



# Early Years Intervention for Deaf Children in Northern Ireland





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# 1. Foreword

It is estimated that there are 1,400 deaf children in Northern Ireland and around 90% are born to hearing parents who have limited knowledge of deafness. Learning to communicate is a very essential part of a child's development if they are to realise their full potential whether it be in their home and family setting, the school environment, their social life and later on their working life.



Put quite simply, good communication skills are essential to a child's ability to enjoy life to the full. The key concern for deaf children is that by restricting opportunities, children will not only suffer educationally but also socially and in relation to family life.

We need to ensure that parents and the deaf child are supported right from the point of diagnosis. We must provide clear, robust, evidence-based information and advice on the options available to families in relation to prognosis, education and communication. We need to help parents understand their key role in their child's communication needs development.

The challenge for all of us moving forward – parents, politicians, policy makers, health and social care professionals and local communities – is to work together and at the earliest possible point to treat each child in a holistic manner and help to provide them with the very best opportunity to achieve the health, happiness and success that they aspire to.

**Edwin Poots MLA**  
**Minister for Health, Social Services & Public Safety**  
**Northern Ireland Assembly**

## 2. Background

In 2012 the British Deaf Association (Northern Ireland) met with the Minister for Health, Social Services and Public Safety. The meeting agenda centred around issues pertaining to social inclusion, health and wellbeing, and the education of deaf<sup>1</sup> children. During this meeting, the possibility of hosting a conference to address such issues was discussed.

The Minister later approached the BDA (NI) in October 2013 advising that a budget had been found to enable a conference to take place.

In light of this most encouraging support, the BDA (NI) set about drawing up a conference proposal in partnership with the National Deaf Children's Society who have been working in this field for many years.

The BDA's vision is Deaf people, including deaf children, fully participating and contributing as equal and valued citizens in wider society. This includes valuing universal human rights such as the right to receive education and access to information in Sign Language. BDA NI have an exciting project 'Deaf Roots and Pride' aimed at Deaf children and young people aged 8-20 who are transitioning from primary to secondary education or from secondary to external environments. The project has four elements which are mentoring, transition, sign-posting and culture.

NDCS has a policy of 'Informed Choice' for parents in relation to raising their deaf child. They have been involved in developing early intervention strategies including parenting classes, 'Communications is Fun' sessions and family sign language. Recently NDCS also developed a 'Healthy Minds' programme for deaf children.

As many professionals come into contact with young deaf children and their families from birth to the age of five years, it was envisaged that the target audience for the conference would be key policy makers and most crucially frontline professionals in the fields of health, social care and education.

The conference took place in Belfast on 20th March 2014 during the BDA's Sign Language Week which coincided with the 10th Anniversary of the Recognition of British/Irish Sign Languages in Northern Ireland.

Keynote presentations were delivered by experts in the fields of Early Intervention, Education, and the Deaf Child and Adolescent Mental Health Service (Deaf CAMHS):

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<sup>1</sup> The BDA uses a capital D to denote adults whose first or preferred language is British Sign Language and who are immersed in Deaf culture. As many Deaf individuals do not use BSL at school, the BDA uses the lowercase d for deaf children of hearing parents.

## Early Intervention



Gwen Carr is an independent consultant in the field of Early Hearing Detection and Intervention and Family-Centred Support. She is also Honorary Senior Research Associate at the University College London Ear Institute. Until May 2014, she was the National Programmes Lead for the NHS Newborn Hearing Screening, the NHS Newborn Infant and Physical Examination and the NHS Fetal Anomaly Screening Programmes in England. Gwen's early career was as a qualified teacher of the deaf specialising in the development of language and communication and in working with very young deaf children and their families. As a consultant to the Government's 'Early Support' programme in England, Gwen contributed to the production of the Monitoring Protocol for Deaf Babies and edited the Deafness Information booklet for parents. She is co-author of the International Consensus on Family-Centred Early Intervention 2013 and works both in the UK and internationally to support the development of early hearing detection and intervention systems.

## Education



Sandra David is profoundly pre-linguistically deaf with Deaf parents and Deaf grandparents. She qualified as a teacher of the deaf in 1990 after teaching so many Deaf adults who required life skills classes at City Lit, London. Sandra progressed to senior teacher responsible for a staff team and has been Assistant Headteacher at Frank Barnes School for Deaf Children in London for the past seven years. Very active in global projects, Sandra is also involved in Deafkidz International, taught English to secondary aged deaf pupils in Sri Lanka in 2012 and is currently supporting the development of a school for deaf children in the United Arab Emirates.

## Deaf Child & Adolescent Mental Health Service

Robert Walker is a Consultant Child and Adolescent Psychiatrist who has worked extensively with deaf children for 20 years. He is part of a multi-disciplinary team working across the whole of central England. Rob is interested in improving deaf children's access to comprehensive services to support their mental health and has a particular interest in autism and attention deficit hyperactivity disorder (ADHD) and how these conditions affect young people who are also deaf.

The keynote presentations were followed up with smaller breakaway workshops in the afternoon to discuss the issues raised in greater depth and consider the context in Northern Ireland. These workshops were led by Gwen Carr, Mary Kean (Senior Quality Manager, NHS Screening Programmes, Public Health England), Sue Barry (Deaf Roots and Pride Project Co-ordinator, BDA) and Caroline Doherty (Head of Emotional Health and Wellbeing, NDCS).

This report is the outcome of this conference.

### 3. Setting the scene

***Every child has the right to reach an acceptable level of language. Language proficiency is vital if they are to function effectively in society, including holding down jobs, enjoying active and fulfilling social interactions and leading law-abiding lifestyles. It is widely accepted that the years from birth to the age of five are critical in developing linguistic skills for life.***

There are at least 1,481 deaf children in Northern Ireland<sup>2</sup>. These children have the same right as their hearing peers for opportunities to develop language. 90% of deaf children are born to hearing parents who have no previous knowledge of deafness hence support primarily comes from Teachers of the Deaf employed by the five Education and Library Boards.

Current educational provision in Northern Ireland tends to be directed by a policy which focuses on an oral/aural approach to language acquisition for deaf children. This approach make the assumption that in order to develop natural spoken language, Sign Language should not be encouraged. Many parents in Northern Ireland have considered the use of Sign Language in raising their deaf children. However, there is very limited support to facilitate such a decision.

A key concern in the development of deaf children is that 'Lack of adequate language development from birth can impact on deaf children's early cognitive development and attachment to their parents. If not recognised early and treated this can lead to a young person developing emotional difficulties, behavioural problems and significantly impact on their mental health.' (National Specialised Commissioning Team, NDCAMHS)

#### ***Deaf children's educational attainment***

Evidence shows that deaf children in the UK are not achieving the same educational levels as their hearing peers. 2012 data from the UK Government<sup>3</sup> is summarised in the table below:

	Deaf children	Children with no identified SEN
Proportion achieving 5 GCSEs (including English and Mathematics) at grade A* to C	37.3%	69.2%
Proportion making expected progress between Key Stage 2 and Key Stage 4 in English	55%	75%
Proportion making expected progress between Key Stage 2 and Key Stage 4 in Mathematics	57%	77%
Proportion achieving expected level (Level 4 or above) at Key Stage 2 English and Mathematics	50%	91%
Proportion achieving expected level (Level 4 or above) at Key Stage 2 in reading, writing and Mathematics	44%	88%

<sup>2</sup> CRIDE 2013

<sup>3</sup> NDCS note on Department for Education figures on attainment for deaf children in 2012 (England)



In addition, the attainment of deaf children at Key Stage 4 has fallen by 2.4% points year on year. This decline is much larger than for children with no SEN which fell by just 0.3% points. Deaf children are also more likely to fall behind as they move through primary school: 21% of deaf children do not make the expected average level of progress from Key Stage 1 to Key Stage 2 in English compared to just 7% of children with no identified SEN. For Mathematics, the corresponding figures are 26% and 8%.

In Northern Ireland, 74% of deaf children attend mainstream schools where there is no specialist provision. 24% of deaf children are recorded as having an additional special educational need, the most common of which is severe learning disability.

## ***Cochlear implants***

Much effort has been invested in implanting from an early age. Around 8% of deaf children in Northern Ireland have at least one cochlear implant.

One research study (Greers et al, 2008) in the United States indicates that the earlier the implant is inserted (i.e. before the age of six months), deaf children's vocabulary levels at age 5-6 years were either better than or equivalent to that of their hearing peers. If the implant is inserted later (i.e. after the age of six months), the parity with hearing peers is lost. However, the same study found that deaf children's expressive language levels did not match those of hearing peers at age 5-6 years regardless of when the implant was carried out.

One factor which could explain the variance is that it is easier for deaf children to link words with objects or particular concepts. Learning a language, however, with aspects such as grammar and syntax remains difficult. It seems that whilst cochlear implants offer an improved chance of achieving higher levels of vocabulary, additional support is required for connected language tasks and syntactical concepts. As the researchers concluded: 'connected language tasks may place demands on auditory memory, which has been shown to be negatively affected by hearing impairment ... Complex language continues to represent an area of weakness for deaf children.'

## ***Deaf children of Deaf parents***

Although deaf children of Deaf parents account for only 10% of the deaf child population<sup>4</sup>, studies have shown that they perform consistently better than deaf children of hearing parents.

In examining 208 studies of over 170,000 Deaf people, Braden (1994) noted that Deaf children born to Deaf parents scored consistently higher on non-verbal tests than deaf children of hearing parents. Studies of mental health incidences show that deaf children of hearing parents have a higher number of referrals, almost double, in comparison to deaf children with Deaf parents.

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<sup>4</sup> This is a generally accepted traditional figure though more recent informal research appears to suggest that the figure is more likely to be nearer to 5%

Much of this is attributed to the deaf child having full access to a rich and fluent language environment with Deaf parents providing rich, natural, conversational interaction. This perfectly highlights how access to capable and fluent language models can make all the difference to a deaf child. Another key factor is that Deaf parents are less likely to suffer disruption and require a period of adjustment when they learn their child is deaf. Their own experience of deafness means that they accept their child's deafness without the feelings of loss that so many hearing parents are subject to.

### ***Summary of the evidence***

Published evidence and research findings appear therefore to imply that:

- Sign Language with cochlear implants or hearing aids improve the chances of deaf children developing age-appropriate language skills
- Fluency in a first language, acquired naturally, is a prerequisite for learning a second language
- Deaf children of Deaf parents do better than deaf children of hearing parents and also have better mental health

# 4. Deaf children, families and early intervention: sorting the wood from the trees

Gwen Carr

2000 marked the beginning of a new millennium. It also marked a new era for deaf children and their families with the introduction of Newborn Hearing Screening globally. Over 60 countries now run such programmes.

In the UK, the NHS Newborn Hearing Screening programmes were rolled out as follows:

- 2001 England
- 2003 Wales
- 2005 Northern Ireland
- 2005 Scotland

## *The changed early intervention context*

Early identification of deafness in itself is not enough. If the real advantages of the Newborn Hearing Screening programmes are to be exploited to the full for the long term benefit of the deaf child, then we need to think more roundedly in terms of early identification plus quality early support. We are required to focus more analytically and evaluatively on what early intervention actually entails.

So what has changed?

<b>BEFORE</b>	<b>NOW</b>
Started by around 2 years (often later)	The first months of life
Deficit context	Potential normal development context
Low expectations	High expectations
Technologically low tech	Technologically hi tech
Poor status of Sign Language and research evidence	Higher status of evidence and citizenship rights
Expert model of service provision	Moves to far greater parental involvement and leadership
Previous professional knowledge and expertise	New professional expertise required

If every deaf child is to develop into a confident and successful individual, the family must be at the centre of all intervention and support offered. High quality early intervention should be a flexible, holistic process that embraces the family's strengths and natural skills. This family-centred approach supports the young deaf child's development and promotes:

- enjoyment of parenting roles
- joyful, playful communicative interactions
- family wellbeing including enjoyment of the child, optimism about the child's future, stable family relations and emotional availability
- family engagement through active participation underpinned by informed choice, decision making and advocacy on the child's behalf
- self-efficacy where the parents feel competent and confident in parenting and promoting their child's development.

### ***An International Consensus Statement***

Many professionals think they know what is meant by 'best practice' and 'family-centred early intervention'. However, interpretations tend to be based on an individual's beliefs and philosophies rather than rooted in evidence hence there is no real shared understanding therefore implementation has varied widely.

The 1st International Conference on Family-Centred Early Intervention for Children who are Deaf or Hard of Hearing (2012, Austria) led to the production of an international consensus statement on best practices to ensure optimum outcomes for young deaf children. Its goal was to agree validated, evidence-based foundational principles taking into account the different interpretations, language and cultural models that could be applied and to promote the widespread implementation of these principles. This consensus statement was developed by a diverse panel comprising parents, Deaf professionals, early intervention programme leaders, early intervention providers and researchers from ten countries. It was then drafted in writing by a core panel of four with a wider international reference group.

A copy of the consensus statement can be downloaded from  
<http://jdsde.oxfordjournals.org/content/18/4/429.abstract>

### ***Improved outcomes for young deaf children***

It is already known that the cognitive ability of the child, maternal level of education, socio-economic status and the age of the child when intervention is offered all impact on the quality of long term outcomes for deaf children.

A review of post 2000 research undertaken on behalf of the NDCS revealed considerable consensus that improved outcomes are evident when a range of other crucial factors exist in unison:

- Early identification is followed by timely and appropriate early intervention
- Early amplification provision is appropriate and well monitored

- Cochlear implants are provided early where appropriate and chosen by parents
- Parents are fully involved with all aspects of support and early intervention
- There is high quality, high frequency two-way conversational exchange in the home
- The home language environment is rich and fully accessible regardless of modality
- Children are supported in everyday living situations to develop their mathematical thinking and to experience mathematical concepts
- Children have access to quality early literacy experiences and joint, meaningful book sharing
- Children and adults talk about feelings, thoughts and beliefs
- Children engage in 'pretend' play which together with many of the above factors contributes to the growth of pragmatic skills, theory of mind and socio-economic development

However, several questions still remain.

- 1) What does 'engagement' actually mean?
- 2) How do we recognise what promotes or impedes it and what can we do about this?
- 3) How can we help and support families to understand and promote positive learning environments naturally?
- 4) What strategies might help overcome the outcome-limiting effects of low socio-economic status and maternal education?
- 5) What IS high quality intervention and family support?

# **5. Confident, resilient and inquisitive deaf children: the importance of developing early language and communication skills**

**Sandra David & Sue Barry**

What is clear then is that the importance of early language acquisition cannot be underestimated. Language is the key tool used by individuals to manage their lives hence an early start to meaningful and accessible communication is vital for all deaf children.

Children with better developed communication skills have better skills for organising behaviour, maintaining attention and inhibiting impulses. A stimulating language-rich home environment in the early years prepares children effectively for the transition to formal education in that they should already have acquired age-appropriate social skills, positive experiences of social interaction with a range of people, knowledge and understanding of the world, acquisition of and gradual expansion of vocabulary, play skills including turn taking and sharing, and knowledge, including names, of family members.

## ***Lack of early language and communication – the impact***

It is widely acknowledged that a child will reach their first word milestone within 9-14 months of age. Full access to a language has a significant effect on a child's development. For deaf children born to non-signing hearing parents, acquisition of both spoken and signed languages is very often delayed. By the age of 14 months the average hearing child will have a vocabulary range of 500 words whereas the average deaf child of the same age will have a vocabulary range of 10-50 words.

This delay in early language acquisition impacts not only on cognitive understanding, social interaction and the sharing of information but also on the deaf child's behaviour, social skills, knowledge and understanding of the world around them, immediate and extended family relationships, self identity and values, and the ability to empathise all of which have far-reaching implications extending well beyond early childhood.

The case studies shared by an experienced classroom practitioner demonstrate clearly the impact of inadequate language and communication skills in the longer term.

### ***Case Study 1***

A 9 year old profoundly deaf boy, who lives with his mother and older sister both of whom are hearing, had frequent angry outbursts at home when the family were getting ready to go out.

The child does not display this behaviour at school at all.

His mother communicated their plans for the day with his older sister whilst the deaf child played with his toys. The deaf child's angry outbursts often occurred when he was suddenly told to stop in the midst of his activity and get his coat to go out.

As most profoundly deaf children do not access incidental information, being told to suddenly change his activity for no apparent reason was clearly frustrating and angered the boy. The solution was for his mother to make time in advance of the outing to sit down with the child and explain clearly the day's plans in as much detail as possible whilst checking his understanding at intervals. From then on, the mother reported a total improvement in the child's behaviour.

### ***Case Study 2***

A profoundly deaf girl, aged 10, lives with her mother and two older brothers, all of whom are hearing. The family are unable to communicate with the deaf child effectively in either English or British Sign Language.

As the girl was unable to have a conversation with her mother about menstruation, upon her first menstruation cycle she refused to participate in PE at school and thought she was going to die. She was forced to talk to her teacher about something the concept of something so private and personal which should take place in the family home.

This illustrates how lack of access to comfortable communication at home can impact on many areas of a deaf child's life.

### ***The case for bilingualism***

Raising and educating a hearing child bilingually has distinctive cognitive advantages provided there is good quality input of both languages. This applies equally to deaf children who are raised and educated bilingually in both a signed language and thereafter a spoken language. Sign Language for deaf children means the crucial first language is visual, accessible, iconic and meaningful.

Recently there has been huge interest in 'Baby Signs' and hearing parents and hearing children are strongly encouraged to participate in baby sign classes. Why is the opposite advocated when it comes to deaf children?

In an interview on BBC's flagship See Hear programme on 12th March 2014, Dr Paddy Ladd, an academic at the Centre for Deaf Studies at the University of Bristol, posed two thought-provoking questions:

- Why can't we give deaf children exposure to and use of two languages?
- Why do we need to make families choose one language over another?

### ***The resilient, confident and inquisitive deaf child***

If we are to encourage deaf children to become resilient, confident and inquisitive individuals, a range of factors need to co-exist holistically requiring a multi-agency approach when working with the child and family:

- Positive parental reaction to the diagnosis of deafness which is dependent on the open-mindedness, attitude, advice and guidance from the disclosing professional
- Parental acceptance and recognition of deafness to include alternative modes of communication
- Strong first language and ability to communicate effectively
- Meaningful early experiences
- Quality parental input, interaction and support
- Positive role models
- Sound knowledge and understanding of the world
- Continuous access to incidental learning

The early language experiences of every deaf child matters. This matters a lot. As Knoors and Marschark (2012) point out, 'If fluent communication in an accessible language, regardless of the modality, is not established within the first two years of life, children will have problems processing, comprehending and producing complex grammar throughout life.' Access to a language rich environment from birth therefore is absolutely crucial.



## 6. The confident deaf child starting early: the importance of good emotional health and wellbeing from early childhood onwards

Rob Walker & Caroline Doherty

*'Too often we see Deaf adults with identified mental health problems that could have been prevented in childhood.'*

**Dr Margaret du Feu OBE, Consultant Psychiatrist**

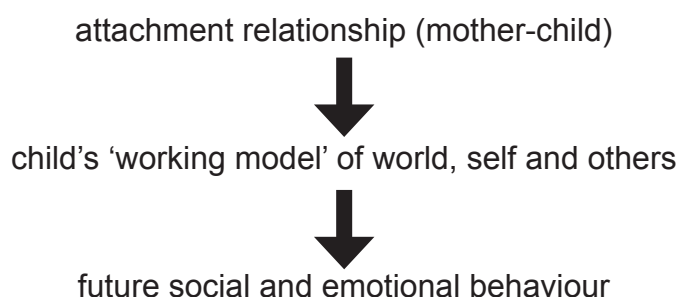
If you ask any parent what they most want for their child, more often than not they will state 'to be happy', 'to feel loved and cherished', 'to achieve', 'to have healthy relationships with others' and 'to be inspired and inspire others'. This is no different for the parents of a deaf child. All parents want their child to feel confident, to be able to meet the demands of life and to contribute meaningfully and positively to society. To do so requires good emotional health and wellbeing.

### ***Bowlby's theory of attachment***

According to John Bowlby, a 20th century psychoanalyst, all children are biologically pre-programmed to form attachments with others as a survival mechanism. The initial attachment relationship occurs at birth and is directed towards a specific person, usually the mother as the primary care-giver. Babies are born with the tendency to display certain innate behaviours such as crying and smiling which stimulate care-giving and responsiveness thus ensuring proximity and contact with the main attachment figure. This attachment relationship is persistent and ongoing rather than temporary. It is directed towards maintaining contact with the mother and is emotionally significant. The young child will exhibit distress during periods of involuntary separation from the mother and will seek security and comfort.

The attachment figure provides the young infant with a secure base for exploring the world and the attachment relationship acts as a prototype for all future social relationships. The relationship leads to the development of an internal working model which is a cognitive framework to help the child understand the world, see themselves as valuable and effective in interacting with others, and accept others as trustworthy. This internal working model, or mental representation, guides the child's general responsiveness to others and thus their future social and emotional behaviour.

This can be illustrated as follows:



Bowlby argues that a child should receive the continuous care of this single most important attachment figure for approximately the first two years of life.

### ***Effects of the attachment relationship***

Secure attachment involves:

- reciprocity
- synchrony
- sensitivity
- turn taking

The attachment relationship affects cognition, language and social development including emotional regulation, self-reliance, resilience, social competence with peers, empathy, symbolic play, problem solving and self worth.

If the attachment relationship is disrupted during the critical two year period, this can lead to potentially serious long term cognitive, social and emotional consequences.

### ***Potential negative effects of deafness on the attachment relationship***

The way in which a deaf child is supported may affect the child's ability to:

- learn socially appropriate behaviour
- use appropriate language
- express feelings and emotions
- develop confidence and self esteem

Deafness also has potentially negative effects on the mother-child bond and thus the crucial initial attachment relationship. These effects can be direct and indirect.

#### **Indirect**

An increasing number of deaf babies are born with additional syndromes which may affect their physical health and/or appearance. The newborn may also be placed in the neonatal unit. A difficult birth, a baby with additional needs, and the stress of a newborn baby spending time in a neonatal unit are all factors which can contribute to maternal ill health, both physical and emotional. The mother may experience a period of grief and have difficulty adjusting to the child's deafness which disrupts the early stages of the attachment relationship.

#### **Direct**

The greatest impact of deafness can be the effect it has on mother-child communication.

Hearing infants respond to the mother's voice even before birth though this may be compensated in deaf infants through the vibrations of the mother's heartbeat. Soothing and comforting a baby usually involves talking to the baby nearby and from a distance. Obviously being receptive to spoken

comforting talk from the mother from a distance requires the baby to be able to hear. Deaf babies need to be soothed by touch, smell and visuals such as breastfeeding, smiling, eye contact and body language. The mother is required to give thought to positioning of herself and the baby in order for this type of communication to fulfil its purpose.

Marschark (1993, p46) points out that ‘the establishment of an effective, reciprocal mother child communication system thus should help not only to promote a secure attachment bond but also to facilitate later social development by making the mother more “available” to the child and by providing for the explicit transmission of social information.’ Very often hearing mother-deaf child interactions are intrusive, controlling, tense and directing. Subsequently, the quality of language input for a young deaf child aged between 8 – 18 months is simpler, less explanatory and has less emotional content. Where communication is more natural, as evidenced in deaf children with Deaf parents, better outcomes exist because of a natural adaptation to communicating with the deaf child and better communication. Does this result in better attachments?

### ***Good emotional health and wellbeing***

Early diagnosis and quality early intervention which includes a range of support for parents – emotional support, empowering communication, the involvement of Deaf adults – all contribute to good emotional health and wellbeing in the early years.

Constant clear communication, access to Deaf role models to raise expectations, stimulation such as exploratory walks, story time and play time to develop natural language and enquiry skills, introducing children to lots of new opportunities and expanding their peer network, and encouraging even very young children to express their emotions build resilience and empower deaf children to become confident individuals. Positive references to deafness, predicting situations and working through solutions all greatly reduce the emotional impact of deafness on the child.

Then we have a deaf child who is ready to be inspired and who will inspire others.

# 7. Turning principles into practice: ways forward

The ten principles guiding family-centred early intervention identified and agreed at the 1st International Conference on Family-Centred Early Intervention for Children who are Deaf or Hard of Hearing should be embedded in position papers, guidelines and legislation in order to ensure optimum long term outcomes for young deaf children.

## **Principle 1: Early, Timely and Equitable Access to Services**

Screening and confirmation that a child is deaf will be effective to the degree that they are linked with immediate, timely and equitable access to appropriate interventions.

*Conference delegates believe that early and timely access to services has already been achieved in part in Northern Ireland. There now needs to be more consistency in the support pathway.*

## **Principle 2: Family/Provider Partnerships**

A goal of family-centred early intervention is the development of balanced partnerships between families and the professionals supporting them. Family-provider partnerships are characterised by reciprocity, mutual trust, respect, honesty, shared tasks and open communication.

*Conference delegates noted that professional multidisciplinary working needs regional consistency, resources and funding in Northern Ireland. The concept of shared leadership with rotating chairs during these meetings was discussed. It was suggested that there should be a lead professional and perhaps families should select this lead based not only on skills. Parent-to-parent support must also be included in the package. Input from Deaf professionals should be welcomed and valued as parents need to look towards the future and see what their child can achieve. It is the role of professionals to support and point the family in the right direction as opposed to rescuing them.*

## **Principle 3: Informed Choice and Decision Making**

Professionals promote the process wherein families gain the necessary knowledge, information and experiences to make fully informed decisions. This includes educating families regarding special education laws and their rights as defined by these laws. Decision making is seen as a fluid, ongoing process. Families may adapt or change decisions in response to the child and family's changing abilities, needs, progress and emotional wellbeing.

*Conference delegates highlighted that current policy leans towards the medical model in Northern Ireland. There must be quality input for all methodologies and all communication strategies, including where families choose to use Sign Language. Better collaboration between professionals is needed to promote more positive messages. Equity must be monitored. The Health and Social Care Board's Physical and Sensory Disability Strategy is a positive step forward but it was recognised that the Department for Education needs to be brought more on board.*

## **Principle 4: Family Social and Emotional Support**

Families are connected to support systems so they can accrue the necessary knowledge and experiences that can enable them to function effectively on behalf of their deaf children.

*Conference delegates advocated a broad range of support, including family support involving parenting classes, peer support, information and advice and support from Deaf professionals, so that families are in a position to choose what works best for them.*

### **Principle 5: Family Infant Interaction**

Families and providers work together to create optimal environments for language learning.

*Conference delegates asked what is meant by 'optimal language learning' and are in favour of a multi-disciplinary agreement as to what this concept entails. Parents need to actually experience a wide range of examples. How parents are utilising the information and guidance should be explored. Research into the experiences of and information and support families actually receive in Northern Ireland would be worthwhile.*

### **Principle 6: Use of Assistive Technologies and Supporting Means of Communication**

Providers must be skilled in the tools, assistive devices and mechanisms necessary to optimally support the child's language and communication development.

### **Principle 7: Qualified Providers**

Providers are well trained and have specialised knowledge and skills related to working with children who are deaf and their families. Providers possess the core competencies to support families in optimising the child's development and child-family wellbeing.

### **Principle 8: Collaborative Teamwork**

An optimal family-centred early intervention team focuses on the family and includes professionals with experience in promoting early development of children who are deaf. Ongoing support is provided to families and children through transdisciplinary teamwork whereby professionals with the requisite skills are matched to the needs of the child and family.

*Conference delegates felt that there needs to be greater recognition of parents as the key. A lead professional could perhaps co-ordinate support.*

### **Principle 9: Progress Monitoring**

Family-centred early intervention is guided by regular monitoring/assessment of child and family outcomes.

### **Principle 10: Programme Monitoring**

Family-centred early intervention programmes evaluate provider adherence to best practices and include quality assurance monitors for all programme elements.

## 8. Summary of recommendations

- 1) Espouse the principles of the International Consensus on Family-Centred Early Intervention and formulate a plan to operationalise them in the Northern Ireland context.
- 2) Undertake a baseline audit of current early intervention service provision and parental experience and perception of this provision in relation to the Consensus principles.
- 3) Promote and develop the routine and systematic involvement of appropriately trained Deaf professionals in the strategic planning and operational delivery of early intervention service in order to:
  - enrich parental understanding and experience of informed choice which should be appropriately balanced
  - share the 'lived experience' of deafness
  - enhance family and child wellbeing
  - contribute expertise to early language learning and communication development
- 4) Develop either an action research project or a service delivery project involving Deaf adults in sharing books with deaf children to enhance the development of the child's early literacy experiences.
- 5) Develop a CAMHS service for Northern Ireland that is fully accessible to deaf children and their families on an equitable basis to what is available for other children.
- 6) Ringfence funding to enable NDCS to continue to offer its Family Sign Language curriculum thus ensuring that families of deaf children can learn Sign Language if they so wish.

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# The British Deaf Association – BDA

## Vision

Our vision is Deaf people fully participating and contributing as equal and valued citizens in wider society.

## Mission

Our Mission is to ensure a world in which the language, culture, community, diversity and heritage of Deaf people in the UK is respected and fully protected, ensuring that Deaf people can participate and contribute as equal and valued citizens in the wider society. This will be achieved through:

- Improving the quality of life by empowering Deaf individuals and groups;
- Enhancing freedom, equality and diversity;
- Protecting and promoting BSL and ISL.

## Values

The BDA is a Deaf people's organisation representing a diverse, vibrant and ever-changing community of Deaf people. Our activities, promotions, and partnerships with other organisations aim to empower our community towards full participation and contribution as equal and valued citizens in the wider society. We also aim to act as guardians of BSL and ISL.

- 1. Protecting our Deaf culture and Identity** – we value Deaf people's sense of Deaf culture and identity derived from belonging to a cultural and linguistic group, sharing similar beliefs and experiences with a sense of belonging.
- 2. Asserting our linguistic rights** – we value the use of BSL and ISL as a human right. As such, BSL and ISL must be preserved, protected and promoted because we also value the right of Deaf people to use their first or preferred language.
- 3. Fostering our community** – we value Deaf people with diverse perspectives, experiences and abilities. We are committed to equality and the elimination of all forms of discrimination with a special focus on those affecting Deaf people and their language.
- 4. Achieving equality in legal, civil and human rights** – we value universal human rights such as the right to receive education and access to information in sign language, and freedom from political restrictions on our opportunities to become full citizens.
- 5. Developing our alliance** – we value those who support us and are our allies because they share our vision and mission, and support our BSL and ISL community.

## *Campaigning for Equal Rights for Deaf People*





**Notes:**



To contact the British Deaf  
Association please look at  
our website: [www.bda.org.uk](http://www.bda.org.uk)

Email: [bda@bda.org.uk](mailto:bda@bda.org.uk)

ooVoo: [bda.britdeafassoc](https://www.ooVoo.com/bda.britdeafassoc)

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