

# Submission to Child Protection Inquiry

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By Damien Howard and Jody Saxton Barney

The first section of this submission is on issues relevant to Indigenous people who are hard of hearing (HOH - those with a mild to moderate hearing loss). This section has been compiled by Damien Howard a hearing, non-Indigenous psychologist and educator. The second section of the submission addresses the issues of Indigenous Deaf people and HOH people and was written by Jody Saxton-Barney a Deaf Indigenous consultant.

Childhood ear disease means almost all Indigenous children experience fluctuating mild to moderate hearing loss during childhood. Studies have shown that up to 80% of Indigenous children in the Northern Territory experience hearing loss. The number of children who have a severe to profound level of hearing loss (deaf) are similar, although still higher, than in the non-Indigenous population – approximately 5%. However, the absence of many types of services to Deaf Indigenous people in the Northern Territory, as well as the multiple other types of disadvantage experienced by the Indigenous community as a whole, means that Deaf Indigenous Territorians commonly experience the most extreme disadvantage in their community, including exposure to childhood abuse.

## SECTION ONE

Damien Howard's background is that he has worked as a psychologist and an educator in the Territory for the last 30 years. He has had a particular interest in the psycho-social outcomes of Indigenous hearing loss for the last 20 years. He has carried out research consultancy and service provision in relation to hearing loss and Indigenous people's participation in schooling, employment, social and emotional wellbeing and involvement in the criminal justice system. More information on his work is available at his website [www.eartroubles.com](http://www.eartroubles.com)

### Introduction

Indigenous children experience middle-ear disease (otitis media) earlier and more often than almost any other population group. *The average time spent with middle ear disease during childhood is 2.6 years for Indigenous children and 3 months for other Australian children.* This ear disease results in fluctuating but chronic hearing loss during childhood, and usually some degree of permanent hearing loss. This widespread mild to moderate hearing loss among Indigenous children is an important issue for child protection to consider in a number of ways.

The following is statistical information regarding the Incidence of Trauma among Non-Indigenous Deaf Children.

- *“Deaf children are more vulnerable to neglect, emotional, physical, and sexual abuse than children in the general population. (Sullivan, Vernon, & Scanlan, 1987)*
- *50% of deaf girls have been sexually abused as compared to 25% of hearing girls. (Sullivan et al., 1987)*
- *54% of Deaf boys have been sexually abused as compared to 10% of hearing boys. (Sullivan et al., 1987)*
- *Individuals with disabilities are over four times as likely to be victims of crime as the non-disabled population. (Sobsey, 1996)*
- *Children with communication disorders are more likely to be physically and sexually abused than children without these disorders. (Sullivan & Knutson, 1998)*
- *Maltreatment of children with disabilities is 1.5 to 10 times higher than of children without disabilities (Baladerian, 1991; Sosey & Doe, 1991; Sobsey & Vamhagen, 1989; Sullivan & Knutson, 2000).*
- *Immediate family members perpetrate the majority of neglect, physical abuse, and emotional abuse. Extra-familial perpetrators account for the majority of sexual abuse. (Sullivan & Knutson, 2000)*
- *Sexual abuse incidents are almost four times as common in institutional settings as in the community. (Blatt & Brown, 1986)*

*Deaf children are at increased risk for traumatisation. The ongoing communication barriers that often exist within the family and in other key settings can cause increased frustration for adults and children*

- *Difficulty in teaching deaf children about safety;*
- *A paucity of useful educational resources such as safety curricula and sexual abuse/kidnapping prevention programs;*
- *Assumptions by perpetrators that deaf children are less able to disclose information about abuse;*
- *Difficulties in teaching/learning skill building and socialization;*
- *Decreased opportunities for incidental learning;*
- *Decreased opportunities for trusting open relationships; less disclosure of abuse to caregivers; and less understanding of the parameters of healthy/safe touching. Deaf people may also experience additional communication barriers, misunderstanding, and fear during the disclosure or investigation of a traumatic event, and exacerbated feelings of isolation and difference after a traumatic event.”*

From *Facts on Trauma and Deaf Children*, published by the National Child Traumatic Stress Network based in Los Angeles (2004).

This research among non-Indigenous children is mainly with children who have a severe to profound Sensori-nueral Hearing Loss. Indigenous children’s hearing loss is most often Conductive Hearing Loss in the mild to moderate range. This hearing loss interacts with the multiple other types of disadvantage experienced by Indigenous people, as well as cultural and

linguistic differences. The next section of this submission describes some of the communication problems and strategies used by the hard-of-hearing and some issues in cross-cultural service delivery.

## Communication strategies, hearing loss and trauma

When a person has a partial hearing loss, they are deprived of the full auditory input that those with 'normal hearing' use to understand what is said to them. Those with hearing loss use their available hearing but also often rely on '*visual*' and '*thinking listening*' strategies (thinking about past events or observable context) much more than those who have no hearing loss. The success experienced in using all these listening strategies relies heavily on how well others support their use.

The following are ways the responses of the hearing person can adversely affect the understanding of those with hearing loss.

People with hearing loss are disadvantaged when others:

- Speak too quietly, too quickly or uses unfamiliar words; this diminishes their capacity to use available acoustic information.
- Have poor visual communication skills (for example if they use little gesture or facial expression, turn away while speaking or speak when they can't be seen); this limits the number of visual cues available to enhance understanding of the verbal message.
- Do not use the available surrounding context to 'illustrate' their words. For example, standing beside a piece of equipment and explaining how to use it but not actually demonstrating the corresponding actions, as they speak.
- Do not introduce the topic they are speaking about in a way that enables the person with hearing loss to accurately place the topic within the wider context of their existing knowledge, enabling the use of 'thinking listening skills'. A suitable introduction will enable the hearing impaired to use what they already know, to understand the spoken words.
- Change the topic is too quickly without 'flagging' the change. Indicating a change of topic enables the listener to 'shift thinking frameworks' and to place the new topic in its correct context.
- Fill the conversation with verbal asides or elaborations that are irrelevant to the main topic being discussed. These make it very difficult to follow the conversation and to extract the important information about the main topic.
- Speak for too long, creating the danger of 'listening fatigue', especially in regards to the listener's capacity to use the cognitively demanding 'thinking listening skills'.

It is usually difficult for those with normal hearing to understand the communication needs of the hearing impaired, unless they themselves have had previous experience of communicating with hearing impaired people, which enabled them to develop this understanding. Among non-Indigenous people, these skills are most evident among those who have a hearing problem themselves or have had long experience with someone with hearing problems. Among Indigenous people, these skills are more common because hearing loss is so widespread in Indigenous communities. This means that Indigenous people are very likely to have had a hearing loss in the past, have one currently or have grown up around those with hearing loss. Although, there are also many Indigenous people who do not have some or many of these additional listening/communication skills.

Not only is personal experience of listening problems less common among non-Indigenous people but most credentialed professionals have been involved in a process that 'selectively favours' those who have few of these skills. This process is formal education. The highly verbal and literacy-based teaching/learning processes within formal education are a significant challenge to people who are Deaf, hard of hearing and/or have auditory processing problems. Because of these difficulties, they are less successful in formal education and therefore less likely to qualify as credentialed professionals. The outcome of this is that **the professionals who will eventually come to work with or provide services to Indigenous people are often least accomplished in the communication skills needed to communicate with Indigenous people with hearing loss.**

This absence of skills among professionals limits the access of Indigenous people with hearing loss to the services provided by these professionals and produces poorer outcomes when they do manage to access services. It also results in frustration and burnout amongst professionals when they cannot comprehend why people do not respond in the way they expect, nor do their interventions have the outcomes they hope for.

There is research evidence of this happening in the education sector where -- unlike most other sectors, there is some awareness and very little research.

- Indigenous children with hearing loss were found to be more likely to have poor school attendance (Couzous, 2003).
- Children with hearing loss or ear disease have poorer literacy outcomes at school (Galloway, 2008).
- Indigenous adults with listening problems are more likely to avoid literacy support (Howard, 2007).
- There was a significant reduction in stress related to working with hearing impaired Indigenous children with behaviour problems after the teachers participated in training designed to improve their understanding of the communication dynamics of working with the hearing impaired and developed the communicative skills needed to work with this group (Howard, 2006).
- Indigenous patients with a chronic disease and hearing loss participate less in health care and have worse health outcomes. Their participation in health care and their health

outcomes improved when health practitioners used amplification during consultations with patients who have hearing loss (Howard, 2008).

## Trauma

Because people with hearing loss tend to rely so heavily on 'thinking listening strategies' anything that diminishes their capacity to attend to non-verbal cues, or focus their thinking on communication, will reduce their capacity to understand what is said. **The trauma experienced through abuse often impacts on children's capacity to understand what is happening and communicate effectively, thus compounding the effects of their pre-existing hearing loss.** Children with hearing loss have a reduced ability to communicate so they are less able to gain the emotional support that can help in their recovery from the trauma. Trauma and hearing loss thus magnify each other's impact on children.

Further, a common outcome of trauma (and a defining symptom of post-traumatic stress) is avoidance of things that remind the person of the trauma. This may include social contexts, particular smells, sights or sounds. If the abuse happened in their home community, they may seek to avoid the places where their family and/or extended family resides and where most emotional and practical support is available.

The following case study (Tommy) highlights these issues.

### Case Study: Tommy

*Tommy grew up in an Aboriginal township and his hearing loss was identified when he was four and, unusually, he obtained a hearing aid that he mainly used at school. Tommy was sexually abused by an older cousin/brother when he was six. Tommy immediately communicated what had happened to his parents who told the police and helped Tommy tell the story of what happened. The police arrested the perpetrator and took a statement from Tommy.*

*The police officers had great difficulty interviewing Tommy. They were not aware of his hearing loss. After initially establishing his ability to answer direct questions (What colour is this?) the questioning began about the incident. During this process Tommy spoke very quietly. The transcription noted there were 56 inaudible comments. Only a few of the answers to questions for which Tommy gave an audible response were actually related to the question asked. Most did not adequately or in any way answer the questions asked.*

*If the police had needed to rely on Tommy's statement it is unlikely that charges would have been laid. However, in the face of DNA evidence, the perpetrator confessed. Later when I spoke to Tommy I used an Assistive Listening Device (ALD) which helped*

*Tommy understand what I said. It was only when I used the ALD that Tommy responded at all, to what I was saying to him.*

*Two years later Tommy's family described the impact of the assault on him. Tommy was distressed, stopped attending school, and had not returned to school in the two years since the assault. His communication significantly deteriorated. He often failed to respond when spoken to and communicated with people much less than before. When he did communicate it was mostly brief utterances and with only one or two people, on whom he was dependant. He became socially withdrawn and spent more time by himself.*

*The impact of the assault on Tommy's communication is analogous to a physical injury to the speech centres of the brain, which damage a person's capacity to understand speech. Although the process that Tommy went through was psycho-social rather than physical, it has had a long-term effect on his ability to attend to, and process speech.*

*After the incident, on those occasions when Tommy did socialise with children his age or older, it was common for him to have difficulty cooperating with them. This irritated the other children and youths who would then become annoyed with him and tell him to go away. Tommy would then often become furious, this was especially so with boys who were of the same age as the youth who had abused him. He would get a stick or a knife and threaten to hurt them. The other kids would go away, leaving him alone until someone with whom he was not angry could come and calm him down. Tommy's family were worried about his behaviour, especially his disrespect towards older boys, which was described as 'against culture'. He spent most of his time at an outstation where he felt 'safe', only occasionally coming into the community where most of his family lived.*

*Tommy had significant additional communication and social problems as a result of the trauma and these impacted on him at a critical time in his life, magnifying his pre-existing hearing related difficulties. His education and social and emotional development were seriously compromised.*

This case study highlights the interacting and compounding effect of trauma on someone with a pre-existing hearing loss. It also demonstrates some of the problems that can emerge when people, such as police, working with a victim are not aware they have a hearing loss.

## Hearing loss and Family life

Another important issue which should be considered when thinking about the area of Indigenous child protection is the amount of additional care that is required when a child, or children, in a family have hearing loss. It is very common that children with hearing loss are more demanding than those without hearing loss. The behaviour and demands of these children also have a tendency to disrupt family life. The primary carers (usually mothers and grandmothers) often need additional support to manage the child/children with hearing loss, or to manage the other children in the family while the carer's attention is taken up dealing with the child or children with hearing loss. One mother described some of the issues in this way.

### Case Study: Jack

*"It starts with Jack (who has a current Conductive Hearing Loss); he is really demanding and screams if people don't do what he wants to do. Now his younger brother is imitating him in being demanding and all the kids scream now to say things. They always want me to sort out their games.*

*Before they used to be able to make the rules of their game and keep them, but then when Jack got that ear problem he wouldn't do that. He always wanted to do it his way. The other kids would just do what he wanted so things were quiet. Then another cousin/brother came to stay with us and he had that hearing loss too and wanted to do things his way.*

*Now him and Jack always fight about what to do and the kids always come to me to sort out things between them or to tell on each other. I have to think all the time about what will make them happy – especially Jack and his cousin/brother.*

*I had to ask my husband for more help with them because I could not do all that and get to work. It has been really hard. I understand them because I got that hearing problem too. But it really hard." (Indigenous mother)*

This Indigenous mother's comments highlight the way that widespread hearing loss among Indigenous children can increase the demands on carers and contribute to the disruption of family life. The child protection system currently fails to acknowledge the widespread prevalence of hearing loss amongst Indigenous children and adults, or the impact this hearing loss has on children and their families. The following are just some of the important points to be considered:

- Hearing Loss impacts the ability of both victims, and those accused of being perpetrators, to communicate in all of the processes of the child protection system
- Currently, child protection workers in the Northern Territory receive no training that would enable them to understand the implications of hearing loss on individual children and

family life, the combined effect that hearing loss, cultural issues and language differences have on communication. Nor are child protection workers given the training enabling them to communicate effectively with those who have hearing impairments.

- The existence of hearing loss should be considered as a significant factor when assessing a family's ability to provide adequate support – this includes foster care arrangements.

Some years ago I discussed this issue with the training section of Family and Children's Services (FACS) and was told, after they had considered the matter, that these issues were not a training priority for FACS.

## Recommendations

1. ***Train professionals who work with Indigenous people in all areas of child protection***  
This includes case workers, police, counselors and foster carers. This training needs to include indicators of hearing loss and effective communication strategies as well as the way linguistic and cultural differences both masks awareness of hearing loss and the way that hearing loss interact with and compound cultural and linguistic factors.
2. ***Assistive Listening Devices should be used as a matter of course*** with anyone who has communication difficulties, this includes Indigenous victims, and Indigenous perpetrators of child abuse. The devices should be used during police interviews; by child protection case workers, and in any communication with legal representatives, medical and counseling services;
3. ***Research needs to be undertaken*** to investigate how hearing loss impacts on communication, with both children and adults, at all stages of the child protection process so that training which is both effective and well informed can be developed to improve the whole child protection process.
4. ***Issues around children's hearing loss should be considered in the assessment of children's support needs.*** The capacity of families and foster carers' to meet the needs of these children should be assessed and adequate support, by the system, needs to be provided to the children, families and foster carers.



## SECTION TWO

This next section of the submission is made by Jody Saxton-Barney who is a Deaf Aboriginal woman, living and working from the regional city of Shepparton in Victoria. Her work ranges across the country and consists of consultancy and training for organisations, departments, community co-operatives and service providers. The work done by the Deaf Indigenous Community Consultancy aims to share professional and cultural knowledge of her years of experience and connection to countries across the nations in the field of Deafness and community development.

Difficulties faced by this minority group (Deaf Indigenous people) are often greater than others within the disadvantaged Indigenous community and the difficulties are greater than those impacting other Indigenous people. They are often suppressed and vulnerable. The compounding factors of being Indigenous and Deaf, without fluent or semi-fluent communication skills are difficult to describe in this submission. There is a complex matrix of needs and issues that are related to cultural groupings within Indigenous communities, communication difficulties as well as exploitation or neglect by others.

### How Indigenous Deaf Australians are different to mainstream Deaf Australians

To understand the position of Indigenous Deaf people it is important to understand how they are different to mainstream Deaf Australians. The use of Auslan (Australian Sign Language) provides a cultural link between mainstream Deaf Australians. In this culture people are identifiable through their signs in terms of age, their schooling, their community (state) in a similar way to the varieties of use of oral language among the hearing community. There are variations of signs that are used around a central core of common signs that link people together as a community of Deaf people.

This is not the case for Indigenous Deaf people. Only 45 of the 575 Indigenous Deaf people I have made contact with and for whom there is information on with my data base can use Auslan, only approximately 19-22 are fluent. Out of the 575 Deaf on my national database 173 are from the Northern Territory, only 6 have Auslan skills while the rest use all forms of hand talk, hand signs and/or finger talk.

### Indigenous Deaf people

Indigenous Deaf people's use of local cultural signs, hand talk and gestures is linked to knowledge of country, history, family, storytelling and lore, ceremonies, customs and performances. Out of the 17 variations of communication sign languages and hand talk signs used in communities served by Deaf Indigenous Community Consultancy the use of these signs off country or in other parts of the country by the Indigenous Deaf person is offensive and disrespectful and punishable by cultural law. Doing this can and has led to the individual Deaf

person being banned or rejected by their communities. I describe this to explain the importance of local communication that cannot be used outside people's Country.

These locally used signs follow the linguistic structures of Aboriginal or Torres Strait languages not Auslan or English. This creates a barrier to having a unified sign language that establishes a single Indigenous Deaf cultural group of the type that exists for mainstream Deaf people. Further, since Indigenous Deaf people are more closely linked to the culture of their family and community, a separate Indigenous Deaf culture of the type that exists for mainstream Deaf Australians is not culturally appropriate. It also means the type of state and territory Deaf organisations and national peak bodies cannot truly represent the aspirations and needs of Indigenous Deaf people.

The connection that Indigenous Deaf people have is one based on their commonalities of being Indigenous and Deaf. They communicate with other Indigenous Deaf people in a vastly different mode of communication than those who use Auslan and are non-Indigenous. The mainstream Deaf community at large will often say to Indigenous Deaf people "just say your Deaf, that's enough, don't complicate your life by being Indigenous too". This response occurs more in urban and city areas and more for fair Indigenous Deaf people such as I am.

Mainstream sign language services that are trained only in Auslan often have limited capacity to bridge the communication divide with Indigenous Deaf people. Many of the Indigenous Deaf community have had little exposure to Auslan. The non-verbal communication or hand talk used in community is different to Auslan and often takes into consideration a vast array of meaning in just facial expressions alone. This kind of communication is context bound to the community and the land on which the Indigenous person lives.

In relation to Deaf Indigenous people acquiring Auslan, Auslan is important for some but the introduction of learning Auslan for education purposes must be given together with the maintenance of traditional oral language, as well as community signs, otherwise the person risks losing their connection with their family, culture and identity. Some Indigenous Deaf people resist or reject opportunities to learn Auslan because it can only happen at enormous cost to maintaining their culture and Indigenous identity. Support for Indigenous Deaf people must be through total communication if it is not to be at the cost of loss of identity or access to their home communication.

## **The Importance of Family**

It is obvious from consultation with these communities the importance of the sense of belonging to family for most Indigenous Deaf people and their families. In the face of all the complex layers of living day-to-day as an Indigenous person in Australia, the families of Indigenous Deaf people create a family unity that includes Indigenous Deaf people.

With the majority of the 575 people consulted with, the main support available is from family. Indigenous Deaf people's prime responsibility and sense of duty is also to their family. Some experience violence, and even abuse from some family members but accept this as 'normal' as they have limited opportunities to see anything different. Mimicking behaviour is common in deaf cultures around the world as a way of learning from the context they are in as well as gaining acceptance.

In Indigenous communities this can mean being taught the way to dance, do ceremony, doing tasks required and being in the company of Elders. But when behaviour of those they are around is anti-social or negative Indigenous Deaf people often believe that this is normal. It is often only when they are enabled by their family to make decisions themselves and experience the consequences that they understand processes they are involved in.

However, they are often involved in family, community and societal processes with only a limited partial understanding of what is happening. Because of their intense focus on family and culture this is especially true when they are involved in mainstream processes, such as in health, education and criminal justice.

Teaching through family can give them greater ability to have their status in community acknowledged and not resentfully seen as an individual who is unfairly favoured due to their hearing loss. Service providers often obstruct Indigenous Deaf people exercising control of their own life by having the "welfare mentality" and acting on "behalf of the client" instead of advocating for the client and working with the family.

It is clear from what has been already said that Indigenous Deaf people's views of family are complex and at times heated due to oppression, racism, discrimination and intimidation. The imposition of other's authority on Deaf family members is often overwhelming and individuals are forced to comply without understanding clearly what their rights are in being free from discrimination and harm. This reality is a constant reminder that early intervention into hearing health and communication support for families will help alleviate the communication burden on families.

Indigenous Deaf people report that they are more reliant on their families than Deaf people in the wider community. As has been discussed their connection to family and country is more primary than any Deaf cultural identity of the type that is more important in non-Indigenous community. That acceptance of family and community as the primary focus in people's lives happens even if it comes with serious negative consequences. For example, being exploited and abused by some family members.

Indigenous Deaf people are often engaged with their communities and many work at supporting others within the community. Those who have talents and abilities are in paid work and living productive lives. However, there are also those who are not coping let alone able to be productive in their life. They are often at the extreme edge of family and society. They are subjected to family and community violence/abuse and have a high level of dis-engagement

from education and other services. They often become targets of “scape-goating” or are exploited in their work for their families doing duties around the home or sent to work for others in a way that is exploitative. Indigenous Deaf people that are targeted as scapegoats are often subjected to being left with illegal goods, believing that they are “care taking”. Often their limited communication skills make them easy targets for taking the blame for other’s mistakes. They are used for free baby-sitting, or used for their resources such as cars, housing, and caring for Elders.

The impact of hearing health on Indigenous families is extreme, the cost factor for families and the knowledge of where to access affordable ear health care and communication support, is escalating out of control as families are provided with mis-information, unrealistic expectations, discrimination, oppression and failure of services to deliver programs. It is common that services manipulate or give only one or two options that the service prefers or are simply expected to accept whatever is arranged for them. Choice for Indigenous Deaf people is often denied or delayed or they are provided with inadequate services.

### The following points and case studies are made about child protection

- 1) Out of the 300 deaf women on a database I have compiled, about 80% have been abused as children.
- 2) Abuse is more likely to be ‘normalised’ with HOH and Deaf Indigenous children because of limited communication within the family unit or in the wider community. Even when disclosed, people may continue to be vulnerable to other abusers. They can be given money or taken to another place but many tend to continue to ‘wait’ for someone else to abuse them.
- 3) Indigenous Deaf children are groomed much earlier and are silenced more quickly if they do disclose.
- 4) Family pressure to silence or shame the victim tends to be increased by the lack of communication or language development of the child.

#### Case study

*One young Deaf girl from the Territory, but who now lives interstate, was abused by a family member. When she gestured what he did to her, she was accused of ‘storytelling’ and was sent away because she was bringing shame on the elder who abused her. When she later went back to Country with better English skills and Auslan, she could explain what he did in pictures and how he told her to keep quiet. She was again sent away and hasn’t been back on country for some time.*

- 5) HOH and Deaf children are liable to experience more prolonged abuse because limited communication may result in abuse not being reported or abuse being 'normalised'.
- 6) Prolonged abuse can traumatise children which impacts on the communication of HOH and deaf children so they become 'profoundly' unable to articulate their concerns.
- 7) Carers in *out of home* placements are not equipped or knowledgeable on the needs of HOH or Deaf children. They are not provided with appropriate training
- 8) Deaf and HOH children often become either more passive or aggressive in their forms of communication if they are challenged about disclosing, especially if it results in them being excluded. For example one Deaf boy was living with his sister due to the abuse by his step-father on country. He was sent him to Alice Springs when they found out about the abuse and he become aggressive and disrespectful.
- 9) Deaf children who are abused look for support from their family. If they do not get this support they are unlikely to seek support from others – such as teachers or care workers. Children or women don't understand where they can go and who they can trust, or have the language or knowledge of their rights to be free of abuse. Fear of exclusion if they report abuse means abuse is more prologued and less likely to be reported. It is common that people do not feel they have the ability to overcome such entrenched or normalised behaviour of people who abuse them.
- 10) Deaf Indigenous children sent to boarding school for education are more at risk from perpetrators.
- 11) Child protection does not have inclusive practices in their cultural plans or in their Risk Framework for Deaf or HOH children. Non-Indigenous interpreters may often misinterpret children's communications.
- 12) The welfare system is not only feared because of its past involvement with Indigenous people (especially the Stolen Generation) but people have a realistic view that it does not work, partly because it is under resourced. People are also likely to be overwhelmed by the way it works.
- 13) The disadvantage in the Indigenous community generally can, through internalised oppression, result in both a lack of respect for and sometimes a sense of ownership of the HOH and Deaf. Many Indigenous people tend to believe that Indigenous Deaf people are not equal to them or seen to be people of knowledge. They are seen as people who bring visual shame by '*flapping their arms around in public*'. While these issues are often similar in the non-Indigenous Deaf community the importance of

shame, the extended kinship and family violence that often extends into community violence, as well the greater dependence of Indigenous Deaf on family, is very specific to our mobs (Indigenous people).

### Case study

*A Deaf Indigenous woman who disclosed her abuse by a family member to other family members at the age of 14 wasn't heard, but was flogged (beaten) and put in a locked room for a week. When the school rang, the parents to find out where she was her mother said she had an ear infection. The girl ran away and was brought back by the police only to be flogged again by her father because he felt she brought shame to him and his business and also his connection to the police through a sporting club.*

*When she continued to disclose, telling police, a teacher and a nurse, she was flogged again by her mother, father, brothers, uncles and grandparents. Some of those who flogged her for disclosing had also been victims of abuse, and did not want to re-live their experiences and so wished for all of it (any discussion of abuse) to be swept under the rug so they can get on with life. Their aggression towards this young woman and their denial of her abuse was part of the ongoing denial in their own lives.*

*Eventually the woman cut off contact with her family and spent years in counseling. She now has some contact with family but still tends still to not discuss her abuse, as she feels they are not equipped to understand or they are shamed by their own knowledge of the abuse at the time. She also spent more time in the white Deaf world and only later reconnected with her Indigenous cultural world.*

This case study illustrates how abuse can lead to loss of family support and cultural involvement for Deaf Indigenous people.

### Recommendations

1. **In examining abuse involving Indigenous Deaf children it is also important for child protection workers** to understand it takes time to learn the linguistics of their home language, their visual language. They need to involve cultural advisors, preferably deaf cultural advisors who are not family. The child needs to be assured that the process after disclosure is a safe one.
2. **Cultural plans are carried out** when abuse of Indigenous Deaf children is being addressed.

We hope your inquiry will consider the issues that have been raised in this submission; issues that have been too long neglected by the child protection sector. We also attach an article on the impact of hearing loss on Indigenous families.

Yours sincerely

**Damien Howard PhD**  
Consultant Psychologist

**Jody Saxton Barney**  
Deaf Indigenous Community Consultancy

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# Ear Disease and Aboriginal Families

**DAMIEN HOWARD AND DIANNE HAMPTON**

The high incidence of middle ear disease in Aboriginal communities contributes to massive levels of conductive hearing loss among Aboriginal children. It has been estimated that, on average, Aboriginal children have middle ear disease for more than two and a half years during their childhood. The equivalent figure for non-Aboriginal children is three months (OATSIH, 2001). Although middle ear disease is usually considered as a health problem, it also contributes to poor social and emotional outcomes. The West Australian Aboriginal Child Health Survey (WAACHS) found significantly poorer social and emotional wellbeing for children who had 'runny ears' (caused by perforation of the ear drum) than other Aboriginal children (Zubrick et al., 2005). Childhood hearing loss has also been found to contribute significantly to learning and behavioural problems at school (Howard, 2004). Aboriginal children with conductive hearing loss were found to tease other children more, peers often rejected them socially and they are more disruptive in class than other students (Howard, 2005).

We know little about the effect conductive hearing loss can have on family life but there is some evidence, from studies of non-Aboriginal children, where far fewer children are affected by less severe middle ear disease, that conductive hearing loss can influence family life. Children with conductive hearing loss may instigate interactions less often and be less responsive to parents (Roberts et al., 1995), so that there is a diminished quantity and quality of social interaction between children and caregivers (Hoff-Ginsberg, 1990; Vibbert & Bornstein, 1989). Western mothers with a child who had experienced chronic middle ear disease were more likely to be depressed and feel that they were less adequate as parents than other mothers (Forgays et al., 1992). Some non-Aboriginal Australian mothers also reported that they found it more difficult to feel close to their child with conductive hearing loss (Dorothy Moore personal communication 1992).

Aboriginal parenting styles that use more intensive and visual communication strategies help to compensate for hearing loss-related communication problems (Jacobs, 2005). However, the early and persistent hearing losses experienced by so many Aboriginal children are likely to adversely impact on child/family relationships. In relative terms, far more Aboriginal children experience earlier, more severe incidents of middle ear disease, more often than do most non-Aboriginal children (Boswell et al 1994).

The proposition that conductive hearing loss has an effect on family life was supported by interviews carried out with parents and health workers in this study. Hearing loss, especially mild to moderate hearing loss, is most often not identified. Since it is not known that children have hearing loss the communications and social problems associated with a current hearing loss are often seen as simply 'bad behaviour'. It is only when parents or health workers are informed through identification of ear disease or hearing tests that they have an opportunity to better understand the social and behavioural problems related to

current hearing loss. Parents have the most direct experience of the way in which conductive hearing loss can affect family life and five Aboriginal mothers were interviewed in the study described in this article. The authors also interviewed three Aboriginal Health Workers (AHWs) and two nurses working in Aboriginal communities. Aboriginal Health Workers who live in small remote communities treat children with middle ear disease while also talking to their parents and observing the children in the community. Community nurses' observations are mostly based on when families attend the health centre. The observations made by parents, AHWs and nurses were consistent with each other and support that conductive hearing loss can have a major impact on family life in the ways that are described below.

## **Being flogged**

It was reported that children who have difficulties with communication because of hearing loss are often punished physically.

'Half the kids get floggings because they (the parents) think they're (the children) ignoring them. I see parents giving kids with hearing loss a flogging when they (the children) have not understood; I see that all the time, everywhere ... I think half the kids (with hearing loss) get hidings sometimes.' (Aboriginal Health Worker)

'Sometimes it is they (the children) don't show any respect to old people and they get really upset with them and they get hidings from old people.' (Aboriginal Health Worker)

## **Bully others**

Children with hearing loss sometimes receive 'floggings' from their family, but children with hearing loss were also observed to 'bully' their parents.

'They are cheeky ... you see a kid (who has middle ear disease) throwing rocks at Mum and swearing and demanding something, and usually most times they will give it to them to shut them up.' (Aboriginal Health Worker)

'I have noticed that it is the kids with chronic ear problems who are the ones you sometimes see hitting their family when they are in the waiting room.' (Remote Area Nurse)

## **Can't handle them**

Other people reported that family members had limited contact with others because of communication and behaviour problems of their children with hearing loss.

'My parents say that they can't handle them (the children) so they don't want to baby sit them because they (the children) won't listen to them. It is hard because there is no-one else I can leave them with.' (Mother)

This parent faced her children's problems related to hearing loss by herself. Other parents described how challenging this could be.

### **Hard to make him understand**

A mother, who has hearing loss, described the challenges she faced when communicating with her son, who also has hearing loss.

'With my son, when I used to get angry, if I get angry with him, he's probably a bit shitty with me and doesn't want to listen ... my son used to be very strong, you know – probably not listening to what I'm saying but still trying to have his say, keep on going and not listening. It used to be hard to make him understand. It took me a while. He used to run off, take off and don't listen. Keep doing it, keep doing it. It was really hard.' (Mother)

### **Depressed and frustrated**

One mother, also a health worker, realised her daughter might have hearing problems after she participated in training on the social problems that can result from listening difficulties. Hearing tests confirmed that her child had hearing problems.

'At the workshop it clicked, the patterns of behaviour and the withdrawal that you described. It was a relief to know. I (earlier) felt depressed and frustrated because I didn't know what was going on. I was blaming myself. I thought it was my fault and I was a bad mother. I felt like I was letting her down. I was trying to figure out what to do. The behaviour problem came at school. They never suggested anything and it was depressing not knowing what to do ... but it was getting me down and it was the stress levels. I was growing at her and yelling. I was pushing her away because I didn't know how to deal with it. It made us grow apart. I did not want to be around her. I didn't want to deal with it, I didn't know how to deal with it. It really stresses me. Other people (people in the family) scatter coz I am going off my head yelling at her.' (Mother)

These comments suggest a process whereby her child's hearing related social problems led to this parent blaming herself and withdrawing from her child. This type of response, also suggested in research with non-Aboriginal parents (Haggard and Hughes, 1991), is likely to lead to the child's social problems becoming even greater. Many Aboriginal families are likely to be caught in a cycle involving increasing social problems among children and decreasing social and emotional wellbeing among their carers. Breaking this cycle involves identifying children's hearing loss and informing families of the predictable social outcomes of hearing loss and how they can be best managed. There are parent information resources available on this topic at [www.eartroubles.com](http://www.eartroubles.com).

### **Marriage and work**

Support from families can be hugely important in helping children to cope, but this can involve significant costs for the family. The following comments come from an interview with a mother whose daughter had moderate levels of hearing loss in both ears.

She said that she needed to help her daughter a lot while she was growing up. Each afternoon she would have to talk to her daughter about what happened at school. Her daughter would often get very angry with the other children and she would need to talk to her to calm her down and help her to understand what had happened. She was often called to the school because her daughter had been fighting with other children. This mother said that she thought one of the main

reasons her husband had left the family was that he felt she put too much time and effort into support for her daughter and did not have enough time for him. She said she had only started working again after her daughter went interstate to a school for children with hearing loss. She had time to work then, when before that too much time was taken up supporting her daughter.

The level of social support provided by this mother helped her daughter to cope with the difficult social situations at school but at considerable expense to her own ability to work and to her marriage.

### **Problems at school**

Health workers confirmed that the children they were treating for ear disease had problems at school.

'All of the kids with that ear problem, they're fighting or bullying the other kids (at school). (Aboriginal Health Worker)

'When they had the school play you see all the kids who aren't singing and doing what the class are doing, and they're all the ones on our list (to check ear disease) and we review them weekly, and it was freaky to see that, yes ... not doing anything that the class is doing, and then looking around like they're not really sure what's going on ... I've seen that at assembly when they present things and when they do their little plays and dances. The ones with that (ear disease) are usually just standing there holding something, like they give them the banner thing to hold or something where they don't have to do much ... the other ones are in the play, (but for them) no singing, no dancing, no movement, just standing there looking at the crowd. It's like - you can tell they're missing out on a lot.' (Aboriginal Health Worker)

### **Drinking and food**

Aboriginal health workers noticed that children with consistent ear health problems often came from families that had other problems.

'Those kids with lots of hearing problems come from families that are doing a lot of drinking ... a lot of the time the parents are leaving and they send their mum to look after them. A lot of the time it's the food too. They're not getting good food. When there is no-one looking after them properly it (the infection) just stays there and never goes away, especially the ones with young mums, like single parent mums and they're young, their friends are having fun and they leave their kid with grandma and grandma might do this way, or drinking or something, and then she might leave it with mum's sister or something. The kids go everywhere. Up and down the community with this family, that family and from community to community, and different people. They can get sent here, there or anywhere.' (Aboriginal Health Worker)

### **Discussion**

It is clear from these comments that hearing loss from middle ear disease can have important influences on a child's relationships within a family and at school. Family members are likely to conclude that children who do not understand what has been said are ignoring them deliberately and they may physically punish them for doing so. Some children are very demanding and even 'hit out' at their parents. These observations are consistent with behaviour that has been observed in schools.

The evidence suggests that many Aboriginal children who have behaviour problems at school and at home are affected by hearing difficulties.

Teachers usually view responses shaped by hearing-related communications difficulties as behavioural problems (Howard, 2004). This can undermine the relationship between a child and their teacher(s), a relationship that is a key determinant of a child's educational opportunities (Malin, 1990). Research in schools also indicates that hearing loss adversely affects a child's relationships with its peers when that child teases others to an excessive degree or attempts to use physical coercion to get what they want (Howard, 2005).

A child's relationship with his/her family is of even greater importance than the relationship with its teachers and peers. For a child, family relationships form the basis of social and emotional wellbeing and long term social development. The child's web of social relationships is critical for individual, family and community wellbeing (Eckersley, 2004). However, it is clear that the listening/hearing problems described in this article have the capacity to significantly disrupt family life, impact on community functioning and damage a child's social and emotional wellbeing. It would also appear that for many children, the recurrence and persistence of ear disease may be related to family alcohol consumption and nutrition.

The difficulties in managing a child with hearing loss, and the resulting demands on family to provide the extra support and nurturing needed, may be difficult for many Aboriginal families when so many Aboriginal children experience so much middle ear disease, as well as many other disadvantages. In many remote Aboriginal communities fewer than 10% of children have normal hearing (Morris et al., 2005). It is likely that this huge prevalence of hearing loss contributes to many individual, family and community problems. Take for example petrol sniffing; the NT coroners report on the death of an Aboriginal child who had been sniffing petrol for many years commented "Health worker notes from his Mutitjulu file and his Alice Springs file record that he was very quiet, uncommunicative and difficult to get a history from. Lack of English, and symptoms from his chronic ear infections were no doubt contributors to this." (Cavanagh, 2005). This child's difficulties in communication probably contributed to the social and emotional problems associated with petrol sniffing as well as limiting his access to health care. Anne Lowell, when researching the educational effects of hearing loss at Galawinku, noted that many children with hearing loss were among the group of children habitually sniffing petrol (Lowell 1994).

Hearing loss is such an invisible handicap that few are in a position to observe associations with social problems in Aboriginal communities. These include parents who become aware of their children's hearing loss, health workers carrying middle ear disease health programs, researchers investigating educational aspects of hearing loss or occasionally a coroner seeking to understand an untimely death. There is a need for more formal research into this area. Over the years there has been research and program support in the medical aspects of hearing loss but almost none into the social, emotional, family, educational and community effects. However, the limited progress in treating ear disease (Morris et al., 2005) means that we must begin to focus on understanding and addressing the social consequences of ear disease.

There is an urgent need for research and programs to support parents as they deal with the family effects of conductive hearing loss as well as for school and community based programs for the many Aboriginal children and adults who experience hearing loss. Further, the staff of programs that seek to address such areas as substance abuse or family violence should be trained in effective communication strategies for people with hearing loss. For too long hearing has been an 'invisible' contributor to many areas of Aboriginal disadvantage. It is time to investigate, develop understanding and act.

Damien Howard is a psychologist and educator with an interest in the social outcomes of conductive hearing loss. His contact details are: Phone: 0889484444. Email: damien@phoenixconsulting.com.au

Dianne Hampton is an Aboriginal Health Worker who operates an ear health program at Kalkaringi for the Katherine West Health Board.

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