Serving our community.
Sharing our culture.

Mental Health Select Committee

Inquiry into the opportunities to improve mental health outcomes for Queenslanders Submission

ABOUT US

Established in 1903 (Deaf Services Limited) and 1913 (The Deaf Society) respectively, Deaf Connect, is a not-for-profit organisation supporting Deaf, Deafblind, and hard of hearing communities across the country, with a focus on community and empowerment. Our mission is standing with the Deaf community, building capacity, and influencing social change. Deaf Connect offers a whole life range of services to support the community including early intervention and therapy services, accredited Auslan courses and community classes, Auslan translation and interpreting services, lifestyle support services, community engagement, information and referral services, aged care support and socialisation services. Deaf Connect are the largest Deaf, Deafblind, and hard of hearing specialist service provider in Australia with over 225 years of collective experience delivering quality services to the community across Australia in Auslan. Deaf Connect are also the largest employer of Deaf and hard of hearing people in Australia.

We would like to thank the Mental Health Select Committee for the opportunity to participate in this consultation.

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FACTS

- Auslan (Australian Sign Language) is the sign language of the Australian Deaf community.
- Auslan (Australian Sign Language) is an accepted communication method recognised by the National Accreditation Authority for Translators and Interpreters.
- Auslan is recognised as a community language[1] (Dawkins, 1991).
- One in six Australian have some form of hearing loss, with that number projected to increase to one in four by 2050. Hearing loss is the second most prevalent national health issue yet remains the 8th national funding priority[2] (Access Economics, 'Listen Hear', 2006).

DEFINITIONS

Deaf

The term "Deaf" refers to those who use a sign language as their primary language. Deaf people are more likely to have been born deaf or to have acquired a hearing loss early in life. This group is relatively small, but not insignificant; there are approximately 30,000 Deaf Auslan users in Australia. Deaf people typically tend to acquire sign language as their primary means of communication in addition to the written or spoken language of the wider community. They are not necessarily fluent in written English and proficiency should not be assumed.

Deafblind

Deafblindness is a unique and isolating sensory disability resulting from the combination of both a hearing and vision loss or impairment which significantly affects communication, socialisation mobility and daily living. There are two distinct cultural groups within the deafblind community. The

[1] Dawkins, J (1991). Australia's Language: The Australian Language and Literacy Policy. Australian Government Printing Service: Canberra
[2] https://catalogue.nla.gov.au/Record/3721645

first group are born blind and lose their hearing as adults. They tend to continue to use speech as their main communication and have a variety of hearing devices to help them to communicate. The second group are born deaf and lose their sight as adults. This group are culturally deaf and use sign language to communicate[3].

Hard of hearing

The term "hard of hearing" is usually used to refer to those who use English rather than a signed language as their primary means of communication. Most people with a hearing loss (estimated at one in six Australians), belong to this group. People with acquired hearing loss will usually continue accessing information and interacting with those around them in English, whether spoken or written, and are well served by assistive technologies such as hearing aids, hearing loops, and captions.

Auslan

Auslan (Australian Sign Language) is the signed language used by the Deaf Community in Australia and is the primary and preferred language of those who identify with the Deaf community. It is historically related to British Sign Language, as is New Zealand Sign Language, and has been influenced, to a lesser extent, by Irish Sign Language and American Sign Language. It is not a signed form of English, rather, it is a language in its own right with its own unique grammatical structures, which are different to that of English. As with any foreign language, many years of study are needed to acquire fluency.

[3] https://www.deafblind.org.au/deafblind-information/deafblindness-in-depth/

Issues impacting Deaf, Deafblind, and hard of hearing communities' access to mental health care

There are several factors that can contribute to a lack of accessible mental health services and treatment for Deaf, Deafblind, and hard of hearing people, with communication difficulties throughout life being suggested as a common causal factor (Fellinger, Holzinger and Pollard, 2012). Communication barriers begin in the home and are the catalyst for ongoing mental health issues throughout many stages of life. Over 90% of deaf children are born to hearing parents[4], and as such, most deaf children are not exposed to Auslan early enough in their lives; consequently, they often do not acquire a language to native fluency. Deaf children who are not understood by the family are four times more likely to be affected by mental health issues than those from families who successfully communicate (Fellinger, Holzinger, Sattell, Laucht & Goldberg, 2009).

Historically, Deaf people have had inadequate access to quality education and there continues to be a limited supply of Teachers of the Deaf who are fluent in Auslan, as well as a limited supply of deaf role models in schools. The prevalence of mental health issues in deaf children is significantly related to adverse experiences at school through exclusion and isolation and language deprivation. In adolescence, level of language used with others at school, whether signed or spoken, is associated with peer relationship difficulties. In late adolescence and adulthood, social environments continue to be important. However, Involvement with a Deaf community contributes positively to self-esteem and social relationships (Jambor, 2005).

Deaf and hard of hearing people often experience difficulties with finding a mental health professional with an understanding of issues experienced by Deaf, Deafblind, and hard of hearing people. Mental health professionals need to be aware that their clients are members of a community where deafness is a culture and not a disability. Currently, there are a limited number of mental health professional who are fluent in Auslan or understand deafness. As there are not enough trained mental health professionals to meet current demand[5], waitlists can be exceedingly long, further compounding mental health issues that are left untreated. Deaf people can also be reluctant to access services provided by Deaf mental health professionals due to privacy and confidentiality reasons. Deaf people also report fear, mistrust, and frustration in health-care settings (Steinberg, Barnett, Meador, Wiggins & Zazove, 2006) which can inhibit them from accessing services.

Introducing an interpreter to the assessment process can create interpersonal complications in therapy between the client and practitioner, particularly if the client's preferred interpreter has not been arranged. Furthermore, the use of underqualified interpreters can lead to diagnostic errors during assessment. Mental health practitioners do not always recognise the importance of using interpreters who are appropriately skilled and qualified; often family members who can sign are asked to interpret for the Deaf person which breaches ethical codes and compromises privacy and confidentiality.

Interventions, techniques, and services that work for hearing clients are not equally effective for Deaf, Deafblind, and hard of hearing people, and standardised tests and mental health measures designed for hearing people are often invalid when used with Deaf, Deafblind, or hard of hearing

[4] https://www.aussiedeafkids.org.au/perspectives-of-deafness.html
[5] https://www.abc.net.au/news/2021-10-10/mental-health-support-when-youre-deaf/100382694

people; this can lead to higher risks of miscommunication and misdiagnosis. When mental health practitioners appreciate deafness as a cultural experience it becomes clear that many of the standard assessment tools have both cultural and linguistic biases and limitations. Several reports of adaptations and sign language translations of standard mental health screening and research instruments, such as the General Health Questionnaire, show acceptable validity and reliability (Fellinger et al., 2005). In the Australian context, both the Youth Self-Report (Cornes, Rohan, Napier & Rey, 2006) and Outcome Rating Scale (Munro & Rodwell, 2009) have been developed in Auslan, demonstrating acceptable reliability and validity and is a user-friendly instrument for Auslan users.

Efforts from mental health practitioners to improve communication prove to be effective in developing trust and building rapport with Deaf clients (Steinberg, Barnett, Meador, Wiggins & Zazove, 2006). Examples of best practice, as suggested by Dr Ryan Teuma[6], were presented at the *Let's Talk About…Mental Health and Deaf People* conference hosted by Deaf Victoria in 2015. These best practice guidelines provide mental health practitioners with examples of how to improve communication and awareness of deafness, including:

1. Talk to the interpreter before you meet in person about your experience or lack of experience of working with interpreters. Ask the interpreter about their experience of facilitating mental health assessments.

2. Request all previous, if any, psychological, psychiatric, correctional and educational assessments.

3. With the client's consent, talk to relevant caseworkers, doctors, teachers, parents and extended family members to gain as much information as possible about the client's general functioning and their communication strengths and weaknesses.

4. Be aware that most psychometric assessment tools are not standardised for deaf populations. To avoid misdiagnosis, liaise with your local Deaf society about ways to ensure your testing is relevant and accessible to the client, and conduct a literature search on psychological assessments of deaf persons.

5. On the day of the assessment, meet with the interpreter beforehand and discuss the nature of the assessment, the topics to be covered, the language to be used, and potential risks and sensitive information.
6. Set the room up so that you, the interpreter and the client have clear sight of each other. Ensure the room is well-lit and private from onlookers, and has good ventilation, comfortable chairs and a table at a height that is practical for all concerned.

7. Do not shout at the client; be aware of your facial expression at all times. Speak clearly and at an even pace. Regularly check in with the interpreter to see if you are speaking too fast or too slowly. Pay attention to your pitch and choice of language, as there are many words in the discipline of psychology that do not have an Auslan equivalent. However, having said this, a competent interpreter will bridge the gap by interpreting the meaning or intent of what is being spoken where necessary.

[6] https://www.deafvictoria.org.au/wp-content/uploads/2020/12/Deaf-Victoria-Deaf-Mental-Health-Report.pdf

8. Ensure that you explore with the client their experience of mental health assessment. Take time to build rapport and trust. Explain slowly and clearly what your role is and what you want to achieve. Explain why you have been asked to provide a psychological assessment. Ask the client if they have any questions before you start getting personal.

9. Explain to the client your experience in working with Deaf people. If it is extensive, this will greatly add to the client's sense of ease and comfort. If it is limited, be upfront about it. Ask the client to assist the process by seeking clarification and providing advice as to where you can improve.

10. It is essential to conduct a basic language assessment and explore how they best communicate, such as sign language, lip-reading, use of hearing aids, gestures, reading, or being oral (using whatever intelligible speech they have.) If they wear glasses, ensure they are wearing these during the assessment. If they are wearing hearing aids, check if these have been adjusted to suit the environment.

11. Explore the client's perception of their Deaf identity and sense of connection with Deaf culture. It is not uncommon for a deaf person to be uncomfortable about their deafness. When conducting a genogram, ask if they are the only deaf person in their family. Explore their Deaf role models. Explore whether other family members sign fluently. Explore how they communicate with their family members who are not deaf.

12. Explore their education in detail. It is not uncommon for a Deaf child to be placed in mainstream schools with hearing children. Ask whether they were subject to bullying or ridicule because of their deafness. Explore their social circle and if they have Deaf friends. Where did they go to school, how was their relationship with their teachers and who helped them with their homework?

13. If the client does not respond to a question or seems to be having difficulty comprehending, try to rephrase the message instead of repeating it exactly.

14. Avoid abrupt topic changes and explain when you are changing the topic or the focus of enquiry.

15. Use visual aids wherever possible. Have a large notebook and thick markers so you can write down key words to guide your enquiry. If the client cannot read at all, draw a picture in simple style. There are a number of pictorial cards that depict emotions, feelings, events and behaviours, which can be found on the internet. These learning aids are concrete, clear and highly visual.

16. Schedule breaks every thirty minutes and check in with the interpreter on how the client comprehends the information. Discuss with the interpreter whether your pitch and vocabulary are too high or too low, or whether you are talking too fast or too slowly. Explore with the interpreter whether they feel comfortable with the level of detail and whether there were any confusing or ambiguous questions or responses.

17. If it is a forensics interview, it is sometimes useful to explore details of an offence after you have gathered information about social and development background: Deaf culture and

identity, psychosexual development, drug and alcohol history, suicide and self-harm behaviours, issues with aggression and violence, for example. This allows the client to feel they are being understood as a person, not as a criminal. On occasion, the client may not want to start the interview with the offence. In this situation, be guided by the client and then return to the offence after you have gathered all relevant background information, to clarify specific details.

18. Learn about a healthy psychological Deaf presentation in contrast to a healthy psychological hearing presentation. In general, it is uncommon for hearing practitioners to be exposed to a healthy psychological Deaf presentation, simply because the Deaf population is a minority in Australia. This exposure could occur through contact with various Deaf conferences and workshops provided by your state Deaf society or Deaf organisation. Learn about possible Deaf adolescent mental health issues, for example:

- Loneliness as a result of being left out of social interactions
- Social isolation
- Inferiority and feeling like a lesser person than hearing people
- Frustration from not being understood or listened to
- Aggressive behaviours
- Fear of rejection
- Low self-esteem
- Shame resulting from being taught to behave and act like a hearing child
- Depression and despair that life will always be a struggle
- Trauma from sexual abuse, rape, bullying or ridicule
- Poor self-expression because of overly controlling parents
- Sexual development problems from delayed, confused, and poor sex education, and Deaf gay/lesbian issues
- Suicide and self-harm – it is very hard to spot warning signals and there is potential for high incidence.

19. When formulating a diagnosis for a client, for example: depression, obsessive compulsive disorder, posttraumatic stress disorder; do not rely on the DSM-IV (Diagnostic and Statistical Manual for Mental Disorders) as it is culturally biased towards the Western hearing population. Misdiagnosis can lead to a number of problems including inappropriate treatment plans, inaccurate medication regimes, client confusion and frustration, and further trauma to the client. Inaccurate forensic assessments have the potential to significantly disadvantage the Deaf client. For example, overestimation of the risk of reoffending or overestimation of the danger to the community may see Deaf people detained in higher security cells unnecessarily and imprisoned for longer.

20. Learn some basic signs such as ‘Hello, how are you?’ ‘Would you like a break?’ ‘Toilet break?’ This will demonstrate to the client that you respect them and have taken a basic step to understand their language.

Other examples of best practice, indicated in Figure 1, include assessment of language use, communicative behaviour, and cognitive functioning, usually undertaken by a signing specialist; this is crucial to avoid misdiagnosis of mental state (Fellinger, Holzinger and Pollard, 2012).

Figure 1

Panel 2: Mental state examination of deaf individuals ideally undertaken by signing specialist

Appearance
Deaf people using visual communication modes (sign language, gestures) might give a misleading impression of being agitated. Nevertheless, some seem to be withdrawn or anxious, potentially because of a reaction to the inability to communicate with medical staff and so a result of the situation and not a symptom of a mental health disorder.

Affect
In sign language, facial expressions not only represent emotions but also have specific linguistic functions. Some problems such as low drive can be made clear by the clinician imitating the symptoms—eg, looking listless and apathetic. Judgment of whether the patient shows affect appropriate to the topic being discussed could be hindered by poor communication.

Thought
Language dysfluency might be wrongly believed to be a result of thought disorder. There is evidence that thought disorder often manifests itself in sign language in a bizarre quality and a meaningless repetition of signs. Signing to oneself might be a symptom of psychosis.

Cognition
Many deaf people have reduced access to information. Poor knowledge should never be attributed to low intelligence without proper assessment. In many cases, information from external sources about behavioural and language functions is helpful, but such outside information should not prevent the patient from being able to express himself or herself.

Recommendations

As a result of the *Let's Talk About…Mental Health and Deaf People*[7] conference hosted by Deaf Victoria in November 2015, several recommendations were made.

Recommendation 1 – Develop a community-based support model for deaf mental health.

Support for deaf and hard of hearing people in the current mental health system in Australia is lacking. Systems are designed for people who are hearing, and adjustments are not readily made for Deaf, Deafblind, and hard of hearing people who need mental health support.

It is recommended that:

- Research be conducted to identify best practice, community-based support models for deaf mental health support
- From data collected, deliver a report with key recommendations for the development of a community-based response to deaf mental health

[7] https://www.deafvictoria.org.au/wp-content/uploads/2020/12/Deaf-Victoria-Deaf-Mental-Health-Report.pdf

- Funding be allocated to support deaf people to become peer mental health practitioners, advocates and deaf interpreters.

Recommendation 2 – Develop training and support to increase the skills and awareness of communication support professionals working with deaf people within the mental health system.

Interpreting and communication support for deaf mental health is a specialised field. Interpreters who work in medical, legal and conference settings are required do undertake further training and professional development to work in highly complex and specialised institutions.

It is recommended that both training and continuous professional development opportunities be provided to increase the skills and awareness of interpreters who work with Deaf, Deafblind, and hard of hearing people receiving mental health support.

Recommendation 3 – Develop accessible resources for deaf people who are accessing the mental health support system.

Many available mental health resources, both printed and online, are inaccessible for people who are Deaf, Deafblind, or hard of hearing; accessible English versions and Auslan versions of resources are required. Online videos require captions and Auslan translations to be fully accessible.

Recommendation 4 – Develop training and awareness programs for mainstream mental health professionals to increase awareness of specific issues surrounding mental health support for deaf people.

There is an overall lack of awareness amongst mainstream mental health professionals regarding the needs of Deaf, Deafblind, and hard of hearing people and their mental health.

It is recommended that this be addressed through the development of training and resources to increase deaf awareness, as well as continued training and development to ensure mental health professional have current and consistent knowledge.

Recommendation 5 – Develop programs that focus on prevention through positive mental health activities and strategies.

It is recommended that programs be developed for Deaf, Deafblind, and hard of hearing people that focus on prevention and development of positive life skills and resilience through exposure to strong role models.

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