their elbow to the table and move their ear to where the hearing aid is, often you will find they will learn a technique that works for them. But it's not going to happen overnight and it is not going to happen when the allocation of time for that person is two hours to test, to fit and to teach all about the hearing aid. So it's very much a gradual incremental education that the person requires. That's a little bit of the background theory.

One other impact of macular degeneration which I spoke of before is facial recognition. We take it for granted that when we look around the room we can identify individuals. With macular degeneration and the loss of that central vision, we all look the same. So people might be passing each other in the street, and up here in Broken Hill I know everyone says ‘good day’ and that is terrific. But when the person walks past and says ‘good day’, if you don't recognize they are your neighbor that can be embarrassing. The impact of vision loss is not just on common everyday things you can't read, it has bigger impact on social things such as recognizing family and neighbors.

Now I am going to spend a little bit of time looking at this participation level, the loss of social contact with friends and family and the fact that our sense of being, our sense of worth, is based on our social roles. As I mentioned before, that might be within the family or within the community as a volunteer. That's the sort of level at which we need to focus our intervention, how can we get a person to be able to maintain their involvement in the local RSL, bowls club or the CWA or whatever it might be?
Life role participation gives meaning and structure to our lives. If we are not involved in all of those things, if people tend to withdraw because of their vision and hearing loss, then they can have that sense of isolation and be more at risk of other health issues if they are not involved in the community.

As I mentioned before, the community is the one that suffers from not having them involved. It's very much a two-way street.
Practical issues, how do we go about getting people to be involved in those important life roles?

Basically it comes down to these issues: people need information and support. They need to know what it is they can do and where they can go to get it. Amplification is important, and we will discuss that in a little bit more detail in a moment, as well as other listening devices. A simple amplified listener in a nursing home might make all the difference for the person who doesn't move in and out of bed very much but they just want to listen to the nursing staff to ask what they are having for lunch. They may not be able to manage a hearing aid so a simplified listener might be just the trick.

The other important aspect is communication strategies. We all know that technology is fantastic but it isn't the miracle. So in addition to the best possible technical intervention, we also need family and carers to know how they can maximize the communication with that person. If I get time, I might just mention the built environment, because again when you look at the architecture around nursing homes, having big rooms with chairs all around the outside and with the television on in the corner guarantees that people aren't going to speak. They are not going to be able to engage because they are not picking up visual cues. They are not looking at each other. There is too much noise in the reverberant room.
Information and support is where there are different levels of intervention. There is professional including medical, audiological and community health where people can get some idea of where they can go to get assessed and what sort of help might be available for them for their vision and/or hearing loss. Self-help groups are so important here.

We know the work of the Broken Hill and District Hearing Resource Centre and how that is expanding. There is SHHH, Self-Help for the Hard of Hearing, Better Hearing and organizations like Menière's Australia, which again is peer support, self-help support. It is not necessarily that level of assessment and intervention but rather one of information and support. These days, of course, we can't forget the impact of the Internet and how people can jump on there and find out sometimes good information, sometimes less than good information.

From the self-help groups what people can get is accurate up-to-date information about what they need to do. If a person has noticed they have got a sudden hearing loss in one ear, a self-help group would suddenly encourage them to get a referral through to an ear specialist to make sure it isn't an acoustic neuroma or condition that couldn't be remediated immediately. Probably just as important as that accurate information is the peer support, knowing that people aren't the only person with this condition, finding out from other people who might have a condition which is even more severe than their own and seeing how well they cope with their condition. So it's encouraging for people to go out and take positive steps to reduce the impact of their sensory loss.

Empathy and understanding is also a very important role for these self-help groups, because sometimes families can't be quite as understanding and forgiving: ‘He hears what he wants to hear’ or ‘you’ve got your hearing aid now, put it on and just don't ask me to repeat.’ Reduce isolation and helpful strategies.

In Brief:

Changes to the Hearing Services Voucher Program

- From 1st of January 2012, new voucher clients of the Australian Government Hearing Services Program will receive service vouchers that last for 3 years instead of 2 years.
- If you hold a current 2 year voucher on 1 January 2012, it is still valid. Your next voucher will be a three year voucher.

- The vouchers will still cover the full range of services (assessment, rehabilitation, hearing aids, and aid adjustments) except they will last for 3 years instead of 2 years).
- If you need a hearing reassessment or hearing aid replacement earlier than normal you will still be able to access these services. Contact your hearing service provider to discuss your hearing concerns.

Improvements to the Hearing Services Community Services Obligations

In addition to the voucher program, Australian Hearing, the Government hearing services provider, provides free hearing services to priority groups with special needs. These groups include children and young adults under 21 years of age, adults with complex hearing needs, and some Aboriginal and Torres Strait Islander people. The funding for these services is provided through the Community Service Obligations (CSO) of the Hearing Services Program.

Changes as from 1st January 2012

- Young adults aged 21 up to 26 years of age (21 to 25 years inclusive) can now access CSO services (including rehabilitation, hearing aids and cochlear speech processor upgrades).
- This will ensure that young adults who formerly lost access to free hearing services from the Government provider, Australian Hearing, upon reaching 21 years of age can now access services This will allow this group of young adults to complete their education or establish themselves in the workforce.
- Increased funding will also provide additional services to other priority groups such as children, Indigenous groups, adults with complex needs and eligible people living in remote communities.
- No special action is required by existing CSO clients to access the increased support for services.
- Former Australian Hearing clients who have regained eligibility (that is are aged between 21 and 26 years of age) will be able to contact Australian Hearing to resume services.

Far West Commonwealth Respite and Carelink Centre

FAR WEST COMMONWEALTH RESPITE AND CARELINK CENTRE

HACC Centre, 72 Gypsum Street

BROKEN HILL NSW 2880

Respite Services

Assists carers of frail older people, younger people with a disability or someone with a chronic illness by—

- Providing information and advice on respite options
- Assistance with short term and emergency respite
- Referral to appropriate services
- Coordination of residential respite bookings

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1800 052 222*

Upcoming Events:

4th January - Hearing Centre to re-open from Christmas break
20th January - General Committee Meeting
27th January - Open Day for Volunteers – Sausage sizzle lunch
22nd February - Social Morning – 10.30am
Next Issue: March 2012

Broken Hill & District Hearing Resource Centre Inc. 2011-2012 Committee

Chief Executive Officer	Anne Woods	**Chairperson**	Neville Gasmier

Vice-Chairperson	Karen Gelmi
Treasurer	Lia Staker
Secretary	Christopher Rawlins

Committee Members

Chris Coombe	Leo Boulton	Olga Kennedy
Valerie Huxtable	Josie Smith	Barbara Luscombe

Would you like to contact us?

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We are open Monday to Friday 10am - 4pm Central Standard Time
Other times by Appointment

WE NEED YOUR HELP!

Volunteers required
Do you have a few spare hours during the week and would love to help others within the community?
We are currently seeking volunteers to help in our reception area and/or fundraising.
If you require further information, please contact the Centre.

The Broken Hill & District Hearing Resource Centre Inc. is a Non Profit organization with gift tax exemption. All donations over $2.00 are tax deductible. If you wish to make a bequest/donation to the Broken Hill & District Hearing Resource Centre Inc. please contact our office.

This newsletter was compiled and edited by Anne Woods on behalf of The Broken Hill & District Resource Centre Inc. Contributions to our newsletter are welcome. The editor reserves the right to use or edit as necessary.

Ideas and opinions articulated in “Hearing Happenings in the Hill” are those of the authors and not necessarily of the Broken Hill & District Hearing Resource Centre Inc.