

Specialised mental health services for Deaf people

Introduction

This short document provides some background information and recommendations for discussion. It is hoped that specialised commissioners will be able to use this as the basis for commissioning in 2009-10.

Background

This document follows the convention of using a small "d" to refer to people with all kinds of deafness (e.g. deafened, hard of hearing, etc.) and a big "D" to refer to people who often see themselves as part of the Deaf community, defined by shared use of a common language, shared culture and identity. Deaf people are often profoundly deaf and have been from birth or a young age.

Nobody knows how many Deaf people there are in England. There is no national data set which collects the information. We can make an estimate, based on the screening of babies' hearing and on figures collected by local authorities.

The baby screening programme suggests there are:

- 1.1 babies/1,000 are born with permanent bilateral deafness
- 2.6 children/1,000 under 10-years-old will be deaf (40+ dbHL)

Local authority data suggests the number of deaf people in England is approximately 54,480 (Information Centre, *The number of people registered Deaf or Hard of Hearing year ending 31st March 2007, in England*). Both these methods are flawed for numerous reasons, but they provide a rough guide when planning services. The total number of deaf people will be high (one in seven according to RNID), but for Deaf people the old assumption of 1:1,000 is likely to be reasonable.

British Sign Language (BSL)

BSL is the preferred language for many Deaf people. There are various regional 'dialects' whereby signs differ greatly. This even extends to signs for numbers (e.g. six is signed differently depending on where you live).

BSL does not follow the same grammar as English. This means that written English is often, at best, an unheard second language. Hearing people learn to write by hearing words, learning to make the sound and then associating this with letters. For Deaf people written words are more abstract as they are associated with a sign. Consequently, the reading age of some Deaf people is low (Conrad, 1979). This is why providing materials in written English will often not work for Deaf people.

Incidence of MH problems

It could be assumed that the incidence of mental health problems within the Deaf community would reflect that of the hearing community. Unfortunately, this is not the case. Research shows that 40% of Deaf people are likely to experience a mental health problem, compared to 25% of hearing people. This is largely attributable to depression and is probably caused by social factors, e.g. isolation, poor family attachment, discrimination, reduced life chances, poorer socio-economic situation. Ninety per cent of Deaf children have hearing parents, but few of these parents learn to sign.

Research also suggests that the incidence of schizophrenia is roughly the same as for hearing people (approximately 1 in 1,000).

Specialised Services National Definition Set (SSNDS)

“Specialised mental health services for Deaf people” is included on the SSNDS because of the small planning population. In theory, Deaf people should be able to access services for physical health problems. But, because communication is so central to the assessment and treatment of mental health problems, the barriers within mainstream services are greater. This is why specialised mental health services have developed over the years, where staff have the skill and knowledge to communicate with Deaf people and have greater understanding of the cultural issues involved. Without these skills, there is evidence to suggest that mainstream clinicians will, for example, over-diagnose learning disabilities.

Recommendation one

SCGs should establish a group to support the commissioning of "Mental health services for Deaf people". This group should include Deaf people and should inform the SCG's commissioning of mental health services for Deaf people.

Recommendation two

SCGs should have a region-wide contract in place for specialist in-patient services. This contract could be negotiated in conjunction with neighboring SCGs – perhaps with one SCG leading on behalf of two or three others. (Carter, paragraph 60)

Recommendation three

Some SCGs develop a protocol governing how Deaf people are assessed and treated by hearing mental health services. This should ensure that basic standards are maintained, e.g. properly qualified interpreters are used, advice is sought from specialist services, etc. Reference should be made to the Mental Health Act Code of Practice. Some SCGs may be able to develop common standards and protocols on how Deaf people should be assessed and treated.

Recommendation four

If specialised community services for Deaf people are not in place, then SCGs should explore how Deaf people are currently treated and whether there would be a benefit in developing a specialist community service, as per the SSNDS. Possible models and further information

can be found in *Deaf mental health services: a guide to commissioning* (www.deafcommissioning.org.uk). If it is decided that developing a service is unnecessary then SCGs should be able to show how Deaf people will receive an equitable and appropriate specialist community mental health service.

Recommendation five

Commissioners work with colleagues in Scotland, Wales and Northern Ireland to improve co-ordination between countries – with particular focus on in-patient services. (Carter, paragraph 56)

Further information

There are other reports which contain useful information, such as the *Forging New Channels* (HAS), *Mental health and deafness: towards equity and access* (DH) and the homicide inquiries (relating to Daniel Joseph and Sarwat Al-Assaf). All can be found at www.deafinfo.org.uk

Carter, *Review of Commissioning Arrangements for Specialised Services*, Department of Health, May 2006