



**Queensland
Government**
Queensland Health

Deafness & Mental Health

***A Report on
the Mental Health Needs
Of Deaf and Hearing Impaired People
in Queensland***

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DEAFNESS & MENTAL HEALTH

A Report on the Mental Health Needs of Deaf & Hearing Impaired People in Queensland

EXECUTIVE SUMMARY

Although Europe and the United States of America have adopted appropriate mental health services for Deaf / hearing impaired people, the plight of this minority group in Australia still needs to be recognised. To date only minimal research into the mental health needs of deaf people has been carried out in Australia (Briffa, 1998; Dwyer, 1994).

This project was designed to identify the mental health needs of the signing Deaf, who are a culturally unique minority group, as well as hearing impaired people who form a much larger group throughout Queensland. As a result of this research major concerns have been identified relating to communication difficulties, the lack of awareness by health professionals of the issues related to deafness, the inappropriateness of services and the inequality of access to information and services for deaf people.

A survey questionnaire, focus group discussions and personal interviews were used to explore the experiences and concerns expressed by members of the Deaf community, hearing impaired people, carers, mental health professionals and other key support workers. One hundred and thirty-five people were included in this study who were recognised by health services, as being Deaf / hearing impaired and of these people one hundred and ten were identified as having a mental health problem.

Twelve key findings have been made in this report to address both short-term and long-term strategies to improve services for deaf people. An implementation plan incorporating these strategies to address the key findings has been drawn up as a separate document.

This project has, through a variety of methods, explored specific needs that were identified by consumers, carers and key support service providers relating to deafness and mental health. The needs of both the signing Deaf who have their own cultural identity and hearing impaired people have been identified. A number of concerns have been identified as a result of this research and it is anticipated that the key findings and strategies will improve the provision of services for Deaf and hearing impaired people in Queensland.

DEFINITIONS

Deaf – For this project, ‘Deaf’ with a capital ‘D’ is defined as a person who is hearing impaired and uses a sign language as a preferred language. They are usually congenitally or pre-lingually deaf and belong to the Deaf community.

Hearing Impaired - Defined as a person who is hearing impaired and who does not use sign language (eg. includes oral Deaf, acquired hearing loss after learning spoken language). Also known as hard of hearing.

deaf – ‘deaf’ with a small ‘d’ includes both of the above groups.

Australian Sign Language (Auslan) - Is the preferred language used by the Australian Deaf Community. It is a visual language, very expressive and has no written form. It is not English. Auslan is recognised as a ‘language other than English’ and people who use Auslan require an interpreter.

Teletypewriter (TTY) – A telephone used by deaf people who type their conversation which can be either read and answered by another with a TTY, or can be relayed through the Australian Communication Exchange (ACE) relay service, to a normal telephone.

Relay Service – A service provided by ACE to aid communication between deaf and hearing people. A third person (a relay officer) is used to relay this conversation using appropriate technical aids and voice.

INTRODUCTION

BACKGROUND

Research by the Commonwealth Department of Health and Aged Care & Australian Institute of Health and Welfare (AIHW) (1999) estimates that close to 1 in 5 people in Australia will be affected by a mental health problem at some stage of their lives. Queensland statistics from the Australian Bureau of Statistics (ABS) 1993, 1998 and 2000 estimates the number of people in Queensland living with impaired hearing in the year 2000 was 185,962 (5.2% of the Queensland population), of these people 6,677 (0.19%) have total hearing loss. Regarding these statistics, it is of growing importance that the specific needs of people with hearing impairment (either partial or total) be regarded when providing health services, and particularly services in the area of mental health.

Research surrounding the mental health issues of Deaf and hearing impaired people in Australia is minimal (Dwyer, 1994; Briffa 1999). In the study by Briffa (1999) special issues were identified relating to Deaf clients receiving treatment in mental health units in West Moreton and Brisbane South. The study focused on Deaf clients of mental health services who used sign language as a first language and who experienced serious mental illness. Multiple problems were identified by the Deaf clients, mental health professionals and interpreters, all concluding that the special needs of this consumer group are not being met by the majority of current mental health services.

This project has been funded by the Mental Health Unit, Queensland Health and is supported by Wolston Park Hospital and the Queensland Deaf Society (QDS). Primarily this project consisted of a mental health needs assessment and survey of Deaf and hearing impaired people, including consumers and non-consumers of mental health services throughout Queensland. The aim of the study was to:

- identify the needs of deaf people relating to mental health issues, focusing on awareness, access and appropriateness of services, and
- provide a plan to improve the services provided.

LITERATURE REVIEW

Prevalence of deafness

Queensland data on hearing impairment was difficult to confirm as prevalence differs from study to study. According to the Australian Bureau of Statistics (Disability, Ageing and Carers, 1993), the number of people with hearing impairment in Australia in 1993 was 999,800 (5.2% of the total population), with 35,900 (0.19%) having total hearing loss. As at June 2000, (ABS Demographic data) the resident population of Queensland was estimated at 3,566,350 (18.6% of the total Australian population).

Using the above information, the estimated numbers in Queensland of people with hearing impairment in the year 2000 would be 185,962 (5.2% of the Queensland population), with

6,677 (0.19%) of these having total hearing loss. Wilson et al (1992) found in South Australia the prevalence of hearing loss was much higher at around 19%. Information from QDS estimates the number of people with hearing impairment as approximately 10% of the total population.

As at July 2000 the number of hearing impaired clients over the age of 20 years seen by Australian Hearing Services (AHS) in Queensland was 105,242 (2.9% of the population) with 93,800 (89%) of these clients being over 60 years of age. This differs from ABS data (Disability, Ageing and Carers: Summary of Findings 1998), where 2.6% of the total population, with 1.8% *under* 64 years of age, have a disabling condition due to diseases of the ear. Estimated numbers in the year 2,000 of people suffering from disability due to hearing impairment at 2.6% of the population, would be 92,725. The estimated number of those in the age group 0 – 64 years would be 64,194 (1.8% of the total population).

It is not yet known how many signing Deaf people are in Queensland. Information from ABS (1993) data estimated that 6,677 people have total hearing loss in Queensland, and figures from the last survey carried out by Hyde & Power (1991) found that at least 2,842 Deaf people sign in Queensland. One assumption would be that the remainder may be deaf people who do not sign. Communication with a teacher of the deaf employed by the Education Department, revealed that of approximately 2,200 hearing impaired students currently attending schools in Queensland, only 500 use sign language.

The number of people with hearing impairment who may be affected by a mental illness is estimated at above 37,000 with 1,330 of these having total deafness. These figures have been derived at by considering the ABS estimates above for Queensland in conjunction with the National Mental Health Strategy, which states that approximately one person in five will suffer from some form of mental illness at some time in their life. Unfortunately, information on the number of deaf clients either in psychiatric hospitals or who access mental health clinics throughout Queensland can not be validated. Also there has been no study located within the Deaf or hearing impaired communities identifying their mental health issues.

Overseas Studies

Much research has been carried out over the last 40 years outside of Australia that focuses on the plight of the Deaf within the mental health area. There are a number of recognised areas of concern, including a lack of understanding of the Deaf culture and manual forms of communication; building a therapeutic relationship; inadequate interpreter services; and assessment and diagnostic dilemmas (Denmark, 1966, 1985; Iqbal & Hall, 1991; Steinberg, 1991; Steinberg, et al 1998).

Jones & White (1990) found that diagnostic tools for psychiatric assessment for the hearing were inadequate for the Deaf or hearing impaired. Although the Minnesota Multi Phasic Index (MMPI) has been translated into American Sign Language (Brauer, 1992) and the General Health Questionnaire (GHQ-12) into British Sign Language (Ridgeway, 1997) there are no psychiatric or psychological assessment tools translated into Auslan in Australia. However, some work on translating the MMPI into Auslan is being carried out by Rodrigues in New South Wales.

Ridgeway (1996), a Deaf Research Psychologist in Britain, used the GHQ-12 (Goldberg 1978) along with an 'Identity and Attitude' questionnaire in interviews with a sample of Deaf

people in the North West of England. It was used to gather information regarding the general mental health of this population. Exploratory analysis found that 38.1% of her sample had a positive score of six or more on the GHQ-12, indicating psychological difficulties. Gilhorne Herbst (2000) cites studies in which there is an association between acquired deafness and depression in both younger and older people.

Psychological and emotional trauma due to abuse has been recognised by Ridgeway (1996) and Kennedy (1996). Kennedy found that most of the Deaf survivors of child abuse seen by herself had previously been seen within the psychiatric system. Kennedy states that there are very few appropriately qualified counsellors for this group and only a small number of Deaf people working in the field. Austen & Klein (1996) reiterated these findings and discussed the benefit of accessing an appropriately skilled clinician and a Deaf counsellor for an incorrectly diagnosed Deaf client who, in turn, provided him with the appropriate cultural and linguistic milieu.

Some Deaf people have been inappropriately placed within the prison system and Ridgeway (1996) highlights the injustices relating to inappropriate provision of treatment. Hindley, Kitson & Leach (2000) found that Deaf offenders were often imprisoned or incarcerated in mental health institutions after committing very serious crimes when, for earlier minor crimes, they were 'let off'. This was either a result of pity felt due to their deafness or because it was less troublesome than organising an interpreter. The need for early mental health assessments and prevention strategies in this area was highlighted.

Lack of communication between staff and deaf clients can cause increased anxieties for both the clients and staff. Other problems that can also result may include; diagnostic difficulties (Denmark, 1966), misinterpretation, inappropriate nursing interventions and an inability to build a therapeutic relationship (Steinberg, 1991). Most articles agree that psychiatric staff who are trained in the culture and language of the deaf would be beneficial in providing quality holistic care for deaf clients (Denmark, 1966; McCune, 1988; Steinberg, 1991; Iqbal & Hall, 1991; Wright, 1992 and Briffa, 1999).

It has been reported that similar problems can occur with clients from non-English speaking backgrounds (Stolk, et al, 1998) and as a result a standard training package and policy promoting the use of interpreters has resulted in improved communication opportunities for these clients. There is no specific training package available for working with deaf people in Queensland. The Queensland Government Language Services Policy (1998), the Queensland Health Multicultural Policy Statement (2000) and the Queensland Health, Language Services Policy Statement (2000) all recognise that some deaf people may require interpreters to communicate with health professionals.

Australian Studies

Research within Australia regarding the mental health needs of deaf people is minimal. Dwyer (1994) in Victoria and Briffa (1999) in Queensland explored the perceptions of Deaf clients and their experiences within mental health services. Briffa (1999) reported that 23 Deaf people had accessed mental health services in West Moreton and Brisbane South, and of these people 15 had been assessed or admitted during the 12 months prior to interview.

Briffa (1999) explored the experiences of Deaf clients, mental health professionals and interpreters uncovering major areas of concern. Some of these issues included: inadequate

communication methods; staff and clients unable to build a good therapeutic relationship; mental health professionals having little knowledge of deaf culture and language; and interpreters having little knowledge of mental health issues and terminology. It was also identified that access to information was inequitable, as it was not written in a language easily understood by Deaf clients. Furthermore, there were no technical aids, such as the Teletypewriter (TTY) available in mental health areas. One of the safety concerns identified was the fire alarms in the health services, none of which were fitted with a flashing light, therefore, making them unsuitable for Deaf people. Other issues that were identified specifically related to the assessment and diagnosis procedures of Deaf clients.

Creedon (1996) in a response to strategic purchasing of mental health services for young people in South Australia highlighted issues faced by deaf people, which were felt had a direct implication on mental health wellbeing. Major issues also surrounded the family of Deaf and hearing impaired people, as 90% of deaf children are born into a hearing family where there is little to no capacity to communicate effectively. Other issues identified included isolation, poor education, social expectations (or the lack of), and the limited understanding by professionals of deafness and cultural factors within health or mental health services that appear to be 'isolating and disempowering'.

Chapman (1999) from the Victorian Deaf Society describes the need for a Deaf Support Team model, which is based centrally but provides a Statewide service. This model would include "a clinician with Deaf awareness, a deaf bilingual and bicultural mental health worker and two Auslan interpreters with mental health competencies". Currently in Queensland, there is no specialised support service for deafness and mental health.

Nonetheless, the Princess Alexandra Hospital (PAH) has been modified to be more 'deaf friendly' as a result of a project conducted by Susan Forster (1999). This project was entitled 'Access for people who are deaf or who have hearing impairments', and upon completion, resulted in the installation of appropriate technical aids throughout the hospital as well as appropriate staff education.

Summary

Many difficulties have been identified by Deaf and hearing impaired persons and those who work with them. It has been recognised that some issues related to deafness may have direct implications to mental health, such as: isolation, being born into hearing families, poor education and minimal professional knowledge of the Deaf culture and language. The study by Briffa (1999) in Queensland covered only the West Moreton and Brisbane South areas and focused on those Deaf people who sign and who were already accessing mental health services. Although numbers indicate that there would be more than 37,000 people with hearing impairment who would at some time in their life, suffer from a form of mental illness, no information is available on how many deaf people with mental health problems actually access services in Queensland. Furthermore, there is only minimal information on the appropriateness of mental health services provided to deaf people in Queensland.

This current study offers Deaf and hearing impaired people, as well as their family/carers and key support workers, the opportunity to share their knowledge of issues related to mental health services. A greater understanding of the requirements of deaf clients, and the needs of their family/carers, as well as a comprehension of service providers is crucial in enabling the provision of equitable and appropriate mental health services for deaf people in Queensland.

RESEARCH METHODOLOGY

DESIGN

The needs assessment of this project uses both quantitative and qualitative data. Data has been gathered from various sources and using differing methods such as the survey questionnaire, semi structured interviews and focus groups, enabled the researcher to use the method of triangulation (Polit & Hungler, 1993; Padgett, 1998) to achieve a comprehensive understanding of the area of deafness and mental health.

RESEARCH QUESTIONS

This study asks:

- ‘what are the identified areas of need in relation to deafness and mental health, with a particular focus on issues of ‘awareness’, ‘access’ and ‘appropriateness’ of mental health services?’ and
- ‘what strategies need to be in place to ensure equitable mental health services are provided to deaf people throughout Queensland?’

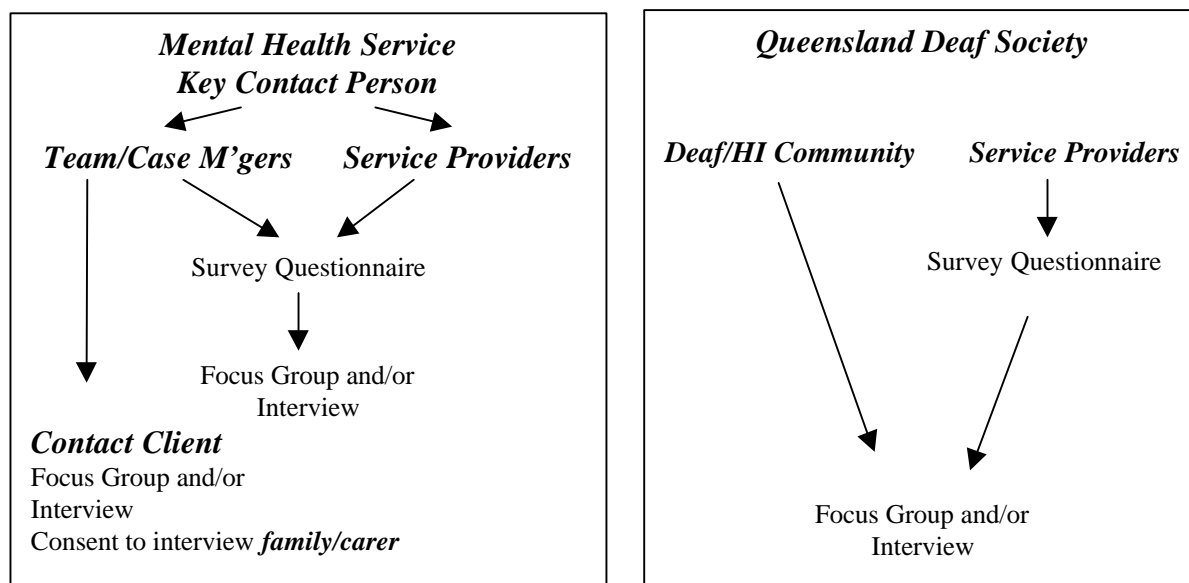
SAMPLE

Participants in this project included deaf clients of mental health services, members of the Deaf community and hearing impaired groups, family/carers of Deaf people with mental illness, key support workers from various areas/departments who worked with deaf people, and mental health professionals who worked with deaf people. All participants were selected with the assistance of staff from Mental Health Services and branches of the QDS (Table 1). This study was approved by the Human Research Ethics Committee within West Moreton Health Division.

Seventy-five (75) people consented to participate in a focus group and/or a semi structured interview. Twenty-five interviews were conducted face to face and two were conducted by telephone (Table 2).

Our client sample consisted of any Deaf / hearing impaired person who had either had an admission to, or been formally assessed in a psychiatric unit within the previous 24 months. As the researcher had previously carried out similar interviews with eleven Deaf clients in mental health services (Briffa, 1999), these clients were invited to participate in the focus groups but were not required to be interviewed again unless they wished to do so. Four of these known clients participated in focus groups. One new client was interviewed.

TABLE 1: SELECTION OF PARTICIPANTS THROUGH MENTAL HEALTH SERVICES AND BRANCHES OF THE QUEENSLAND DEAF SOCIETY



DATA COLLECTION

Data was collected via survey questionnaires, focus groups and semi structured interviews (Appendices A-G). Once analysis was completed, a workshop was held to frame key findings.

Survey Questionnaire

Thirty-five out of eighty-two service providers responded to the survey questionnaire, which requested information on deaf people who accessed each service. Survey questions surrounded the use of interpreters; the staff’s ability to sign fluently; the appropriateness of the service for Deaf and hearing impaired people, and any identified areas where the service could be improved for Deaf and hearing impaired people.

Focus Groups

There were nine focus groups held in various areas around Queensland, including Cairns, Townsville, Rockhampton, Toowoomba and Brisbane. Seven focus groups were organised with the assistance of branches from the QDS and the Far North Queensland Deaf Interpreter Service. These focus groups were comprised of Deaf people who were involved with the Deaf community. Many of the groups included Deaf people who had had a previous experience in dealing with mental health services. There were also two focus groups held with Key Support Workers, who were both Deaf and hearing.

Issues explored included deaf peoples’ awareness of mental health issues, access to information and suggestions for the improvement of mental health services for deaf people.

Interviews

Interviews were carried out with five people who had severe to profound hearing loss. Four were post lingually deaf and did not sign although one was learning Auslan. One was born Deaf and brought up orally, however, now prefers to use Auslan to communicate. One of this group had a cochlear implant. Out of seven mental health professionals interviewed, two had a hearing impairment, with one requiring a hearing aid. Neither communicated in sign language. Ten key support workers were also interviewed with eight being able to communicate in Auslan.

All interviews were conducted by the researcher and interview guidelines were followed to ensure the consistent information was gathered. Each participant was asked if the interview could be audio taped, if not, the researcher took notes with permission. The questions for the interviews all related to the participant's own experiences. The different definitions of 'Deaf' and 'deaf' caused some communication problems and concerns were acknowledged regarding access to and appropriateness of mental health services.

TABLE 2: INTERVIEWEES – GROUP AND DEMOGRAPHICS (N=26) (DOES NOT INCLUDE 2 PHONE INTERVIEWS)

<i>Interviewee</i>	<i>Sex</i>	<i>Av Age</i>	<i>Hearing</i>	<i>Hearing Impaired</i>	<i>Deaf</i>	<i>Auslan Fluency</i>	
						<i>Yes</i>	<i>No</i>
Client	1F	30			1	1	
Carers	2F, 1M	58	2	1			3
Deaf / Hearing Impaired Group	5M	50		4	1	1	4
Mental Health Professionals	4F, 3M	43	5	2			7
Key Support Workers	7F, 3M	37	8	2		8	2

Workshop

Once the analysis was completed, a workshop was held to discuss the findings, and was well attended by all stakeholders. The participation of all members assisted the process of framing key findings.

PROCEDURE

In order to gain an estimation of the number of deaf people who had mental health problems in Queensland, letters outlining the description of the study and requesting participation were sent to various groups and services. Mental Health Services throughout Queensland, General Practitioners, General Practitioners & Psychiatry, and the QDS were some of the services involved. Each service was asked to provide the name of a key contact person in each area, preferably someone who was responsible for the care of Deaf / hearing impaired clients. As a result of the concerns identified in the literature regarding deaf people in the justice system, a similar letter was also sent to Queensland Corrections.

The key contact person was then provided with information about the study and asked to disseminate the information to other staff and service providers in their area. Most importantly the key contact person was required to complete the survey questionnaire after discussion with their teams. They were also asked to speak to other service providers in their area who may have contact with Deaf / hearing impaired people, and who would be willing to complete a survey questionnaire. Follow up reminders for the return of survey forms was mostly done by e-mail, phone or directly from the researcher.

Deaf / hearing impaired clients of mental health services were contacted through the key contact person / Case Manager and given information on the study. They were invited to participate in a focus group and/or one-to-one interview by the researcher. An interpreter was used whenever necessary. If the client was with a family member or carer, then consent was requested from the client to also interview the family member or carer for the study. As only one trip was made to each of the major centres in Queensland, some of the clients did not have the opportunity to participate as they were unable to attend.

Deaf / hearing impaired groups were also contacted by branches of the QDS throughout the State. These groups were invited to participate as were key support workers / service providers from various agencies who had an involvement with deaf people.

The researcher ensured that all participants had a full written explanation of the study and where appropriate an explanation was also given using sign language. Confidentiality of all participants in the study was discussed and it was explained that any names or initials provided to the researcher would be replaced with a code number. Each participant was required to sign the consent form prior to participating in the study (Appendix I).

ANALYSIS

Thematic content analysis, as described by Burnard (1991) and Sarantakos, (1998) was the strategy used to interpret the data collected. All the information from the survey questionnaires was collated, and notes were taken from each of the focus groups. Each of the interviews was transcribed and re-read so that the researcher was familiar with the dialogue outlined in the transcripts. All statements were identified and evaluated and those appearing to be important and meaningful were related directly to the central questions within this study. The aim of analysing the information in this way was to find similar or contrasting themes occurring in the experiences of each participant. If positive experiences were recognised, reasons for these were explored. If problem areas were identified, feedback was requested as to how these could be rectified, and future plans were made to put these into place.

Assistance from the steering committee was necessary to minimise the potential of bias being introduced by the researcher, and to assist in the recognition of the need to use an interpreter (Sarantakos, 1998).

To ascertain the general health of the deaf people, all participants in this study (focus groups and interviews) were asked to complete a General Health Questionnaire GHQ-12 (Appendix H). Unfortunately, as a result of time limits the questionnaires were not translated into Auslan. However, where necessary, an interpreter was used for questions and answers. It became evident early in the project that the information gathered from the GHQ-12 could not be guaranteed as completely accurate.

During the first three focus groups, even with the assistance of an interpreter, many of the Deaf people did not fully understand what was meant by the statements and choice of answers. Clarification was continually asked for, and it was recognised from an interpreter that the use of 'double negatives' was a problem. It was obvious that interpretation of the tool was not easy, and it may not have been appropriate for some people in these groups. A decision was made to discard the GHQ-12. Ridgeway (1997) a Deaf Research Psychologist in Britain successfully used the GHQ-12 translated into British Sign Language; however, to her advantage she is fluent in the language herself.

The findings of the other data analysis were combined to provide an exhaustive description of the subject under study. To add credibility to the study, the final stage of this data analysis occurred in conjunction with the researcher consulting with participants, members of the steering committee and other key stakeholders during the workshop.

ETHICAL CONSIDERATIONS

To gain informed consent, the study was explained in sign language when necessary, as well as in writing to all prospective participants, as stated earlier.

The survey questionnaire completed by service providers requested basic demographic data on each of the Deaf / hearing impaired people who accessed that particular service. Due to the relatively small Deaf community and, as many deaf people access more than one service, the initials and date of birth as well as their postcode was requested to reduce duplication.

There are a few study limitations that need to be taken into consideration. Firstly, the researcher is not Deaf or hearing impaired; however, does possess reasonable signing skills. It was noted that the majority of Deaf people in the study displayed a positive attitude towards the researcher and were glad that someone working in the mental health area had signing skills. Secondly, an interpreter was used for eight of the nine focus groups, but was not used for any of the interviews.

RESULTS

The results will be displayed in the following order:

1. The Survey
2. Differences Identified Between Deaf and Hearing Impaired
3. Issues Identified Relating to Deaf People
4. Issues Identified Relating to Hearing Impaired People
5. Issues Identified Relating to Professionals and Other Key Support People

The focus for this mental health needs assessment was primarily on the issues of ‘awareness’, ‘access’ and ‘appropriateness’ of services, as identified by Deaf people, hearing impaired people, professionals / other key support people.

1. The Survey

Overall, the response rate to the survey questionnaire sent to service providers was fairly poor. Out of eighty-two survey questionnaires distributed, only thirty-five (42.7%) were returned, 17 of which were from mental health services. When the information was sent out, a contact person was requested and in most cases from the surveys that were returned, one was provided.

There was, however, the possibility of inaccurate information being passed on from service providers. An example of this occurred when a contact person supplied the details of a client for the study; however, when the researcher visited this particular mental health in-patient unit, three more clients were identified. The researcher requested further information about these clients from the service, although, even after reminders this information was not received.

Many reasons can be given for the poor response rate, which may include:

- no deaf clients in the service;
- contact person not knowing any deaf clients in the service;
- pressure of work among staff;
- poor appreciation of the problems associated with deafness;
- project not seen as important;
- deafness not ‘flagged’ on clinical records;
- deaf people not having mental health problems; and
- deaf people not accessing services.

Approaching services such as the QDS, the Far North Queensland Deaf Interpreter Service, Queensland Correctional Services, Health Centres and Private Practitioners for information, has also aided this project. Although some forms were not totally completed, any duplication of subjects has been identified and taken into consideration.

With research showing 1 person in 5 having a mental health problem at some time in their life, it could be reasonable to assume that at any time, up to 37,000 people with hearing impairment and 1,340 people with total deafness, may require services for a mental health problem. However, information obtained from the thirty-five responding service providers did not show such high numbers.

One hundred and thirty-five (135) people (77 males, 56 females and 2 unknown) throughout Queensland were identified by service providers as being Deaf or hearing impaired. One hundred and one (101) of these (59 males, 40 females and 2 unknown) were described as those who *do* have an identified mental health problem and are shown in Table 3. A further thirty-four (34) Deaf / hearing impaired people identified on the survey forms *do not* have an identified mental health problem or it was *not known* if they had a mental health problem. Of the 135 people, 88 were from the greater Brisbane area and Toowoomba, with 61 identified as having a mental health problem.

TABLE 3: CLIENTS IDENTIFIED AS HAVING MENTAL HEALTH PROBLEM, SERVICE PROVIDER AND AGE (N = 101)

<i>Provider</i>	<i>Under 20 yr</i>	<i>21 - 30</i>	<i>31 - 40</i>	<i>41 - 50</i>	<i>51 - 60</i>	<i>61 +</i>	<i>NK?</i>	<i>Total</i>
Mental Health	1	4	18	8	6	8	9	54
Community Health	3	1						4
Private		1	6	3	3	3	3	19
Corrections			2	1		2	1	6
Unknown	1	6					11	18
Total	5	12	26	12	9	13	24	101

The survey form also asked if an interpreter was used for the client, how often, and if the interpreter was qualified or a family member or friend. Of the 135 people above, 71 required an interpreter. For fifteen of these, the interpreter used was not qualified or was a family member or friend. Twelve clients never had access to an interpreter. Of these 12 clients, two had used a mental health service, one was in a Correctional Centre and the others were seen privately or the service provider was unknown (See Table 4).

TABLE 4: FREQUENCY OF USE OF INTERPRETERS (N=71)

<i>Interpreters Required for 71 people: Frequency of Use</i>				
<i>Never</i>	<i>Sometimes</i>	<i>Often</i>	<i>Always</i>	<i>Not Known</i>
12	41	6	10	2

2. Deaf, Hearing Impaired: What's the Difference

This report aimed to identify similarities and differences between Deaf and hearing impaired people. As stated earlier 'Deafness' was defined as using Auslan or another sign language to communicate and 'Hearing Impaired' related to those deaf who do not use a sign language to communicate. It has been recognised that the first group share a culture and language and

belong to the Deaf community whereas the hearing impaired group state that they belong to neither the Deaf or the hearing community. The latter group can include those born deaf and brought up orally or who have become deafened post lingually. However, it was also identified that much depended on the culture and attitude of the parents of the deaf person.

As one participant stated, *“I could have been placed within a signing culture context. I would have grown up totally signing. That’s the level of deafness I have physically, but culturally I’ve always worn very good hearing aids so I’ve coped as a hearing person to some extent”*. Another participant although brought up orally, chose as an adult to communicate in Auslan.

There appears to be negative connotations associated with deafness and sometimes also with the Deaf community. Some Deaf and hearing impaired people choose not to be associated with the Deaf community and although not identifying themselves as part of this community, they may still need to use the same technical aids that the Deaf people require. These include hearing aids, TTY, captioned television and flashing lights for the TTY and doorbell.

The Deaf people are seen by some of the hearing impaired group as happier, as they belong to a community with whom they can communicate and socialise. It is similar in comparison to any other group of non-English speaking people. The hearing impaired group on the other hand, see themselves as *‘caught in the middle’*, not belonging to the Deaf community because they do not sign, and not belonging to the hearing community because they are deaf. It was because of the large number of hearing impaired people in Brisbane having no support systems that the *‘Discovery Club’* was born. This Club is facilitated through the QDS at Newmarket and has been recognised as a great support for hearing impaired people.

Whereas the Deaf people use sign language to communicate and require an interpreter, the hearing impaired group use a variety of ways of communication. These include:

- lip reading;
- relying on residual hearing;
- using some sign language as well as speaking;
- siting closer;
- looking at people’s eyes and mouth more; and
- touching more to attract attention.

Many deaf people state that they do not lip read well. Even within the Deaf community, only about 30% lip read well enough to understand conversation (source QDS Information kit). Misinterpretation can happen and both hearing impaired people and Deaf people will often nod, to avoid appearing foolish.

The use of signs to assist with communication can be most beneficial to the hearing impaired person who knows sign language and who speaks well, although one participant identified difficulties when interpreting for a person who required signs to receive information, but preferred to communicate verbally when conveying information. This person was difficult to understand and often, due to limited English language skills, spoke in *‘deaf language’* which to the hearing person who is not familiar with sign languages, can sound illogical and unstructured.

One interesting finding in this project has been the various modes of communication that are used in both groups, and that Auslan is not used by all Deaf people. In fact those people who are isolated from the Deaf Community may use only basic 'home signs' or use gesture to try to communicate.

Some participants had experienced negative connotations associated with deafness / hearing impairment. With regard to the education of youth, one participant stated that some deaf students believed they were unable to achieve or do certain things because of their hearing *problem*. The students tended to think 'I'm a problem' or 'I've got a problem', whereas with a more positive association, the hearing impaired group may have had greater confidence in themselves.

Both the Deaf and hearing impaired group stated that there was a great lack of general awareness of communication issues related to deafness / hearing impairment within the hearing community. Sometimes if the hearing impaired person is not directly included in the conversation, only a word or two may be heard and they may wonder if they are being talked about, leading to the suspicion and paranoia. Both groups believe firmly that all health service staff need to be educated on how to communicate with deaf people.

Another major theme identified was the 'lack of identity' felt by those who saw themselves as neither belonging to the Deaf community or to the hearing community. This can result in presenting symptoms of anxiety and depression. Information relating to mental health problems associated with deafness, particularly post lingual deafness, along with suggested coping mechanisms would be highly beneficial to this group of people.

3. Identified Issues Relating to Deaf People

'AWARENESS'

Within the Deaf community and the hearing impaired people with sound command of the English language, it was recognised that there are a few well educated deaf people do have good knowledge of issues related to mental health and services available. However, more often than not, the vast majority of these people do not. Questions such as: '*What does mental health mean?*' and '*What does mental health problem mean?*' displayed clearly the lack of knowledge between the two meanings.

It became clear from the early stages of the study, that there was little difference in how the Deaf perceived 'mental health' and 'mental health problems'. Most of the identified meanings related more to the problem area. As an example, most groups listed '*crazy*', '*depression*', '*stress*', '*violence*', '*life problems*' as meanings of 'mental health'. Some groups also listed '*breakdowns*', '*suicide*' and some of the major mental illnesses such as '*bi-polar*' and '*schizophrenia*'. One group stated that they knew what the names of some of the illnesses were, like '*schizophrenia*', but asked the question '*what is schizophrenia?*'

When asked what 'mental health problems' meant, most groups continued to add similar things and either the names of mental illnesses, or symptoms such as '*hearing voices*', '*unhappy*', '*confused*', '*drug addiction*', '*grief*', '*suspicion*'. Only some Deaf people from two groups stated that mental health may be positive things such as '*feeling confident*' and '*feeling happy*'.

Many of the participants in the groups stated that they weren't really sure whether their answers were right or not and also stated that many Deaf people when they saw the word 'mental' actually thought 'crazy'. Many Deaf also used the same sign for these two words, even though there are two signs used, one for 'mental' meaning 'of the mind', and one for 'crazy'. They stated that more education and information provided to the Deaf community would be helpful in decreasing the stigma and fear associated with the word 'mental', and increase their understanding of it.

One participant stated “*..the vast majority of deaf people in the community, I would be most surprised if they really understood depression for instance, what it was all about, and because of that I don't think they know where to go, how to articulate what it is they are experiencing and those two things get quite out of hand and they're very unwell. This is when they go to the doctors, but in the early stages, early intervention could assist them*”.

Many deaf people stated that they miss out on information simply because they are deaf. When a person is born deaf or deafened in the early years of life, they do not have the same incidental learning of hearing people. Because they do not hear, they miss out on normal conversations that the hearing community take for granted.

The first language of the Deaf community is Auslan, which is a visual language, not a written language. Auslan is not the same as English. English is usually a Deaf person's second language and many Deaf people do not have a good command of it. Those deafened in childhood, may also have this problem. In this study, some deaf people were identified as using only 'home signs' and 'gestures' to communicate and did not know Auslan. These difficulties and the subsequent isolation that occurs with deafness may be reasons for deaf people having little awareness and understanding of mental health issues.

'ACCESS'

Key support workers reporting on their own experience, identified that there were many Deaf women who appeared to be suffering from depression but were reluctant to talk about it because of the fear and stigma attached. Deaf people themselves stated they're reluctance to talk about mental health problems in case others thought they were crazy. One Deaf interviewee stated: “*We've heard a lot of stories about Deaf people being locked up and hidden away*”. Some Deaf people were also reluctant to discuss problems with anyone, including their doctors.

In many instances it was recognised that Deaf people are usually in crisis before help is sought, especially in areas where early prevention strategies could have assisted them. For some, the police were involved usually when a warrant was served under the Mental Health Act 1974 Section 25, or under Section 26. This is when a police officer finds it necessary to take a person believed to be mentally ill and a danger to him/herself or others, to a place of safety. Unfortunately, this serves to confirm the fears a lot of Deaf people hold, as expressed above.

As there are no specialised mental health service for deaf people in Queensland, many barriers currently exist for any Deaf person presenting for assessment or admission to mental health services, in addition to the barriers that exist for the staff in the provision of care. Furthermore, the majority of staff do not know how to sign and for many Deaf or hearing

impaired, their English language skills may not be sufficient to fully comprehend in writing what is occurring. There is also a fear by the Deaf person of misinterpretation of what they are trying to communicate. Added to this is the fact that many of the Deaf do not know of their right to request an interpreter. Disempowerment of deaf people in the past may also prevent them from requesting an interpreter, even those clients currently accessing mental health services stated that they may feel reluctant to ask for one.

Once again information and education within the Deaf community was seen as necessary to increase knowledge and decrease fears.

The following two cases identified in this study show a great need for mental health promotion and prevention strategies, as well as appropriate early assessments. (*Names have been changed.)

- Jane*, a young Deaf person in her early twenties and living independently, was displaying strange behaviour for a period of four years prior to being seen by a mental health service. The service had been contacted earlier but Jane had refused to see them. The service became involved only after a warrant was arranged when the situation became life threatening for her. She had become reclusive, never leaving her home to purchase food or to pay for the telephone and electricity. Her phone and electricity were cut off. Her front door was locked with no flashing light to show if anyone was there, and those people who were trying to support her were not able to have regular contact. It was noticed that she was losing weight rapidly, leading to one person contacting the mental health service again and a warrant was organised.
- Peta*, a young Deaf person in her early twenties was living with her family. She was displaying strange behaviours recognised by parents for a period of over 6 years. Contact had been made with a mental health service where client and family were seen by mental health worker and psychiatrist without an interpreter. Her strange behaviours such as signing to herself, were blamed on deafness. The parents stated “*We tried to get (community mental health worker) to see her behaviour, even saw him and a psychiatrist the second visit, but never saw them again. They said the problems were related to deafness....*”. Much later, an interpreter recognised that the person was delusional and contacted the mental health unit, where once again a warrant was required as the Deaf person refused to attend. As the interpreter went with the police to explain everything to the Deaf person, the interpreter was seen as the instigator and the Deaf person refused to communicate with that interpreter. In an area where interpreters are too few, this is an unfortunate situation.

When the participants were asked about the information they had seen on mental health issues, many of them asked ‘What information?’. Most Deaf people did not have access to information on mental health issues and if they did, it was not understandable to them. Also information provided to the hearing community, such as ‘awareness’ advertisements, were not captioned or signed, thus, not allowing this information to be accessible to deaf people. Many also stated that some interpreters were not proficient in signing for mental health areas and even with an interpreter, some people still found it difficult to understand.

Currently there are no mental health promotion or prevention workshops provided by mental health staff within the Deaf community.

‘APPROPRIATENESS’

The Deaf people stated that most health professionals required education on issues related to deafness, such as how to communicate effectively with the Deaf, and to increase their knowledge of the Deaf language and culture. It was made clear that the Deaf people surveyed would prefer to have Deaf mental health professionals such as psychologists and nurses, support workers and case managers. It was suggested that a ‘Referral Centre for the Deaf’ be established where Deaf people would feel more comfortable knowing that their deafness would be understood. This was seen as a long term goal. Until then, they expressed a need for mental health professionals to become more knowledgeable of the Deaf culture and language as well as to improve their communication skills with deaf people.

Deaf Community Access Workers with a knowledge of mental health issues were also deemed highly necessary, to liaise with the Deaf community and mental health units. They could provide information and education on issues related to deafness to service providers as well as to assist Deaf people gain greater knowledge and awareness of mental health issues.

A hearing person who needs counselling or some assistance can usually phone up a service. Most services do not have a TTY for the Deaf. The Australian Communication Exchange (ACE) relay service can be used, but it means going through a third person, and deaf people expressed concern about confidentiality. Some Deaf people were also apprehensive about using a TTY with a hearing person who has little knowledge of the ‘Deaf language’. Many Deaf people stated that they prefer to use a fax and some now use the mobile phone short message service (SMS) but these are inappropriate for counselling.

To improve services for deaf people, technical aids such as flashing lights, personal listening devices, loop systems and appropriate interview rooms need to be provided. To illustrate this further, Briffa (1999) found that during a fire drill, a Deaf person was left in the mental health in-patient unit, as the fire alarm was not fitted with a flashing light. A carer of one of the Deaf participants stated: *‘they had a fire drill in the in-patient unit and XXXX was left in the room. If it was a real fire, he would’ve died.’*

It was found that Deaf people in hospital feel more isolated than hearing people, as there is rarely any one who signs. Interpreters are generally used only for doctors appointments, and not for the every day contact on the ward.

The following case studies of Deaf people who have been seen at mental health service, identify some concerns regarding follow-up care. (*Names have been changed.)

- Bob* is a Deaf man in his thirties with a diagnosis of schizophrenia. He became non-compliant with medication leading to a relapse. His family contacted the mental health service to express concerns, but his Case Manager was on holidays and no one else had taken over the role. A doctor’s appointment was made. At the appointment, a family member who is the main support for the client and who was also very concerned about his symptoms becoming worse, was present and able to describe what was occurring. As no interpreter had been arranged the doctor chose to wait until the following week to re-assess the person with an interpreter. The family member was upset and did not feel supported, as he knew that Bob was really quite unwell and he did not know how they would get through another week. The following week Bob who was at this stage very psychotic, was hospitalised.

- Danny* is a Deaf man in his forties who also has a diagnosis of schizophrenia. He missed an appointment for his depot injection and was not followed up. Almost a year later, Danny was recognised as being delusional by a support person fluent in Auslan. Danny agreed to seek help, but only from a previous Case Manager at a mental health service that he had previously attended. The Case Manager could not see the client as he no longer worked in that catchment area. An appointment to see anyone at this service could not be made for a month. To seek help, the support person needed to take Bob to another area for assessment. The support person felt alone in trying to convince Danny to go for assessment. The support person then went with Danny to the mental health clinic for assessment, where they waited 5 – 6 hours before being seen. Danny was hospitalised for many weeks following the assessment.

Other situations have been recognised in the past where Deaf consumers have not been provided access to an interpreter, and as a result they have been incorrectly hospitalised in a mental health services, or have not been able to comprehend the medical procedures that have taken place. One of the key support workers interviewed gave this account:

'He used to go to the doctor every few days to have his blood pressure checked because it was so bad. He didn't understand about it because an interpreter hadn't been there to explain it to him. One day when I visited he asked me if he had AIDS. He thought he had AIDS because they kept taking his blood, and I said to the staff he needs to have an interpreter when he goes to the GP, and they said 'No the GP writes it down it's fine.' And it's not fine.'

Another similar scenario occurred when the parents of a Deaf person made an incorrect referral to a Mental Health Service because of their child's uncontrollable behaviour. This change in behaviour was later found to be due to the adolescent trying to become more independent. No interpreter was initially called in as the parents were provided with information, although they could not sign. Again the Deaf person's opinion was not heard for many months until an interpreter was eventually requested to attend.

SUMMARY

The Deaf community's need for greater understanding of mental health and mental health problems has been identified, as has the need for interpreters in assisting mental health professionals in all aspects of service provision for Deaf clients. Deaf people also require information in a language understandable to them, as well as their rights to an interpreter. They require equitable and appropriate access to services and a safe environment. In addition, mental health professionals require training to work more effectively with deaf people.

Any information provided to the Deaf people needs to be done in an appropriate way, to increase their awareness and knowledge of mental health issues and perhaps also assist in decreasing the fears associated with the term 'mental'.

4. Identified Issues Relating to Hearing Impairment

‘AWARENESS’

For many in the hearing impaired group, the mental health problems were identified as relating to their deafness. They spoke of a sense of loss, depression, decreased self confidence and anxiety with regard to their hearing loss. There was an identified need for a booklet to be produced on the emotional problems that may be encountered due to deafness, which may also contain appropriate coping strategies.

‘ACCESS’

Unlike those in the Deaf group who were identified with the more serious mental illnesses, many in the hearing impaired group stated that they believed people with hearing loss experienced more anxiety disorders and suffered from depression. Some of these problems were associated with life experiences, including parents attitude to the deaf child and to their child’s deafness, and choosing to have the child brought up orally rather than to learn Auslan.

Problems identified by the hearing impaired participants included:

- Loss of self confidence;
- Low self esteem;
- Depression;
- Greater anxieties than usual;
- Serious behavioural problems;
- Substance abuse;
- Suspicion and paranoia; and
- Feelings of isolation.

One testimony from a Hearing Impaired person who was interviewed told how isolating ‘*A lot of people get very introverted because, well I know my world is very, well I don’t really hear much, so I stick to myself pretty well, and that I don’t like*’.

Some hearing impaired people stated that when they tried to access a mental health service after attempting to get help elsewhere, they were advised that they should see a general practitioner or a counsellor privately, as they were perceived as not having a serious mental illness.

‘APPROPRIATENESS’

Some hearing impaired people tried counselling services and others were seen by the mental health service to no avail because the treatment was inappropriate for hearing impaired people and the counsellors had no knowledge of the problems associated with deafness.

A key support worker who was included in the study gave these details: ‘*most of the clients here do have mental health issues. They do. And they’re not being resolved.... We refer them to mental health services and I’ve gone there to the interview with them and given them (staff) the background, but they tend to treat them (hearing impaired people) the same as a*

hearing person. They give them ... stress management stuff and it says 'listen to music, sounds crashing onto the beach, etc'. It's not modified to suit deaf or hearing impaired people.'

For the group of deaf people who do not use sign language, some experienced relationship breakdowns due to behaviours such as direct eye contact, sitting closer, and touching to get attention. These were often seen as inappropriate within the hearing community.

Technical aids such as an audio loop system have been identified as a necessary part of communicating with deaf people in a group situation and a TTY is required for confirming appointments or messages. Recognition that a hearing aid does not make a deaf person hear as well as a hearing person was also thought important with this group.

A Deaf client who took part in the study recounted, 'When they see my hearing aid, they think I can hear the same as a hearing person'.

SUMMARY

The needs of deaf people who do not sign have been outlined. The major concerns identified are: inadequate communication methods and the emotional problems experienced by these people (ie anxiety and depression) related to their deafness. The education of staff and other service providers on issues related to deafness and hearing loss has been identified as a necessary strategy to improve communication and ensure that appropriate treatment is provided. Information on the emotional problems associated with hearing loss was also requested for the hearing impaired group, along with coping strategies.

5. Issues Relating to Professionals & Other Key Support People

'AWARENESS'

Some health professionals, especially those who have had experience working with Deaf clients, have a growing awareness of the problems associated with Deafness and mental health. However, this project confirmed previous findings that most mental health professionals did not understand issues related to deafness, such as culture, language and resources. This can also be said of many other health professionals.

Some personal experiences of deaf people in hospital demonstrated that staff have a minimal awareness of the needs of deaf people. Some of these experiences included:

- information about deafness not being passed on during handovers;
- a Deaf person being left in the room during a fire evacuation drill; and
- staff trying to communicate with a deaf person in the dark, and shining the torch on the patient's face instead of on their own face.

The Queensland Health Multicultural Policy Statement (2000) and the Queensland Health Language Services Policy Statement (2000) acknowledge that some Deaf people need more appropriate access to services through interpreters. During this project it was found that

many mental health staff were unfamiliar with these policies and were not aware of the Queensland Government Language Services Policy (1998).

‘ACCESS’

On the whole, most professionals who work with Deaf / hearing impaired clients appear open to learn about issues related to deafness. However, access to this information by way of professional development still needs to be established. Some staff have learnt basic sign language in their own time and at their own expense in an attempt to provide a better service for their client(s). This project identified only two staff members whose signing skills allowed them to communicate well with the Deaf clients. Neither of these however, were accredited interpreters.

Also confirmed in this study is the need for interpreters to have training in mental health. In addition, recognition of the level of language skills and use of signs other than Auslan was also recognised as a problem requiring much consideration on communication methods. One participant stated, *‘For interpreters there’s not enough training, so interpreters may inadvertently do things that are disadvantaging the patient. By that I mean if we as interpreters don’t know the language level of that patient, we don’t know a little bit about their illness,... we don’t always know whether their disjointed production of signs and syntax is normal or whether it’s because of their illness’.*

Because many professionals do not understand the Deaf language, the way a deaf person processes information, or their culture, this can all act as a barrier to provision of interpreters. Many times it was stated that an interpreter was provided for one appointment only, or for one appointment per month, but for subsequent appointments no interpreter is arranged.

One participant stated: *‘We didn’t have an interpreter for a while and it was very difficult. We’d write notes back and forth and it wasn’t 100% communication. I can write but like it’s grade 4 or 5 writing. One doctor wrote something down and he said ‘this is the problem’ and I couldn’t read it. I asked the nurse, very helpful She changed the language and made it a bit more legible and I could read that, and my father visited me and he said it’s different from the original transcript and the meaning has been lost somewhere ...’*

Communication breakdowns may occur as a result of professionals holding the following views / beliefs that:

- communication between themselves and the client is adequate;
- note writing conveys the full amount of information and is completely understood by both parties;
- Auslan is the same as English;
- family member’s interpretation to the client is adequate;
- interpreters are only required in specialist cases;
- deaf people can lip read adequately enough to understand the entire conversation;
- it is too costly to utilise interpreters; and
- interpreters are often unavailable at short notice, for example, in a crisis situation.

Accessing Case Managers and the inconsistency between Case Managers involved in managing a Deaf person's care was identified by family and key support providers as problematic.

An example of 'best practice' in Queensland was demonstrated at the Princess Alexandra Hospital (PAH) where the service has become more 'deaf friendly' through the provision of appropriate technical aids for deaf people and education of staff on deafness and communication strategies as part of their induction.

'APPROPRIATENESS'

Although interpreters were recognised as a valuable and essential component to any interview or assessment with a Deaf client, some additional problems have been raised even when interpreters have been used. These are:

- difficulties arising when specific symptoms were discussed with the client; and
- lengthy and in-depth information that needed to be conveyed to the client such as the Mental Health Act was also found to be extremely difficult.

In psychiatry, good communication is essential for any assessment. Clearly when people do not communicate in the same language there is a high potential for misunderstanding to occur.

Complications that were identified relating to symptoms of clients included:

- determining if the behaviour is illness related or deafness related;
- the clients misinterpretation of questions and comments, but nodding to cover up;
- communication issues in respect to semantics and understanding symptom related terms;
- a clients tendency to paranoid misinterpretation; and
- difficulties undertaking standard cognitive testing.

One staff member related the experience of not being able to communicate with a Deaf person, and an assumption was made that the person was mentally well. The Deaf person was not a management problem on the ward and the only way they communicated was when they signed thumbs up to staff. When the interpreter was used, the client was found to be floridly psychotic.

Another key support worker concluded that certain Deaf people who have never sought a mental health service for their problems, could be due to a 'lack of insight', which is common to many schizophrenic people. The key support worker stated: *'They don't see that they have a problem. They see everyone else as having a problem. Not themselves, so they then withdraw themselves from the Deaf community, and usually, when they withdraw themselves from the Deaf community they also tend not to use interpreters then either. So I don't know where they are or what they're up to any more.'*

In Queensland Corrections, four Deaf / hearing impaired people were identified as having a mental health problem. One of these people, who had been incarcerated for a lengthy period of time, only recently had the opportunity to more appropriate care by staff, as a result of working with the interpreter from the Deaf Society. It has been identified that psychological assessments used with Deaf people are inappropriate. Unfortunately, there is limited research

and information available in Australia to produce more appropriate tools. As a result of working closely with an interpreter, more appropriate assessments could be carried out.

Employing Deaf, hearing impaired or bi-lingual staff has been identified as a reasonable start to providing more appropriate assessments, support and treatment for this group of people.

SUMMARY

This section has identified issues relating to health professional's minimal knowledge of deafness, and the perceived barriers to accessing appropriate treatment by deaf people. Also identified were the difficulties related to symptomatology and appropriate assessments.

Promoting the use of interpreters, providing training for interpreters, educating mental health staff and other service providers on deafness and adapting services to accommodate the needs of deaf people were seen as essential steps to overcoming these barriers. Appropriately trained mental health professionals including those who are either Deaf or hearing impaired working with interpreters would be the ideal situation.

DISCUSSION

This research focused generally on Deaf and hearing impaired people with mental illness. As a result of its broad nature there have been limitations of this type of research identified. Some of these areas include the specific needs of Aboriginal and young people who are deaf.

A high incidence of hearing impairment has been identified within Aboriginal communities, and although not the focus of this project, some interesting information has been obtained. Some Aboriginal languages actually incorporate signs and although not able to communicate orally, the Deaf aboriginal person may be able to understand what is being communicated purely by the signs used. Their sign language is not Auslan. It was also found that some Deaf Aboriginal people attended schools for the Deaf, often returned to their own communities and never continued their involvement with the Deaf communities in major centres. Some of the Auslan signs used have been carried back to their own communities but often the Deaf person loses those skills through lack of use as other community members do not use Auslan. This may also happen with deaf people who return to rural communities and families who do not sign.

The specific needs of young people was another area that this project did not specifically focus on. However, there is a program entitled 'Step by Step – The National Mental Health Education Project for Young Deaf People', which is co-funded by the Australian Youth Foundation and under the auspice of the Victorian Deaf Society. This project received funding in 1999, and is particularly focused on promoting the mental health wellbeing of young deaf people.

Although this study identified deaf people with mental health problems in the Correctional Centres, the scope of this study did not enable closer investigation into the reasons for their incarceration. In looking at forensic psychiatry and deafness, Hindley, Kitson and Leach (2000:209) suggest that 'all deaf patients detained under any mental health law should have their detention and treatment reviewed by a specialist psychiatrist for deaf people as soon as practicable'. The researchers also suggest the need for better links between Departments and mental health services for the deaf, to provide more appropriate assessment and services for the deaf person. Although there is no specialist mental health service for deaf people, the increased need for improving links and partnerships with other sectors is emphasised.

Other limitations of the study may include the survey itself. When compared with information provided from other sources such as ABS it appears that the survey may well be incomplete. The reasons for this might include: mental health units not responding, 'deafness' not being identified, key contact people only providing information for their own service and not covering a larger area of service providers in the same area and verbal responses not being placed on the survey forms and forwarded to the project officer. A more complete survey would need to include larger amounts of face to face contact in all areas throughout Queensland. Even though the major centres in Cairns, Townsville and Rockhampton and areas in Brisbane and Toowoomba were visited, quite a few Deaf and hearing impaired people live in the rural areas which were not visited.

Many similarities have been identified between Deaf and hearing impaired people and people from Non-English Speaking Backgrounds (NESB). An appropriate service could be established to respond to the mental health needs of Deaf people as has been provided for NESB people. As a result of such a service, the cross cultural needs of these deaf people would be recognised and the provision of appropriate health care would be delivered.

The negativity of deafness within the hearing world and family issues such as poor communication, along with the isolation that deafness brings, are identified areas where there is great implication for mental health problems.

This project confirms some of the problems identified in earlier studies. These issues include: the lack of knowledge and misconceptions of the Deaf culture and language held by many mental health professionals; the small number of interpreters with mental health training; and the limited amount of information produced for Deaf people in an appropriate style. Added to this, is the lack of understanding from other service providers regarding deafness and the narrow view many deaf people have of mental health issues. It has become apparent that there are few, if any, mental health prevention and promotion strategies being employed within the Deaf community throughout Queensland.

A positive aspect of this research has been the interest shown by some case managers with Deaf clients, who are interested to learn basic sign language and generally find out more about deafness. However, reports from some consumers state that there has been inconsistency between case managers when they are provided, and they believe that many may learn sign language only to move on and not have contact with that Deaf person again. Similarly, follow-up care of the client in the community also needs to be consistent, and provided by staff who can appropriately communicate with the client. On some occasions Deaf people reported that they did not have a case manager and found that without follow-up care, major problems such as non-compliance lead to their readmission.

Generally, a family member, interpreter or support worker recognises that the person has relapsed, and not the mental health staff. This would indicate that there is a clear need for staff to improve their communication with deaf clients, either by becoming fluent in sign language which can take three or four years, or by working in partnership with interpreters from the Deaf Society.

Educating staff on the topic of Deafness, including the culture, language and recent policy initiatives in relationship to the Deaf community have all been identified as an important strategy in providing appropriate care to this community. Such education would be in addition to the Cultural Awareness sessions currently held on NESB and Aboriginal and Torres Strait Islander groups. The cross-cultural awareness sessions for each of the three groups could be conducted as part of an induction into the work place for new employees, as well as via professional development and performance enhancing programs for existing staff as a means of updating these staff of new information.

Some staff assume incorrectly that a deaf person can lip read clearly and read and write well, and therefore, assessments are carried out using these modes of communication. This is often more time consuming than working with hearing clients, much more tedious and certainly not appropriate. It is recommended that education is carried out including information on how

best to communicate with deaf people, together with contacts and resources which would be beneficial for all service providers.

It has been recognised that interpreters are not always provided at health services or may not always be available when required. In some hospitals, a list of bi-lingual staff is maintained. Under the Queensland Health 'Non English Speaking Background Mental Health Policy Statement' (1995) these staff members are encouraged to gain accreditation through National Accreditation Authority for Translators and Interpreters (NAATI) and are called to assist clients when required. It is suggested that a similar approach be adopted for those staff fluent in Auslan. For legal and safety reasons, policy also needs to be in place reflecting the role of staff members in an interpreting situation. Protocols and guidelines within the mental health area are also required and which would need to be clarified between the person interviewing and the interpreter prior to the assessment commencing.

Although valuable, the course at Southbank TAFE on Mental Health Issues for Interpreters, may not cover all areas related to signing. A course conducted by Kris Chapman from the Victorian Deaf Society, is specifically designed for sign language interpreters working in the mental health area. It is often the experience of many years of working in the field of mental health that allows a professional to gain appropriate knowledge and experience. Similarly, interpreters' skills improve with years of working in that area. To ensure that Deaf people receive appropriate treatment, prior to there being skilled professionals specialising in the field of mental health and deafness, it is essential that mental health teams and sign language interpreters are committed to working together.

An important part of providing ongoing and appropriate care to deaf people who access mental health services, rests with Queensland Health's commitment to form partnerships with public sector agencies and other non-government organisations including the Queensland Deaf Society. Such partnerships would enable appropriate information to be shared and provide an opportunity for best practice guidelines to be established.

There are a number of groups that may also provide valuable insight into the difficulties people who are Deaf or hearing impaired, cope with. The Discovery Club is an important support group for hearing-impaired people, that was established to enhance the personal and social development of its members. Some groups such as the Richmond Fellowship in Brisbane, now employ staff who are fluent in Auslan to be Support Workers for Deaf clients who have been discharged into the community under the Project 300 scheme. The opportunity exists for mental health service providers to work with these groups and to provide information on identified mental health problems for any of their members.

Further research needs to be carried out on appropriate assessment tools for Deaf people. The development of an interactive computer program as suggested by Steinberg et al (1998) and Lipton et al, (1996) would be an ideal mode of communication for deaf people. However, it is also necessary to assess the level of signing skills each Deaf person may have and whether that person understands Auslan, or uses Signed English, home signs, domestic codes, or any other communication mode. Using today's technology and trialing such things as video-conferences with sign language interpreters is also suggested as one way to improve assessments for Deaf people in rural areas.

Clearly, further work needs to be undertaken to provide the most appropriate services for Deaf and hearing impaired people. In addition to this, the recognition needs to be made that

there are varying levels of need for people, for example people with minimal hearing loss, who can speak, read and write English would require a different level of service to those with moderate to profound deafness.

It has also become apparent that Deaf and hearing impaired people experience emotional problems that they believe only other Deaf and hearing impaired people can identify with. Unfortunately, there are very few counsellors or mental health professionals in Queensland who have a good understanding or can identify with these difficulties surrounding hearing loss.

SUMMARY

Although some services providers have begun to make improvements in their service to Deaf and hearing impaired consumers, many gaps still remain within the mental health area. Some of the difficulties that have been recognised relate to the Deaf community's lack of knowledge and understanding of areas pertaining to mental health, and the often-incorrect perception mental health professionals have surrounding issues related to deafness. In addition to this, it has been identified there is unequal opportunities for access to services and information by deaf consumers and when services are provided to deaf consumers they are often inappropriate. In conclusion, this research suggests key findings that are both short-term and long-term, thus facilitating a continuum to the most appropriate mental health services for deaf people, throughout Queensland.

KEY FINDINGS

It has been stated that the only way a comprehensive and appropriate service for Deaf or hearing impaired people may be achieved is through the development of a specialist unit in the mental health field, employing both Deaf and hearing staff who sign. Clearly this would be a long-term goal, however, even such a service may not guarantee that people in rural Queensland would have all of their needs met. Keeping this in mind, the following key findings have been prepared using approaches advocated by the National Mental Health Standards (1996) and the Second National Mental Health Plan (1998).

- Improve knowledge and awareness, and decrease the stigma attached to the word 'mental', via mental health promotion and prevention strategies. This would be achieved through education and information sessions made available to the Deaf community and to other deaf / hearing impaired groups.
- Provide information on mental health issues for Deaf people in their visual language, Auslan. If written information is provided, consideration needs to be made regarding the English language proficiency of each deaf person.
- Carry out training on the culture and language of Deaf people, and the communication needs of those deaf people who do not sign, for mental health and other health professionals. This training could be conducted as staff / professional development, in-service and/or tertiary studies.
- Produce a resource and information booklet for staff to accompany any deafness training.
- Increase the awareness of health professionals regarding the rights of Deaf individuals to have access to an interpreter, especially for assessments and reviews, where terminology symptomatology can be difficult to communicate effectively.
- Encourage mental health professionals who have knowledge of Auslan to work in conjunction with the QDS with regard to mental health issues. This would enable a forum for sharing information as well as provide the opportunity for professionals to improve language skills and perhaps work towards gaining accreditation as an interpreter.
- Increase collaboration between the QDS and mental health professionals so as to work with people who are hearing impaired. An opportunity currently exists to assist this group in developing a booklet on 'the emotional traumas of hearing loss and suggested coping strategies'. Mental health professionals may gain a better understanding of the needs of people with a hearing impairment, and the different communication strategies used by this group.
- Modify mental health in-patient units to be more 'deaf friendly' by installing appropriate technical aids, such as flashing lights, teletext TV, TTY and/or fax machines where inadequate.

- Modify community mental health clinics to be more ‘deaf friendly’ by the provision of an interview room with an audio loop system, TTY or fax machine where required.
- Conduct research into the adaptation of mental health assessment / diagnostic tools, for use in Australia specific for people who are Deaf / hearing impaired.
- Increase the number of mental health workers who are Deaf or hearing impaired, employed in health services throughout Queensland.
- Provide professional development opportunities for staff and Case Managers in mental health services to improve their communication skills, follow-up care and Auslan skills, thus increasing the effectiveness of their service to Deaf and hearing impaired consumers.

CONCLUSION

This report has identified a variety of mental health needs of Deaf / hearing impaired people throughout Queensland via a combination of qualitative and quantitative research methods. As a result of this research major concerns have been identified relating to communication difficulties; the lack of awareness by health professionals of the issues related to deafness; the inappropriateness of services for deaf consumers, and the inequality of access to information and services for deaf.

To ensure that the rights of deaf people throughout Queensland are taken into account in policy reform and service provision, particularly in the mental health field, twelve key findings have been compiled, and an internal working document has been produced as a means of progressing these key findings.

**SURVEY QUESTIONNAIRE
Deaf & Hearing Impaired
Survey & Mental Health Needs Assessment**

For this project, the following definitions apply.

Deaf – A person who is hearing impaired and uses a sign language as a preferred language.

Hearing Impaired (HI) – A person who is hearing impaired and who does not use sign language (eg. Includes oral Deaf, acquired hearing loss after learning spoken language)

What kind of service do you provide? _____

Do you provide a service to people who are Deaf or Hearing Impaired? **Yes / No**

If yes, please complete the following for each person. All information will be confidential, but to reduce the possibility of doubling up with people using more than one service, initials, date of birth and postcode would be helpful. If you need more space, please photocopy this sheet

Inits & DOB	Postcode	Sex	Deaf or HI (see above definitions)	Is an Interpreter used for service provided? Always, often, sometimes, or never	Who provides interpreter service? Yourself or Deaf person	Is interpreter a family member, friend or qualified from Deaf Society?	Mental Health Problems? Yes, No or Not Known	If yes, what diagnosis?

What specific problems related to deafness, if any, have you encountered? _____

How many staff do you have who are fluent in Auslan? _____ **How many are NAATI accredited interpreters** _____

What mental health services are provided in or to your area? _____

Are these appropriate for the Deaf and/or hearing impaired?

Yes

No

How can these services be improved for the Deaf? _____

How can these services be improved for the Hearing Impaired? _____

If you are not a mental health service, what more can the Mental Health Service near you do to help you in providing a better service for your Deaf and hearing impaired clients?

If you would like feedback on this project, please supply your name, address and contact numbers (email address if you have one) either on this form, or separately if you wish to.

Name: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

Please return this form to **Dianne Briffa** at either of the following addresses:

**Service Development
Wolston Park Hospital
WACOL QLD 4076**

**Qld Deaf Society
34 Davidson St
NEWMARKET QLD 4051**

FOCUS GROUP GUIDELINE

1. Welcome and Introduction to Project
2. Introduction of members
3. Consent form and General health questionnaire
4. Background information on the project - OHP
5. Depending on how large the group is, we will work as one group or break into smaller groups to discuss the following.
6. Issues to be address:
 - What do the words “mental health” mean to Deaf / hearing impaired people? (whole group?)
 - How can we make sure that Deaf people gain better knowledge (greater awareness) of mental health problems and services available?
 - What problems / barriers exist for Deaf / hearing impaired people in relation to mental health services – focus on
 - Access – phone, referral, fears
 - Communication
 - Information provided for Deaf / hearing impaired people
 - Staff who work mental health service
 - How can mental health services be improved for Deaf / hearing impaired people? (Summary with whole group)

GENERAL HEALTH QUESTIONNAIRE (GHQ-12)

*(Goldberg D.P., 1978)**Your Initials Only* _____ *Sex:* Male / Female *Date of Birth* _____*Are you:* Hearing / Hearing Impaired / Deaf (please circle one)*Your preferred language:* Oral / Sign language (please circle one)**Please read this carefully.**

We should like to know if you have had any medical complaints and how your health has been in general, over the last few weeks. Please answer ALL the questions simply by ticking (✓) the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past.

It is important that you try to answer ALL the questions.

Thank you very much for your co-operation.

Have you recently ...

1. been able to concentrate on whatever you're doing?	Better than usual	Same as usual	Less than usual	Much less than usual
2. lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
3. felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
4. felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less than usual
5. felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
6. felt you couldn't overcome your difficulties?	Not at all	No more than usual	Rather more than usual	Much more than usual
7. been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
8. been able to face up to your problem?	More so than usual	Same as usual	Less so than usual	Much less able
9. been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
10. been losing confidence in yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
11. been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
12. been feeling reasonably happy, all things considered?	More so than usual	About same as	Less so than	Much less than usual

		usual	usual	
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APPENDIX D

CLIENT INTERVIEW GUIDELINE

Deaf / Hearing Impaired Person who has used a Mental Health Service

Initials:

How long in mental health service:

Educational / Employment:

Diagnosis:

Sex: M / F

Age:

Born Deaf? Y / N **Level:** Mild Moderate Profound

If not, when became Deaf:

Reason for Deafness:

Language: Oral Auslan Signed English Cued Speech

1. As a deaf/HI person, do you see yourself as part of the Deaf community, hearing community or other?
2. Tell me about your family. Are they hearing / deaf? Do they sign? What is their sign language like? Would it be OK if I was to interview them as well?
3. Now I'd like to ask about mental health or emotional problems you have had, or might still be experiencing. How would you describe your problem?
4. Have you been told that you have a mental illness? (diagnosis)
5. Tell me how you feel about that?
6. When you first started having problems, were you able to talk with anyone about them? Who could you talk with? Who helped you the most?
7. How do you think the Deaf community feel about people with mental health problems?
8. Can you tell me about your experiences in relation to the following: (use prompts if necessary)
 - **Access to services** – Were you able to get help early? (any service, eg GP) Or does a crisis usually occur before help is sought?
 - **Communication problems once service is accessed** –How did you communicate with staff and others? what form of communication is used and is it appropriate and/or effective
 - Was an interpreter provided? Who arranged – you or staff? Feelings about using interpreters.
 - **Your understanding of mental health problems.** Is information provided in a way you understand – leaflets, what about videos in Auslan?
 - **Professionals – their understanding** of deaf issues, culture and language
 - What about your **involvement in treatment?** Do staff talk with you about your problem, medications, their effects and side effects, what will happen in the future. Tell me about

your experiences with staff (on the ward) (in the clinic) (home visits) – amount of contact, feelings

9. Have you ever been admitted to hospital for your mental health problems? When were you last admitted to a psychiatric unit OR when were you last assessed in a clinic/hospital?
10. Can you tell me why you were admitted or assessed? What happened just prior to you coming to hospital / clinic?
11. Do you think that because you are deaf, that you did not receive help earlier? Why is this?
12. Can you describe facilities the hospital / clinic provide especially for deaf people? (Do they have TTY, Fax, captioned TV, alarms that have a flashing light, interview rooms have loops for those who have hearing aids, how do you know when your name is called?)
13. When a Deaf or hearing impaired person is in a psychiatric unit, what do you think needs to be provided for them? Is this provided for them now?
14. Do mental health services need to be improved to make a deaf person's stay in hospital better?
15. When discharged from hospital, what kind of follow-up care is provided? Is this OK for you?
16. If you had one wish, what would you like to see for the Deaf community in relation to mental health services in the future?
17. Any more suggestions, or anything more you would like to tell me?

FAMILY / CARER INTERVIEW GUIDELINE

Name of Person:

Relationship to client:

Educational / Professional background:

Sex: M / F

Age:

Hearing / Hearing Impaired / Deaf

Language: Oral Auslan Signed English Cued Speech

1. As a carer of a Deaf person, what experiences have you had or do you have with Deaf / deaf/hearing impaired community?
2. Does _____ use sign language to communicate? Do you believe that you communicate well with _____ ?
3. As this project is to assess the mental health needs of both Deaf and deaf/hearing impaired, how would you describe _____ 's problem.
4. What made you start to think that something was wrong with _____ ?
5. Did you discuss these problems with anyone, trying to get help? Why or why not?
6. How did you eventually get help for _____ , or how did _____ eventually receive help?
7. I will ask you now if you can tell me of any problems identified by yourself, where _____ had problems either getting treatment or continuing treatment. We can look at the following areas to help guide you.
 - Access to services – Was _____ able to get help early? Or does a crisis usually occur before help is sought? What about help for you?
 - Communication problems once service is accessed – what form of communication is used and is it appropriate and/or effective
 - The Deaf person's understanding of mental health problems
 - Professionals – their understanding of deaf issues, culture and language
 - What about your involvement in _____ 's treatment
8. Thinking about the service provided now, where do the gaps lie?
9. How do you think that mental health services can be improved ?
10. What would you like to see with regard to MH services for the Deaf in the future?

11. Do you have anything else to add?

APPENDIX F

NON-CLIENT INTERVIEW GUIDELINE

Deaf / Hearing Impaired Person who has not used the Mental Health Service

Initials:

Received help for emotional problems?

If Yes For how long?

Diagnosis if any:

Educational / Employment:

Sex: M / F

Age:

Born Deaf? Y / N

Level: Mild Moderate Profound

Language: Oral Auslan Signed English Cued Speech

1. Tell me about your family. Are they hearing / deaf? Do they sign? What is their sign language like?
2. Can you describe what mental health means to you? Mental health problem?
3. As a deaf person, do you see yourself as part of the Deaf community, hearing community or other?
4. Now I'd like to ask if you have ever felt that you might have mental health or emotional problems. If yes - How would you describe your problem?
5. Have you been told that you have a mental illness? – If no, go to Q6
6. When you first started having problems, were you able to talk with anyone about them? Who could you talk with? Who helped you the most?
7. How do you think the Deaf community feel about people with mental health problems? What about your own thoughts about it?
8. Have you ever tried to get help for anyone else and not been able to? (If yes) We can look at the following areas to help guide you.
 - **Access to services** – Were you able to get help early? (any service, eg GP) Or did a crisis usually occur before help is sought?
 - **Communication problems** once service is accessed – How did you communicate with staff and others? Was an interpreter provided? Who arranged – you or staff? Feelings about using interpreters.
 - what form of communication is used and is it appropriate and/or effective
 - **Your understanding of mental health problems.** Is information provided in a way you understand – leaflets, what about videos in Auslan?
 - **Professionals – their understanding** of deaf issues, culture and language

- (Only if treated) What about your *involvement in treatment*? Do staff talk with you about your problem, medications, their effects and side effects, what will happen in the future. Tell me about your experiences with staff (on the ward) (in the clinic) (home visits) – amount of contact, feelings

(Only if admitted – Q9 to 15)

9. Have you ever been admitted to hospital for your mental health problems? When were you last admitted to a psychiatric unit OR when were you last assessed in a clinic/hospital?
10. Can you tell me why you were admitted or assessed? What happened just prior to you coming to hospital / clinic?
11. Do you think that because you are deaf, that you did not receive help earlier? Why is this?
12. Can you describe facilities the hospital / clinic provide especially for deaf people? Do they have TTY, Fax, captioned TV, alarms that have a flashing light, interview rooms have loops for those who have hearing aids, how do you know when your name is called?
13. When a Deaf or hearing impaired person is in a psychiatric unit, what do you think needs to be provided for them?
14. How can services be improved to make a deaf person's stay in hospital better?
15. When discharged from hospital, were you provided with a Case Manager who could sign? If not, how do you communicate? Is this OK for you?
16. What would you like to see provided in community that would improve mental health services for the Deaf or hearing impaired person?
17. Any more suggestions, or anything more you would like to tell me?

KEY INFORMANT INTERVIEW GUIDELINE 1

Community Spokesperson

Name of Person:

Educational / Professional background:

Sex: M / F

Age:

Hearing / Hearing Impaired / Deaf

Language: Oral Auslan Signed EnglishCued Speech

1. Can you tell me a little about your role in the Deaf / deaf/hearing impaired community.
2. Within this community, do you have many hearing impaired people who do not use Auslan, but perhaps are oral?
3. Are there differences between D & d? Can you please explain the differences between Deaf and deaf/hearing impaired? (numbers, language, education, employment, values)
4. As this project is to assess the mental health needs of both Deaf and deaf/hearing impaired, I will ask firstly, if you can tell me of any problems identified by yourself, where the Deaf have had problems. We can look at the following areas to help guide you.
 - Access to services – Do Deaf know where to go to get help early? Or does a crisis usually occur before help is sought?
 - Communication problems once service is accessed – what form of communication is used and is it appropriate and/or effective
 - The Deaf person's understanding of mental health problems
 - Professionals – their understanding of deaf issues, culture and language
5. Now we'll look at the same areas with regard to deaf / hearing impaired people.
6. How do you think that mental health services for this group can be improved ?
7. What would you like to see for mental health services for the Deaf in the future?
8. Do you have anything else to add?

KEY INFORMANT GUIDELINE 2
Mental Health Staff

Name of Person:

Educational / Professional background:

Sex: M / F

Age:

Hearing / Hearing Impaired / Deaf

Language: Oral

Auslan

Signed English

Cued Speech

1. Having a Deaf person as a client, what experiences have you had or do you have with Deaf / deaf/hearing impaired community?
2. What knowledge do you have of the Deaf culture, sign language, resources?
3. Does _____ use sign language to communicate? Do you believe that you communicate well with _____ ?
4. Do you know how _____ was referred to this service? Was a diagnosis already made or did you have _____ assessed?
5. Was an interpreter used for the assessment? Is an interpreter used for all visits?
6. I will ask you now if you can tell me of any problems identified by yourself, where _____ had problems either getting treatment or continuing treatment. We can look at the following areas to help guide you.
 - Access to services – Was _____ able to get help early? Or does a crisis usually occur before help is sought?
 - Communication problems once service is accessed – what form of communication is used and is it appropriate and/or effective – consider hospital / community care
 - The Deaf person's understanding of mental health problems
 - Professionals – their understanding of deaf issues, culture and language
 - Problems associated with diagnosis
7. Thinking about the service provided now, where do the gaps lie?
8. How do you think that mental health services can be improved ?
9. What would you like to see with regard to MH services for the Deaf in the future?

10. Do you have anything else to add?

WEST MORETON HEALTH SERVICE DISTRICT

**Consent Form
Survey & Mental Health Needs Assessment
Deaf and Hearing Impaired People**

A Survey and Mental Health Needs Assessment of people who are Deaf or Hearing Impaired has been funded by the Qld Health Mental Health Unit with support from Wolston Park Hospital and the QDS.

Deaf and Hearing Impaired people, family / carers, and members of organisations who work with this special group of people, will be contacted through the Deaf Societies and health services and given the opportunity to participate in this survey. An interpreter will be provided when necessary.

Why do this study?

- To find out a Deaf / Hearing Impaired person's understanding of 'mental health' and 'mental health services'
- Investigate issues related to mental health and 'awareness', 'access' and 'appropriateness'
- Gather participants' ideas on what is required

All interested people will be invited to participate in any or all of the following:

- a focus group – will take between 90 minutes to 2 hours with breaks
- a short 'General Health Questionnaire' – about 15 minutes
- an interview – 30 to 60 minutes with breaks if necessary. The interview will be audio taped if that is OK with you. Once information is transcribed the tape will be erased.

All information you provide will be treated confidentially. The information will be kept only with an identification number. As this is voluntary, you are free to withdraw at any time. If you would like to participate, please sign the consent below.

This project has been fully explained to me and I understand that any information I provide is confidential. I am happy to be involved in this project.

Your signature

Date

Project Officer

Date

Witness

Date

If you have any questions at any time, please contact Di Briffa on Ph: 3271 8838 or Fax: 3271 4008.

Independent Contact: If you have any complaints about the study you can contact the Ethics Officer, WMHSD Human Research Ethics Committee on 3271 8642 or 3835 9900 pager

72124. Email stevel@wph.uq.edu.au All complaints will be treated in confidence, investigated fully and you will be informed of the outcome.

ACTION PLAN

- (1) To publish and disseminate the project report as a first step in raising awareness of the issues which confront deaf and hearing impaired consumers of mental health services.
- (2) To adapt or develop a set of care standards to guide staff and consumers in a bench mark model of care for persons who are deaf or hearing impaired.
- (3) Provide funding for a lead agency to establish appropriate partnerships as a platform from which an information resource base and State wide information dissemination plan can be developed. The plan is to establish an information resource base and to develop a set of agency partnership arrangements through which a sustainable information dissemination plan to raise awareness of the needs of this consumer group can be implemented. The consumer issues pertaining to this group will also be raised within the Consumer Participation project, currently underway in the Mental Health Unit and the consumer outcome models being developed in the Systems and Outcomes Team in the Mental Health Unit.
- (4) To research the use of deaf and hearing impaired adapted diagnostic tools which may be in use in units which specialise in the assessment and treatment of deaf and hearing impaired persons who have a mental illness. To work through the Principal Adviser in Psychiatry position to determine implementation and training options within Queensland Health mental health service facilities to provide more effective assessment, diagnostic and treatment outcomes for this consumer group.

Develop, trial and evaluate appropriate assessment diagnostic tools for deaf and hearing impaired persons at an inpatient and community based Mental Health Services (MHS). It is also proposed to seek permission to adapt in whole or part the “Guidelines for Mental Health Services: working with people who are deaf or hard or hearing” already developed by the Victorian Department of Human Services. These guidelines would be used as an awareness raising and facilitative tool to improve outcomes for this consumer group.

- (5) Develop training modules, in consultation with Disability Services Queensland (DSQ) suitable for internal MHS and externally with non-Government organisations, to be incorporated into the professional development package for mental health staff as part of the disability module.
- (6) To ensure that accessible TTY facilities are available to this consumer group each hospital in each District could either:
 - (a) have a phone with a TTY facility.
 - (b) ensure there is a TTY phone accessible to all mental health inpatient facilities.

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