



Let's Talk About...
***Mental Health
and deaf people***

Shaping a better, stronger, supportive future



Mental Health and Deaf People
Let's Talk About... Mental Health and Deaf People
Conference 16–17 November 2015
Deakin University, Burwood, Victoria

Report by Melissa Lowrie and Gary Kerridge, Deaf Victoria

Executive Summary

On 16 and 17 November 2015, Deaf Victoria hosted the Let's Talk About... Mental Health and Deaf People conference at Burwood Corporate Centre, Deakin University, Burwood. The purpose of the conference was to apply a bottom-up approach to discussions of what is working and not working in Australia's mental health system for Deaf, hard of hearing and Deafblind people. These discussions have revealed the ways that Deaf, hard of hearing and Deafblind people are currently accessing mental health services.

This conference would not have been possible without the generous support of our conference sponsors:

- Mental Health Australia provided \$20,000 in a conference grant to support this conference.
- Deakin University provided the use of the Burwood Corporate Centre and its world-class audio-visual technology, free of charge.
- Vicdeaf, through Auslan Connections, provided heavily subsidised interpreting and captioning, as well as in-kind support.
- Deaf Children Australia, Able Australia, the Karli Health Centre, the Deaf Society of NSW and beyondblue all provided funds to assist with the plenary sessions. Deaf Victoria is most grateful for their support and looking forward to working with them further in the future to achieve the much-needed outcomes.

The conference centred on the Deaf/hard of hearing/Deafblind consumers of mental health services and their experiences in accessing the system. It was attended by consumers who are Deaf, hard of hearing or Deafblind, and a range of professionals from both the mental health and deafness sectors. Presentations and discussions allowed participants to learn from each other and provided information that was central to devising a plan of action.

The conference covered a wide range of topics, including but not limited to:

- Audism
- Domestic violence
- Alcohol and substance abuse
- Mental health in the workplace
- Suicide and self-harm
- Deaf Indigenous Australians and mental health
- Deaf youth
- Theoretical approaches.

The topics were far-reaching and encompassed the concerns of Deaf, hard of hearing and Deafblind people, children of Deaf adults and parents of Deaf children.

This report recommends the following five actions, based on the evidence collected at this conference:

1. Develop a community-based support model for Deaf mental health.
2. Develop training and support to increase the skills and awareness of communication support professionals working with Deaf people within the mental health system.
3. Develop accessible resources for Deaf people who are accessing the mental health support system.
4. Develop training and awareness programs for mainstream mental health professionals to increase awareness of specific issues surrounding mental health support for Deaf people.
5. Develop programs that focus on prevention through positive mental health activities and strategies.

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THE CONFERENCE

On 16 and 17 November 2015, Deaf Victoria hosted the Let's Talk About... Mental Health and Deaf People conference at Burwood Corporate Centre, Deakin University, Burwood. The purpose of the conference was to apply a bottom-up approach to discussions around what is currently working and not working in Australia's mental health system for Deaf, hard of hearing and Deafblind people. These discussions have revealed the ways that Deaf, hard of hearing and Deafblind people are currently accessing mental health services. The conference centred on the Deaf/hard of hearing/Deafblind consumers of these services and their experiences in accessing the mental health system. It was attended by consumers who are Deaf, hard of hearing or Deafblind, and a range of professionals from the mental health sector and the deafness sector. Presentations and discussions at the conference allowed participants to learn from each other and provided information that was central to devising a plan of action.

This report summarises the discussions and presentations held at the conference and makes recommendations for action.

The Steering Committee

The conference was led by a group of experts in their respective fields. The group also has strong links with the grassroots Deaf and hard of hearing community, and with organisations and services for Deaf and hard of hearing people, as well as the mental health sector in Victoria. The conference leaders included:

- Melissa Lowrie, Manager of Deaf Victoria leads the agency responsible for advocacy of Deaf and hard of hearing people in Victoria.
- Gary Kerridge, an expert in the disability field, is currently employed as the National Disability Coordination Officer at Deakin University.
- Dean Barton Smith, a leading expert in disability and mental health and current CEO of Victorian Mental Illness Awareness Council of Victoria.
- Karli Dettman, founder of Karli Health Centre and a qualified Deaf mental health counselor, specializing in Deaf counseling.
- Sandra Spadea, a deaf mental health worker, with a lived experience of the mental health system.

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Keynote Speaker

Deaf Victoria was pleased to host Dr Brendan Monteiro, who has been working as a consultant psychiatrist in the field of mental health and deafness since 1987. Dr Monteiro is from the St George Health Care Group in Manchester, United Kingdom. He has a special interest in the forensic aspects of mental health and deafness, and has been instrumental in setting up and directing forensic services for Deaf people in the UK.

Dr Monteiro presented to the conference as our keynote speaker on both days. On day one, he spoke on the concept of audism and its relationship to the mental health of Deaf and hard of hearing people. On day two, Dr Monteiro focused on the mental health system for Deaf and hard of hearing people in the UK, providing

¹'Deaf' with a capital letter refers to people who are culturally Deaf, engage with the Deaf community and use a sign language like Auslan; it is not capitalised when referring to the audiological condition of deafness. 'Hard of hearing' people have hearing loss, but do not identify with the Deaf community. 'Deafblind' people are those who are both deaf and blind.

examples of how a best practice model could be used and adapted here in Australia.

Dr Monteiro has worked and published extensively in the field of mental health and deafness, including:

- At least 5 Peer Reviewed articles.
- Contributing a chapter on deafness and communication in a book “Neurological Boundaries of Reality” (Farrand Press 1994).
- Lecturing extensively on topics related to Mental Health and Deafness in the UK, Europe, USA, South Africa, Japan and Australia.

It was an enormous privilege to have him with us at this conference.

Attendance and structure:

There were 160 people from all over Australia in attendance at this conference. The balance of Deaf consumers and carers to professionals was approximately half and half.

The first day of the conference was structured to focus on Deaf consumers and carers telling their stories and sharing their experiences in accessing mental health services under a number of key themes. The second half of the day consisted of eight separate plenary session topics, which are summarised throughout this report.

Day two focused on theoretical approaches to treatment and statistics in relation to Deaf/hard of hearing/Deafblind people, and professional development for those who work with Deaf/hard of hearing/Deafblind people who have mental health issues.

TOPICS OF DISCUSSION

Audism:

Dr Brendan Monteiro, a consultant psychiatrist for Deaf people with mental health issues in the United Kingdom and who has an international reputation in this field, presented on audism.

Dr Monteiro defined the concept of audism as a feeling of emotional superiority based on hearing status. This can be seen in two ways:

- Hearing people feeling and/or acting superior to Deaf people because they can hear and treating Deaf people with a negative or oppressive attitude.
- Deaf/hard of hearing people who use spoken language having a negative or oppressive attitude towards Deaf people who use sign language.

Dr Monteiro gave an example of audism in a mental health setting:

As a psychiatrist in hearing services I will expect people to come in with an anxiety attack, to be seen for maybe half an hour, an hour, be diagnosed, a bit of on-the-surface counselling and some sort of care plan going forward, maximum two to three hours, even if there is waiting time. From what I can see (from the Deaf person's experience in the same setting found in Anna's Story [page 7 of this report]), it was roughly thirty-six hours, and not only that, she came in with an anxiety attack and the process made her even more anxious. So the anxiety was sort of magnified. Ludo Timmermans did some research in Belgium published in about 2004–05: the average inpatient stay for hearing parents in psychiatric hospitals was four months; the average inpatient stay for Deaf people in psychiatric hospitals was seventeen years. So you can see the difference between that. I mean, this displays audism to the nth degree.

– Dr Montiero, 16th November 2015

Addressing audism in a mental health setting requires recognising that Deaf and hard of hearing patients have a hard time getting access to services and that this needs to be corrected. In order to assess anyone with a mental illness, communication is required.

Communication is a vital tool in psychiatry/psychology that enables understanding and promotes interaction between doctors and patients. Doctors assess, diagnose and develop treatment for their patients through communication. There are certain facts about deafness that need to be accepted. Deaf, hard of hearing and

Deafblind patients will not be able to function without some sort of environmental aid, be it an interpreter, captioning or a beneficial environment in which to lip-read. These aids are not a correction of deficiency, but a conduit to better communication. Without access to these aids, doctors and mental health professionals cannot speak to Deaf patients about their treatment plan or explain how to take their prescribed medications and any side effects of these medications.

Dr Monteiro estimated that the average assessment of a person may take one hour, but with a Deaf person requiring an interpreter it may take three hours, and also needs to factor in the cost of the interpreting. The reality of this is that it takes more time and costs more when working with a Deaf person.

Dr Monteiro noted that in general, services are hearing focused. This contributes to audism because the general view is that hearing services are superior. Instead of the hearing services adjusting to the needs of Deaf people, they expect Deaf people to adjust to meet the needs of the service.

Service providers often try to avoid the cost of interpreting. They try to fit an appointment that requires three hours into a one-hour time slot. Many Deaf people who go to hearing-based mental health services have said that advocating for themselves to access the services was far more stressful than having the mental health condition in the first place.

Dr Monteiro described the UK model. This model has three different services for Deaf and hard of hearing people. Awareness of these services is good and as a result, when a Deaf person presents with a mental health issue, general practitioners know exactly where to go for information and support.

Dr Monteiro gave an example of why the right advice and support are critical:

In 1987 when I started as a consultant psychiatrist, I would receive a letter from a GP reading something like: 'This deaf man has assaulted another person. He might be mentally retarded, schizophrenic or anything, please see and advise.' Literally what he had done is put the top of a tin can on another guy's head. They were having a fight after a few drinks. He managed to be closer to the can, otherwise he might have been the receiver. So this case definitely needed specialist counselling from a service that could provide professionals with Deaf awareness and sign language skills. So the attitude changed mainly because of exposure to services.

- Dr Montiero, 16th November 2015

This case of referral to a specialist is a specific example of best practice in a mental health service that is inclusive of Deaf and hard of hearing people.

Some other examples of best practice are:

- The use of interpreters who are experienced in mental health settings
- The development of community-based support to provide individual support and advice to mainstream services
- The development of training and awareness around designing and implementing Deaf mental health support.

Anna's Story: An Admission to Hospital with the help of a friend:

One night I had a severe anxiety attack. Having had a history of mental illness for a very long time, I knew I had to go to the hospital. I drove to the hospital and presented myself to the nurse there. I asked for an Auslan interpreter. I told her that I have severe anxiety and was having a breakdown. I told her I am having suicidal thoughts. We were writing back and forth on paper and she told me to sit and wait.

I sat there and waited in the waiting room for 30–45 minutes. My anxiety got worse and worse. I was on FaceTime [an app for video calls], signing to my friend. At 11 pm, I was then taken to a hospital bed and waited until the interpreter arrived. She arrived at 12.15 pm. I was amazed at how quickly the interpreter got there – it was only because my friend Andrew is an advocate and made some calls through his networks to make it happen. Everything went smoothly after that. By 2.30 am there was a plan in place for the morning – we agreed that at 10 am on Saturday, the doctors would visit me with an interpreter to discuss whether I could go home or have to stay in a psych ward. I was satisfied with this and went to sleep.

At 10 am the next morning, the nurse came in and told me that there was no interpreter available. So I had to wait even longer so they could source an interpreter for me to see the doctor. After waiting hours and hours, at 3 pm they admitted me straight into the psych ward with no discussion or anything. I panicked because I had not yet seen a doctor with an interpreter and this was not what I agreed to. I wanted to go home with special support. I texted Andrew for help.

I was still in Emergency at that time and had been there since 11 o'clock the night before. At 3 o'clock the next day, I am still in Emergency. I started to panic really badly and started machine-gun texting Andrew. In this state, I can text a hundred words per five seconds. I was very, very distressed. I couldn't calm myself down or face the doctor. In the end, Andrew sent me a text and asked me to show the text to the doctor. In the text, he had explained a few things: that I am Deaf and needed an interpreter, and not to try and diagnose me with anything, and I might not understand what was happening. He offered to help them find an interpreter for me. Andrew also asked that the hospital let me access wi-fi so that I could then at least get FaceTime on my iPad to communicate and was able to get an interpreter through that if I needed to. Dealing with Andrew, the hospital was really great. Hospitals are normally not allowed to text. But in this case they did text Andrew so that Andrew could give them the advice to help them get an interpreter.

By 7.30 pm, I had an interpreter. I was scared because I have never been to a psych ward. Up until then, I thought I was just suffering from depression. It was a Wednesday and the doctor told me that I should be okay to go home on Friday. However, they wanted to see me again the next day and would book an interpreter for 10 am. I asked the nurse later that day if they had booked an interpreter yet and the nurse said, "I need to check the website. It's a \$370 booking fee. I will do it at 8 o'clock in the morning, when they open". I started to panic again – I knew that two hours' notice to book an interpreter was not enough time.

The next morning, I was waiting in my bed at 10 am and the three doctors came towards me with no interpreter. I was just so tired from the day before. I started to get really upset when they tried communicating with me via pen and paper, and I wouldn't respond. They thought I was really angry, but I really wasn't. I was just so tired.

I had texted Andrew again and once again Andrew was texting the doctor asking them not to go any further, and he will come into the hospital at 1 o'clock and advise them of some way to work with [me] so he could help get interpreters in quickly. The doctors, again to their credit, were really good and they listened. After Andrew arrived and was able to secure an interpreter, I asked him to sit in on my counselling session. When the doctors asked a question that I found difficult, Andrew was able to explain things, particularly related to deafness, Deaf culture and interpreting access. The doctors really listened.

For the first time in a fourteen-year struggle, I was finally diagnosed with the right mental health issue and able to access the right treatment.

The system, it failed me. I had to use my friend Andrew and his networks to get access to what the hospitals should have known and provided in the first place. If it weren't for his help, I would have been in the psych ward for weeks. This just demonstrates that something needs to change.

Amandas Story- My struggle with mental health issues and raising a family with autism and deafness.

I was born in Canberra in the 1970s and I am the only person in the family of five who is Deaf. I was diagnosed profoundly at 18 months old. I was enrolled in a small school at the age of three and stayed there for four years. I was happy there, and was taught with both speech and sign language. Suddenly one day I was taken out of that school and put in a large mainstream school. Signing was banned, and I had to use my speech and the little hearing I had to communicate. I became an angry child, wild and out of control. Schooling and growing up as an oral child was enormously difficult.

At fourteen years of age, I was moved to Sydney and enrolled at a school with a Deaf unit. Seeing the Deaf students changed me. I no longer thought I would die. I used to cry myself to sleep because I was so afraid of dying, as I thought all Deaf people die young and I was the only one. I had dreadful social skills and it took me a while to adjust to fit in with my peers.

I endured a lot of trauma in my life that contributed to my downward spiral. I became a drug addict and had a drinking problem for many years. I was gang-raped as a young woman and tried to take my life three times. My great-grandfather sexually molested me when I was nine till I was eleven. I was angry and very depressed for so long and I had forgotten how to live.

I also fell pregnant at a young age and gave birth to a deaf little girl, Sophie. I had no support and was unable to raise her. The grief of not raising my child tore me apart for many years and it became unbearable when I hit rock bottom. Today she is a beautiful young adult and as her mother, I have reconnected with her and we are close. I am grateful for that. My daughter has ADD and suffers from depression too.

I struggled with depression since high school because of the bullying I endured every day. I had things such as drawings on the blackboard with 'Go back where you come from', [getting] locked up in lockers because I had a shrill scream [and] the bullies loved hearing me screaming. I got into endless physical fights and never really understood why. I hated the fact that I was deaf. My mother wouldn't talk about it, she wanted me to be 'hearing' and would tell me over and over that the Deaf community and Deaf people who sign are a bad influence and stupid. She said I was 'too good' for them, but I struggled with trying to be hearing and to be good enough for her.

After school, I moved out of home and enrolled at TAFE, where I found my freedom to immerse myself into the Deaf world. It changed me, and since then I found my identity as a Deaf person.

My relationship with my mother became toxic and dysfunctional. My mother is a wonderful person and many people love her, she is very kind and caring. However, the damage between my mother and I became too hard to be repaired. I could not continue to live feeling responsible for my mother's depression and sadness. I could not continue to feel that I was not good enough for her. I made the choice to cut the invisible string between my mother and I. It was the hardest thing I had to do.

I am glad to say I am okay now, I have been positive and living my life happy as I am for two years now. I learnt one thing – accepting yourself, as you are, Deaf and all, then it is easier to grow up as a Deaf person.

- Continued on page 36.

Domestic Violence

Debra Swann and Kate Frost, two Deaf survivors of domestic violence, presented on the topic of domestic violence, their experiences in getting help and the barriers for Deaf people.

Deaf victims of domestic violence often face unique circumstances:

- Information can travel quickly within the Deaf/Deafblind community, compromising confidentiality and the victim's safety.
- Law enforcement and shelters are often not skilled at communicating with Deaf, Deafblind or hard of hearing individuals, and often do not provide interpreters.
- The perpetrator may take away the Deaf person's communication devices.
- The perpetrator may give false information to the victim to make them believe they have fewer options.
- The victim may be isolated from family, friends, services, resources and options.
- Ringing a hotline is very difficult: the hotline counsellors often want to ring you back and won't email or SMS you due to the risk of the perpetrator finding the email or text.
- AVOs have to list a person's address; however, if the victim is Deaf, the perpetrator could attack when they are sleeping, because they know the victim cannot hear.

Some examples of what Deaf victims of domestic violence face and the tactics that perpetrators use to abuse Deaf victims are:

- Intimidating through gestures, facial expressions or exaggerated signs, floor stomping and pounding on the table or door
- Signing very close to a victim's face when angry
- Criticising the victim's sign language skills or communication style
- Not informing the victim when people try to call on the phone or try to catch their attention
- Excluding the victim from important conversations
- Leaving the victim out in social situations with hearing people
- Talking negatively about the Deaf community
- Wrongly interpreting so as to manipulate the situation if the police are called
- Not allowing their children to use sign language to talk with the victim
- Not allowing their children to be proud of Deaf culture
- Criticising the victim's speech and English skills.

Swann and Frost have three specific recommendations around tackling domestic violence for Deaf people:

1. Develop a website on domestic violence specifically for Deaf people based on the Deaf Hope International website in the UK. This website has resources in sign language and information that is easily accessible, and when you press the Escape key, the website will instantly change the computer screen to Google and erase any way of the perpetrator tracing back to the website.
2. Develop a school education program based on healthy relationships, domestic violence education, and what is and isn't acceptable.
3. Set up a 24/7 hotline for Deaf people in domestic violence situations that is accessible to all people; this could be in the form of online chat.

Mary's Story- Finding my voice

I have been deaf since I was six weeks old and had the measles. Living with my small amount of hearing and not being validated the way it should have been has led me to having a life of heartache, inner pain and a severe social phobia. I was brought up in a very dysfunctional and abusive family. I was one of six children and as the only deaf one, it was easy for me to become invisible. My self-esteem was crushed from a very young age and it wasn't until I was out of the abusive environment that I took myself to a doctor and told him I didn't think I could hear properly. Finally my hearing loss was taken seriously and from then on I have had hearing aids in my ears.

Of course this didn't undo the trauma I had suffered at home and at school because nobody understood why I never spoke and why when I did, it was a tiny whisper. I was forever being yelled at to speak up by my father. Life was a constant struggle with depression and anxiety but I was so young, I didn't understand these feelings. I knew there was something wrong with me because I wasn't like anyone else.

As an adult, my marriage and bearing of three sons was tough. After fifteen years of marriage, I ended up alone with my sons and trying to be mum, dad, friend and everything to them. I developed a severe eating disorder and depression. I wanted to disappear; I felt I was a burden to everyone, including my sons. I have had so many hospital admissions all over Australia, but have experienced some horrifying treatment and ignorance towards me because I was deaf. It was never taken into account that I was not just shy, I was deaf, and although I had hearing [aids], they never completely fill the gaps.

I am lucky to still be here. Many times, I have given up, but continued to seek treatment until I found the right one for me. I found a terrific psychologist who would speak up, face me, repeat herself without complaint and treat me as if I am hard of hearing, not deaf and dumb as I grew up to believe. I relied on writing as being my voice for a long time; now I am working very hard to find and use my voice again.

Today, I still struggle with severe anxiety and anorexia nervosa; however, I hope in time that I will beat this battle.

Alcohol and Substance Abuse in the Deaf Community

Debra Swann, a Deaf case manager with a lived experience of substance abuse, and Sandra Spadea, a person with a family member of lived experience, presented on this topic.

Deaf and hard of hearing people who abuse substances often face unique circumstances in accessing help, including the following:

- Deaf and hard of hearing people, as well as children of Deaf adults (Codas), are more vulnerable to substance abuse:

Commonly, Deaf people are at more risk of substance abuse because of lack of information. [We argue that] Codas are likely to be at a high risk also, because they're not aware.

– Debra Swann, 16 November 2015

- Alcohol Anonymous/Narcotics Anonymous/eating disorder groups are not eligible for funding of interpreters and captioning, therefore they are inaccessible to Deaf and hard of hearing people.
- There is very little information available in sign language or with added captions online for Deaf and hard of hearing people who want to seek help:

Mental health professionals need to try to imagine that they find themselves in another country and they struggle with drug and alcohol issues. They go to try and access services that are presented in a different language – a language that is not provided to you via an interpreter. The information will be meaningless to you, especially if you're feeling isolated and alone. That's how Deaf people feel in their own country; information comes that is meaningless and complex.

– Sandra Spadea, 16 November 2015

- There are very few trained professionals in the field of substance abuse who have knowledge about working with Deaf people, hard of hearing people, Deafblind people and Codas. Therapy sessions become about the patient educating the therapist about Deaf cultural issues, rather than treating the problem. Some Codas feel they are not able to access services because commonly mental health workers are more interested in the family dynamic and Deaf heritage so they ask questions about deafness, which means they aren't asking questions pertaining to the person's wellbeing or treating the person who is ill.

Some recommendations around substance abuse from Swann and Spadea are:

- Provide resources and information on drugs and alcohol in sign language and online.
- Provide funding for Alcoholics Anonymous/Narcotics Anonymous/eating disorder groups and other community-based support so they are able to provide interpreting and captioning support for their meetings.
- Carry out research into the effects of substance abuse on the mental health of Deaf people and Codas.
- Advocate for the provision of specialised training for Deaf and hard of hearing people, and people fluent in sign language, to become NA/AA support workers and counsellors.

Rachels Story- My CODA brothers struggle with addiction.

I'm Deaf and my parents are Deaf. I'm a big sister to a brother. We are one year apart in age and we share sign language as our first language. We are very close and my brother, Parker, was my best friend – he was always cheeky and made me laugh. He was very talented with basketball, football and cooking. He struggled at school, but he was amazing at expressing himself. He left school at thirteen after mixing with the wrong crowd.

We had moved to a new area and gone to a new school. He tried heroin and stole to feed his addiction. He ended up in a youth detention centre at the age of fifteen. As we got older, he would always socialise with my Deaf friend and I. He never saw us being different to him. He very much felt the same as us.

Parker spent seventeen years in and out of prison and always felt that he was misunderstood. When I was visiting him in prison at one stage, I asked if he was seeing a psychologist or counsellor. His response was they had no understanding of him and they asked too many questions about deafness. He felt that he shouldn't have to explain about deafness or explain himself. Parker was a Coda (Child of Deaf adults) and he felt that the Deaf language and Deaf culture was very much a part of him. They were always asking him about deafness, not about himself and his issues. He went for many years without access or support. The only information he received was through reading books or [watching] documentaries. I found it shameful.

When Parker was aged thirty-two, this was the longest time he had been out of prison and free of his addiction. In a horrible twist of fate, he passed away in an accident.

It's time for things to change for Deaf and Coda addicts. The needs of Codas have been ignored for far too long. I would like to see Deaf sector organisations put the needs of Codas firmly on their agendas. There needs to be more research into the mental health and wellbeing of Codas and their support needs.

Clara's Story- Forgiveness

Nine deaf boys sexually abused me as a young girl in a Catholic school over a number of years. I was also bullied by a couple of deaf students at the school. At the time, I did not know the word 'sexual abuse' while growing up. My language was underdeveloped and when I was at school in the 70s and 80s, there was no education on these issues. I also abused alcohol and had no idea that of the destructive and serious side effects of this. I blamed my troubles on the fact I was deaf and it took me a long time to accept my deafness.

Eventually my troubles led me to a number of suicide attempts, which saw me enter the mental health system. After a long time, I found a counsellor skilled in Christian counselling and [they] provided me with Auslan interpreter access. I have been seeing this counsellor for eight years and I feel I am a changed person. I am a much better, happier and healthier person without alcohol. I used to abuse alcohol to escape from anger, hurt and pain. I have been sober now for nine months; however, I struggle in times of heightened anxiety and depression.

Forgiving the nine deaf boys has been a very long process, but forgiving people who have hurt us badly is very healing and powerful, and really helps us to leave our sad past behind and move forward. A lot of people stay bitter and are stuck with their lives because they are not willing to forgive themselves and others every day or they don't want to see a counsellor. Daily forgiveness is very important for everyone, because it gives us peace, love and joy, and anger and bitterness can be very destructive for our mental and physical health.

I am able to enjoy life much more now.

Frasers Story- Growing up deaf in a small country town

I grew up in a small country town without any knowledge of sign language, therefore [I had] some communication problems. As a young teenager, I became frustrated, bored and confused, and this took me on a downward spiral to depression and binge-drinking. At the time I didn't know what 'depression' meant and drinking was just my way to cope with the bad feelings.

I ran away from home and drifted around all over the place to find myself. I finally settled down in Bendigo and started doing a lot of exercise – mainly swimming – and joined a church group. They stopped me drinking; however, it didn't last because I had no interest in religion. I found out that there was a Deaf club every Friday night in Melbourne, so I decided to go and check it out. I was shocked when I arrived to see them all signing to each other, and slowly but surely I started picking it up. However, I fell back in the trap and started partying with Deaf people and started drinking again.

Over time, my health got worse and my depression skyrocketed. The doctor tried giving me antidepressants, but I didn't understand the instructions for taking the medications as I couldn't hear or understand him at the appointment. I ended up taking too many tablets and found myself in hospital. The doctors there said that I needed to go to a detox program in Footscray to stop drinking and dry myself out. I have now stopped drinking; however, I was disadvantaged because Alcoholics Anonymous meetings do not have funding for interpreters or communication support. Recovery took longer for me because I couldn't access this service.

Mental Health in the Workplace

Stephanie McDonald was born profoundly Deaf, and utilises a cochlear implant and hearing aid. She has worked in a variety of workplaces including Allied Health, Disability Employment Services (DES) and IT industries.

Working full-time in these challenging roles with deafness was difficult, and caused some anxiety, high levels of stress and difficulty in coping with the large workload.

McDonald shared her experiences about mental health issues in the workplace for people who are Deaf/hard of hearing and how to maintain mental health in an effective way.

McDonald claims that a mentally healthy workplace is: “One that protects and promotes mental health and empowers people to seek help for depression and anxiety, for the benefit of the individual, organisation and community.”

McDonald noted that, according to beyondblue:

- 45% of Australians between the ages of 16–85 will experience a mental health condition in their lifetime.
- 21% of Australians have taken time off work in the past 12 months because they felt stressed, anxious, depressed or mentally unhealthy.
- It is estimated that untreated mental health conditions cost Australian workplaces \$10.9 billion annually.

Anecdotal evidence about mental health issues in the workplace for people who are Deaf/hard of hearing is presented in the Queensland Health report *Deafness and Mental Health (2008)*. The evidence indicates that when depression and anxiety are triggered for Deaf people due to their workplace environment, much of this stems from poor communication practices in the workplace. Poor communication leads to reduced opportunities for the Deaf employee, which has a significant impact on their self-esteem and wellbeing.

This report notes that:

Some barriers Deaf people face include communication issues, lack of accessible training opportunities, poorly defined career path, limited participation in the social milieu of the workplace and limited opportunity to engage with the public. Deaf people are often found to be overlooked for promotion and career enhancement opportunities, which can contribute to feelings of worthlessness leading to an array of mental health disorders.

– Queensland Health, *Deafness and Mental Health (2008)*

<https://www.health.qld.gov.au/metrosouthmentalhealth/deafness/docs/dmh-guidelines-4.pdf>

As a result of the *Deafness and Mental Health* report, the Australian Government established the National Mental Health and Disability Employment Strategy in 2008. The strategy aims to address the barriers faced by people with a disability and/or mental illness that make it harder for them to gain work and keep work. From this was created the Employment Assistance Fund, which helps to find and retain employment for Deaf and hard of hearing people.

However, these measures do not improve the social interaction or workplace experience of being a Deaf person in a hearing environment.

Carl's Story- A battle in the workplace

I have found myself employed as a disability expert advising the council on disabilities. Ironically, being a person that had to advise the council on disability access, I had difficulty getting the access that I required. The council decided in their wisdom that my access amounted to interpreters. And that was it. So in their minds, providing interpreters was enough. When you have a look at the whole system of how councils work, there are lots of things you have to do. I had to deal with departments, individuals and community organisations. One of the difficulties I had in working with the department was that they wouldn't commit to disability. Disability is not their core business.

They don't want to think about disability access unless they are forced to do it. For example, if I have a project with them on emergency management and advise them what they need to include to be disability accessible, they will eventually say it's too much for them and just simply stop responding to my requests. This happened with several departments.

I tried to get the council to come on board and meet [me] halfway. I can't have an interpreter with me all the time, so I have to do things in a different way, such as emails. Some people were very good with emails and others were not so good. What that meant was that there were often projects that I had to do that were delayed. My boss would be on my back to finish them. There was one particular project where I had to do an online survey. My boss took eleven months to get back to me with information I required, and every month she was telling me to finish it. I was saying to them that without the online survey, I couldn't finish the project and I was waiting on other people to respond to their emails.

One day I met with my boss and she said something that was really the responsibility of another department. I had been waiting on them for three or four months. She refused to understand what the issue was and said, 'Carl, this was left with you and this has been going on for eighteen months or so'. Now I'm a successful disability advocate and have been for over thirty years. I can handle myself. However, after months of this, I just couldn't take any more. It got to a point where she said, 'This was left on you'. I said to her, 'No. No more. I'm not wearing this anymore. That's enough', and I sat down at my desk and I was hyperventilating. Eighteen months of this. I got an email from my boss that said, 'Before you rudely stormed off ... I wanted you to forward me all of the emails that you sent to this particular person'. Now the thing was that my boss had been CC'ed to every one of those emails, so she knew what had happened. So I found all of the emails, fifty-one emails altogether, and I sent them to her. I replied, 'Deal with that'. And I was angry.

The next day, to cut a long story short, on my desk there was a letter of discipline. I took the letter, I went downstairs to meet with the Human Resources person as instructed. I walked in the door and I just sobbed. I bawled and sobbed. The Human Resources person was good and organised for me to see a counsellor. Having to see a counsellor at that point in time, I was lucky. I have extensive networks. I contacted a friend who is an interpreter, and within an hour [they] came to me and we went off to see the counsellor.

I was lucky, because I know most people don't have that luxury. If any other Deaf person had just broken down, most people don't have that luxury of calling somebody like I did. Over the weekend I basically just cried and cried and cried. By the Sunday, I said to my wife, 'Jenny, I can't deal with this on my own, I have to see a doctor'. The doctor was good but the problem was that Jenny, she is Deaf, and my doctor is not a person who can easily lip-read. My wife had to interpret for me. He did the normal thing. He offered me antidepressants. I didn't want that, so he gave me diazepam to calm myself down. Every day I cried. Everybody supported me, particularly my wife and three boys.

Then, over time, something else happened where I got a phone call from the police because I had smashed somebody's car. The mirror fell off and I didn't know. The policeman came to my house and then that was it. We were all distressed. It was the straw that broke the camel's back, trying to deal with what I call bullying, victimisation and all of that. I just broke down. I wanted to hit something. Not my family, but I was aiming at the wall. I could just imagine a big hole in the wall, to make me feel better just to damage something. I held it back. I was so angry. So frustrated.

In the end, my wife phoned Lifeline for me. I am lucky because I have good English through the National Relay Service, I could type back and forth with Lifeline and we had a chat. In the end we ended up in the hospital, and again my wife was the interpreter. I was in the hospital for about eight hours. At some point Jenny had to go home because the boys were on their own all alone. I was in there on my own. I had to face doctors, nurses and a social worker with cerebral palsy (which is not a problem, just very difficult to try and lip-read). I was distressed and crying, and it got to a point where communication and everything was really, difficult. I requested several times for an interpreter. Every time they said an interpreter will come, but it never happened once. Jenny had to continue interpreting for me and the stress on her was enormous.

I'm one of the lucky ones. I have a network. And if I didn't have those networks, where would I be? I would be lost. I know people. I know interpreters. I know social workers and psychologists, and I asked them for help to the hilt. Not everybody can do that. The whole process is hearing based. You come into the hospital, you have to meet the nurse, and you have to talk to them. When you are distressed, you don't want to write notes. Your family help out and do things for you; however, the stress on your family is enormous and it's not ideal to rely on them.

Everything is so hearing focused and you have to wonder what sort of information gets exchanged between Deaf patients and hearing professionals, and whether it's actually accurate or not. Are they making the correct diagnosis based on fractured information? Do they really have the full story? The mental health system is not user friendly. Not for Deaf people. Not for everybody. But particularly not so for Deaf people.

Suicide and Self-Harm

Alana Roy, a psychologist specialising in Deaf and Deafblind clients, presented on suicide and self-harm. She reported that in the wider Australian community:

- Approx. nine suicides each day
- Women more likely to attempt suicide
- Men are three times more likely to complete suicide

As a part of Dr Roy's PhD thesis, her literature review included an extensive search for studies focused on suicide or self-harm in people without limitation on the years of publication, but she found little relevant research. There is a gap in research and understanding of self-harm and suicide prevention, rates, diagnosis and treatment. Dr Roy explained that Turner et al. conducted a literature review on data from the 1940s to 2006 across multiple databases and only found thirteen articles with a focus on self-harm or suicide in Deaf people.

She did find that:

- Few studies focus on suicide or self harm
- Little evidence that suicide rates are higher
- Higher levels of depression and risk
- No firm evidence of effective suicide prevention in Deaf and deafblind people

Dr Roy also found significant barriers in talking about mental health in the Deaf and Deafblind community. Some of these barriers are:

- Stigma and shame e.g. losing face in the community: disclosure can be challenging. In these communities many worry about shame, stigma, not getting jobs, losing face, no longer being seen as a role model or advocate
- Gossip and lack of trust
- Audism and medical model
- Lack of access to service and communication
- Difficult to access self harm and suicide support via text, Skype, interpreters and email

She noted a number of mistakes that both hearing and Deaf mental health professionals often make when working with Deaf and Deafblind clients in crisis:

- Pretending or assuming they can sign or understand the client
- Not having adequate training and skills in Deaf, deafblind trauma and risk assessment,
- Audism- assuming they know more or are correct because they can hear
- Not consulting with Deaf/deafblind specialists and community.

Specifically, in the case of Deaf mental health professionals, mistakes include:

- Assuming they know the client e.g. because they grew up with them and/or have case managed them for a long time
- Being able to communicate effectively but not having clinical risk assessment skills
- Assuming that Deaf and Deafblind clients want or should want Deaf or Deafblind professionals to support them and are reluctant to engage with hearing professionals.

She stressed that mental health professionals and the Deaf/hard of hearing/Deafblind sector need to work together, respect each other's differing points of view, and offer options and choices to those at risk.

The most important thing for the person who is self-harming or suicidal is to obtain access to a professional who they have a good connection with and can trust, and who has the skills to work with at-risk patients. They should have access to hearing, Deaf and Deafblind professionals and role models. This is a personal choice and should not be judged.

It was noted that some Deaf and Deafblind people do not want to be affiliated with a Deaf-specific agency they know well, and may instead choose to have contact with hearing professionals for confidentiality and so seek support outside the Deaf and Deafblind community. However, at this point in time there is a lack of Deaf and Deafblind professionals with Medicare rebate capacity, which limits the choices available for Deaf and Deafblind people.

Dr Roy's recommendations are:

- Provide funding for research into mental health issues in the Deaf and Deafblind population.
- Review the professional capacity of the hearing, Deaf and Deafblind psychology and counselling services available, and also access to the Medicare rebate and NDIS.

Patrick's Story- Recovery and Male Pride

In 2006, my then-wife gave birth to twin girls. She developed severe postnatal depression. I was working full-time at the time and she was the stay-at-home mum. Alarm bells rang for me when she texted me one day to tell me that she had gone shopping and that the girls were on the floor with the dog looking after them. I rushed home from work, with my mother and mother-in-law both rushing over in a bid so that someone will get there in time, and luckily everything was fine. It was at that point I had to act and make sure she got help. Both families offered immeasurable support. We went off to a sleep school to get the twins in a good sleeping habit, and my mother and father, my sister and my mother-in-law all took turns coming over to help me settle, feed, bath and put the girls to sleep. My wife slept pretty much every chance she could get – she was ill and there was nothing we could do.

I had to juggle holding down a job, being an almost full-time carer to baby twin girls, and also look after my wife. Whilst my wife and the girls were getting all the support, love and help they needed, I felt like the forgotten one and I let my pride present to the world that I was strong and able to cope. When it was the middle of the night, when I was trying to get the girls to sleep on my own, I was curled up in a ball crying with the two crying babies in my arms. And no one knew.

After the girls turned one, my wife decided that in order to get better, she wanted to return back to work full-time, whilst I gave up my job to become a full-time father of the girls. However, when she said she wanted to work, this meant she went to work, came home, bathed the girls and went to bed. I was left carrying the babies, so to speak. It was then that my five-year secret battle with depression began. I developed a severe skin infection that was related to stress; however, I used to stand under the shower with hot water full blast (no cold water at all) and burn my skin, because the pain was a release from the pain I was going through inside of me. I would then take a bath with bleach to dry up the burnt patches all over my body. I now know it's an extreme form of self-harm. I started binge eating, resulting in a lot of weight gain. I was very unwell, yet to the outside world, they just saw me as a father of twins who was doing the best he could. No one had any idea.

After a particularly bad day, I had spent the whole day contemplating suicide. I was at the verge of planning the act when I looked at my beautiful girls and realised that I couldn't do this anymore. I rang the beyondblue helpline and was told they couldn't help me. In a distressed state, I built up the courage to tell a visiting friend, who long suspected I wasn't well, what was going on, and he sat me down and had a good talk to me about my options. He told me to see my GP, gave me the number of the local CAT team and encouraged me to tell my family. I told my family, who were in varying states of shock, and quickly made an appointment to see a GP and again a psychologist. I didn't have an interpreter or any support with communication by choice. I felt I could lip-read and hear well enough to get by and I could. This was my choice.

I faced the fact that I was deeply unhappy in my marriage, and there was no hope of trying to fix it. I needed to talk about what I was feeling and find my happiness again. Eventually my wife and I divorced and arranged to share the care of the girls. I started telling my friends what was happening with me, starting with my friends at my football club. What followed was an outpouring of support, and a number of other men telling me they were glad that I said something because they were secretly struggling too.

It has now been six years since the day that I decided to tell my family and friends my struggle. I am happy to say that despite what has been a very difficult six years, I have now found happiness again. My skin is now clear, my health has improved and my weight is slowly but surely starting to come off. I have found love again and [am] engaged to be married. I have a wonderful relationship with my now ten-year-old twin girls and enjoy life to its entirety.

My story is one of recovery, the power of male bonding and the need to bypass pride.

Deaf Indigenous Australians and Mental Health

Jody Barney is a leading Aboriginal Deaf consultant, a proud Birri/Gubba–Urangan/South Sea Islander woman from Queensland who has spent the last thirty years working with communities across Australia. She has authority and access to work with Deaf and hard of hearing Aboriginal and Torres Strait Islander people in justice, education, welfare, community development and health. Her work is done with the utmost cultural respect, where she ensures the cultural safety of all community members attending the session.

The work done by Jody Barney highlighted the need to have a robust and culturally engaging discussion at the Let's Talk About...Mental Health and Deaf People conference, focusing on working effectively with Deaf and hard of hearing Aboriginal and Torres Strait Islander people in the mental health sector.

Deaf and hard of hearing Aboriginal and Torres Strait Islander people are a minority within a minority, and even more so are those who live, experience and manage their mental health issues. Due to the high prevalence of hearing loss among Aboriginal and Torres Strait Islander communities, and due to chronic ear disease, poor housing, inadequate sanitation services, and lack of cultural safety in accessing health services, many people often aren't diagnosed with deafness until they reach school age or older.

Culturally, Aboriginal and Torres Strait Islander peoples are more aware of their environment, using visual modes of communications and signing systems to communicate. This occurs between nations during, for example:

- Ceremonies during customs such as 'lore' or 'sorry business', which are traditional times of healing
- Initiations, grieving and rituals such as participating in decision-making practices like funerals and marriages.

All members of the family, clan and community have a role and duty to uphold traditional customs in these circumstances. These are often cultural obligations that have no exemptions. Each family member must follow the culture of their family and adhere to the lore (law) held up by the senior lore men and women. Therefore, use of the spoken word is often forbidden and this can be implemented for weeks or even months in some communities.

Traditionally, those who were known to have hearing loss were often observed by the Elders and given appropriate names, totems, roles and song lines. Many Deaf community members were seen as being able to predict weather and notice changes to the landscape, and so were often given the role of seeking food because their observational skills were more astute.

Jody Barney stressed that the entrenched fear and transgenerational removal of family (since colonisation) has impacted everyone in the community today, even the Deaf members within communities. The ongoing displacement felt by those who are not with their kin or on their country can and has heightened the presence of mental health concerns for Deaf Aboriginal and Torres Strait Islander people today.

With the communities travelling frequently, there can be seen a growing presence of rural, remote Aboriginal Deaf people popping up in coastline communities and metro cities. When Aboriginal peoples move across the country, there are vast differences in their use of 'hand talk' or signing systems that don't transfer into Auslan. These are more in relation to their totems and connection to kinship systems whereby a 'mum' can mean any kind of significant female in their lives: it could be their wife, sister, aunty or a friend.

Many urban Aboriginal Deaf people have access to Auslan, learn spoken English and engage with their culture daily, or some not at all. The various forms of the modern family unit can compound their mental health when trying to fit in, be accepted or even try to understand why they can't explain how they feel. It is often difficult for the services to understand hearing Aboriginal cultural groups, let alone Deaf members of the community. The struggle that service providers, interpreters, mental health workers and Deaf workers all face is accepting the identity of a Deaf or hard of hearing Aboriginal person. This affects their need to return to wellness and their treatment options.

While the Deaf community is quite small, the Aboriginal and Torres Strait Islander (signing) Deaf community is even smaller. The prevalence of hearing loss among Aboriginal and Torres Strait Islander people is much higher, but the use of Aboriginal signing systems and hand talk is much less. Therefore the use of cultural ties, connections and awareness will greatly improve the health and wellbeing of Deaf and hard of hearing Aboriginal and Torres Strait Islander people.

This is done by making sure that interpreters who are booked have had cultural awareness training. If they

are known to the Deaf person, they can assist in the message getting across correctly. Often these ties can't be discussed and the confidentiality of their work can often restrict them in providing the best possible support and access. The conversations that interpreters, health workers and practitioners are able to have will improve the outcomes of the person who is unwell.

Often a point is explained using scenarios, which Jody Barney did in this conference session; however, due to cultural protocols these scenarios won't be put into this report. The overall message for readers is that without understanding the importance of these connections and the proper protocols, the health and wellbeing of Deaf Aboriginal and Torres Strait Islander people will not improve.

The work being done in the mental health sector is based on a different way of doing, a different way of learning. While practitioners and health workers use the various taught theories that follow a Western medical approach, this does not positively impact Deaf Aboriginal and Torres Strait Islander people. Western medicine focuses on the individual, whereas Aboriginal and Torres Strait Islander peoples need the focus to be on the community, the collective. It is hard for non-Indigenous people to understand this sometimes, especially around family structures, kinship systems and the strong connection to the land.

A lack of understanding about culture affects the support processes for Deaf Aboriginal and Torres Strait Islander people. A Deaf person who is unwell may focus on something that is happening four or five hundred kilometres away. Even though this cannot hurt them in theory, it does in reality, so ingrained are their culture and their sense of belonging to their family and land. This is their culture. This is when workers miss the importance of the culture and only focus on the person in front of them. Most Aboriginal people won't even talk about themselves in general and so they turn up to appointments with three or four people in tow. Those people are there to talk for them – this is their culture.

Most Aboriginal people actually go to mainstream services rather than Aboriginal services. It is believed that because the community is close-knit, they don't want their community to know they are in need of mental health services. However, this is a catch-22 situation: the expertise in Indigenous Australians is not found in the mainstream services. Mainstream services are still struggling to work with Aboriginal people in general, let alone Aboriginal people who are Deaf or hard of hearing, or have mental health issues or drug and alcohol issues.

Deaf Youth

Paula Zalcborg is a counsellor and family therapist who works specifically with Deaf and hard of hearing children, adolescents, adults and their families. She is fluent in Auslan and currently employed at St Mary's Primary School on a part-time basis. She has her own private practice where she sees children, adolescents and adults for individual counselling, couple counselling and/or family therapy.

Zalcborg spoke about attachment theory. A child obtains physical and psychological safety through proximity to a parent who is available, sensitive and responsive to the child's various needs. The parent also has the role of repairing any relationship breakdowns that might threaten that sense of safety. Within attachment security, the parents serve as the secure base, which provides the child with the safety needed to explore and interact with the world. Attachment security enables the child to regulate their fears in order to be free and to learn from objects and events in their environment. As the child matures, physical proximity to their parents becomes less necessary, while psychological availability remains crucial throughout childhood and throughout adolescence. This is critical in the emotional and social development of the child.

Some parents develop a strong, healthy attachment with their babies. Others have a lot of difficulties, frequently related to their own upbringing. Often when a family comes to counselling, none of its members are feeling particularly safe. Parents may feel they will be judged negatively and blamed for any problems their child might be manifesting. The child may not feel safe as they may have been told they are going to counselling because of their behaviour. The therapist's first task is to facilitate a sense of safety among all the members of the family. The therapist needs to become the secure base.

Sometimes, when parents receive news that their baby is deaf, this can bring about feelings of loss for the perfect baby they hoped for. This can cause some parents to become distant from their deaf baby. This can make the bonding between mother and baby inconsistent and fragmented. This insecure attachment may then cause a deaf child's social and emotional development to be insecure, delayed and fragile. This has a huge impact on the deaf child's understanding of the world, their ability to trust and their ability to have meaningful relationships. It is important to note that approximately ninety per cent of deaf children are born to hearing parents, who often have no prior experience of deafness. Most of these parents will have had no prior contact with a Deaf person.

Parents will see audiologists and cochlear implant teams quite frequently as the child grows. The parents get used to handling hearing aids, ear moulds and processor bits and pieces, and become familiar with hearing aid jargon. What parents do not learn is the language that is related to the child's emotional understanding of their deafness. It is crucial that deaf children, their siblings and their parents also understand this aspect of deafness.

It is not uncommon for deaf children to come home from school and say to their parents, "I hate being deaf." Often parents feel their child's pain and offer words of encouragement like, "Don't worry, darling, you're the best runner in the class, or you're really good at spelling, or you're in the top reading group." This does not actually validate what the child is feeling. Zalcborg encourages parents to say, "Yes, it must really suck when you can't hear. It must be awful for you. You must get so frustrated and angry at times." This is actually hearing the child and validating what they are feeling. She also encourages deaf children to talk about their frustration when they are constantly missing parts of conversations, and feeling left out and confused.

Deaf young adults also need the skills to be able to advocate for themselves. Many children struggle with accepting that they can feel being Deaf is okay and should not be a barrier to following their dreams. Zalcborg notes that a lot of her work is with teenagers who are oral, and often they get overlooked in terms of the issues to do with being oral. Some examples are:

One teenage oral deaf male suffered from high anxiety, especially in social situations. He was going on an excursion with his hearing schoolmates and he needed to tell them to face him when they spoke to him so he could lip-read. He was quite horrified at the thought of telling someone he was deaf.

– Paula Zalcborg, 16 November 2015

An oral 25-year-old young lady, who had a mild to moderate hearing loss and was also very shy and withdrawn, was suffering from depression when I met her. She had gone through high school as the only hearing-impaired student in the class. When she finished year 12, she took off her hearing aids and didn't tell anyone she was deaf. This included tertiary teachers. She struggled through several courses, not completing any of them. When she came to me, she was suffering from depression, had symptoms of anorexia and was incredibly socially isolated. I had a session with her, her sister and parents. Very soon into the session, it became evident that the family had never really accepted their daughter's hearing loss. Even some of the extended family did

not know at age 25 that she had a hearing loss. So the first work I did with this young lady was to talk about what her hearing loss meant to her. Again, the feelings of enormous shame and embarrassment came up. Bit by bit, I encouraged her to start wearing her hearing aids, role-playing job interviews and work situations with her. During the session with this young lady's family, I asked them what they understood about her hearing loss. They replied that it was the same as wearing glasses. This is often an analogy that people make that is actually quite wrong. The parents were both medical doctors.

– Paula Zalcborg, 16 November 2015

Teenagers strive to be accepted and fit in, and most importantly they do not want to be different. This is particularly hard for deaf kids. It is very hard to fit in when you have a hearing loss, because that makes you different from the start. We can see from these stories that a common theme in oral-based deaf youth is extreme difficulty in understanding and accepting their own deafness. They have intense feelings of shame. They often feel that hearing people, especially within their peer group, are constantly judging them. It is common that they feel they are not good enough and get very angry and upset about this. These can be kids who are academically equal to their peers, but still feel other people judge them as being stupid. They often walk around with great frustration and resentment towards hearing kids, whom they feel do not understand what it feels like to be deaf.

Deaf kids tend to learn to use various strategies to protect themselves from feelings of rejection. One of these strategies is what we call the 'Deaf nod'; when they nod and smile or laugh and hope it's at the right time in the conversation. They do this in an attempt to save face and fool the hearing person into thinking they know what is being talked about. At times this works, but in the long term what does it do to a teenager's self-esteem, always second-guessing and never being a hundred per cent sure they have all the information?

Deaf kids often want to know what is happening or being said in a conversation. They are regularly dismissed with "Don't worry about it, I'll tell you later". Unfortunately, the information is rarely relayed later, and so the person is still left in the dark, waiting and wondering.

Many deaf kids have some degree of language delay. For some, the delay is quite severe. The impact of deafness is influenced by various factors such as quality of family environment, parental adaptation and coping with deafness. For instance, families often discuss the day's events at dinnertime. Where a deaf child is the only deaf member of their family, they will have full access to these conversations as they sit quietly eating their dinner. This lack of direct communication can cause a high incidence of anxiety and depression in the deaf child and can affect their ability to develop close and meaningful relationships.

Exploring friendships is such an important part of adolescence. Without appropriate role models, this can be fraught with difficulty. Anger and resentment build up over the years and the adolescent becomes depressed or withdrawn. A common complaint from deaf children is, "I feel really lonely at school, but I feel even lonelier at home when I can't understand my family talking. I'm always the last one to know what's going on."

Most oral teenagers do not identify with the Deaf community. When they meet signing Deaf people, they often feel intimidated and reluctant to communicate. Many deaf kids speak well and one would never know from their speech that they are, in fact, deaf. Often oral deaf kids experience identity confusion: they do not identify with their Deaf peers, yet they feel alienated from their hearing peers. Most oral kids see their deafness primarily as a disability, impairment and physical disorder. But for many Deaf kids who have grown up using Auslan, being Deaf means being part of a unique culture with its own language, traditions and values. Zalcborg encourages all her oral clients to learn Auslan and to find a place where they feel accepted as a Deaf person.

Mentoring is very important for deaf children. We need to encourage this to happen more, particularly for deaf students at the vulnerable stage when they are in Years 8 and 9. They will benefit immensely from seeing and meeting other young people in Year 11 and 12, or at university, who are happy and secure. This can be of particular value when they are starting to wonder about friendships, relationships and their future.

Zalcborg's recommendations are:

- Review the newborn screening program to ensure a whole-of-wellbeing approach so there is improved social/emotional support to parents at the point of diagnosis.
- Explore the growth of peer group programs, such as Hear For You, teenage oral deaf and signing Deaf peer support programs.

Amanda: my son Thomas and his journey with autism

I got married in 2002 to an amazing man who comes from a Deaf family. I had my second child, Thomas, in 2004. When Thomas was born, he had three newborn screening tests. Finally at ten weeks old they confirmed he was deaf. That red stamp 'FAILED' still creeps up in my mind sometimes. I had this nagging feeling inside me that something was not right about Thomas. He was such a difficult baby with feeding, handling and touching, and would never sleep. He was always rigid.

We went to a sleep clinic and it was an awful experience, we were looked down [on] as 'Deaf parents'; the nurses' body language was so easy to read. They scowled at us for signing to Thomas, they scolded at us for not being 'strict enough'. We didn't last long there. We had access to an interpreter; however, they would not respect us.

Thomas achieved his milestones way earlier than expected; his signing and speech was advanced. I still had that nagging feeling that something wasn't right. Thomas was diagnosed as having ADHD at eighteen months old; however, I still felt something wasn't right. He attended four different schools and every single time he would get himself in trouble. I knew there was an explanation but I was told, 'He's lashing out because he's frustrated with communication' among other theories. He was suspended many times.

I refused to give up and allow anyone to tell me that I had a 'naughty little Deaf boy who was demonstrating typical Deaf behaviour'. We saw eleven psychologists and psychiatrists – each one of them said, 'He is demonstrating typical Deaf behaviour'. It didn't matter how many times I told them that I had two other Deaf children and worked with Deaf children and I knew this wasn't the case. Then we were told it was our 'parenting skills' – they said that because we are 'Deaf parents', he is frustrated because of the communication we use (we sign at home). So we did numerous courses on parenting Deaf children, as well a specialised language program from Germany. We were humiliated each time. Labelling became a thing to every appointment, meeting and session. I felt I wasn't good enough to be a mother because everyone was telling us we were the problem, not them.

I refused to give up; while seeking an answer I tried everything including the Gap Diet, the Failsafe Diet, behaviour management – endless stuff. We were and still are his 24-hour carers. Finally, we tried a new psychiatrist – he said my son is autistic and there is no doubt. He was almost eight.

Since the diagnosis, we were too late to register for any early-intervention programs or access the Better Start funding and I was furious. In eleven years, we only received three hours of respite twice, and no other support or help. I have only met one other Deaf child with autism and he is in a special school. I have another friend who is Deaf with a Deaf autistic son and they live in America. We share our pains via Facebook messages.

Thomas is a kid of many words; he would talk endlessly about dinosaurs, but very rarely opens his heart. When he does, it kills a little bit of me and breaks my heart more because I did not know how to help him and I didn't know where to go for help. Thomas completed a survey for Bond University to assist their research: he wrote that he wished he was dead.

There is no one in Australia who is experienced in deafness and ASD – especially someone who could sign. Autism QLD rarely contacts us to offer support even [though] we are a member and get news, but we get no help from them or any strategies.

Today he is in a better emotional situation, he is happier and we are working very hard to maintain a safe and calming environment for him at home and at school. I am afraid of what it will be like when he starts high school.

Amanda: My daughter Louise and her journey with the Cochlear Implant

I had a baby girl, Louise, who was born profoundly Deaf. My husband, Simon, asked the ENT specialist on the same day she was diagnosed if she can have a cochlear implant and I was shocked. My initial reaction was no. I had fears that she will lose her 'Deaf identity'. My husband and I agreed to six months of research. Within me, I had made up my mind and that was a no. Simon's fear was the surgery itself.

We noticed she had issues with her vision and after testing were told she had DVM [delayed visual maturation]. My worries about her vision did alter my decision toward the cochlear implant. After a lot of research, we agreed to go ahead with the implant. It worked well for her.

Five years later, Louise came home from school one day and said she wanted a second cochlear implant. Shocked, I asked why. She said everyone got two and she wanted the same. We said no. We felt she wasn't mentally prepared for the hard work that an implant at a later age will require. A year later she kept on asking, saying she wanted to hear from her other 'ear'. We discussed it with her in depth and made the decision to let her go ahead with it.

She struggled with the switch on for six months. She hated it. She felt she couldn't make it work and because we put so much pressure on her to work hard to make it happen, she felt she wasn't good enough. I started to wish I didn't allow it to happen because she was too old for the second implant. It is better to be implanted as a baby or when you are older and therefore more cognitively prepared to manage the rehabilitation process. She was neither. Louise struggled so hard with the second implant and after about eight to ten months, she finally got used to it. Although she was happy and could settle down, her self-esteem was already low and I felt so responsible for that.

I felt I couldn't reach out to the Deaf community about my little girl's wellbeing, because they still held largely negative views on cochlear implants and would blame that instantly. There was no one in the mental health system who is a Deaf person that is able to both speak and sign, so we were unable to access the support we needed.

Amandas: my son Kurt, the CODA

My little man, Kurt, was a very much wanted baby. I already had three children and they were all Deaf. I secretly hoped that he would be hearing, because we had to battle for the right access for the first three. It took medical professionals seven years to really confirm that Kurt is completely hearing and will not lose any hearing unless something happens in the future.

Kurt always said and still says today that he wished he were Deaf. He feels like he missed out because he is the odd one in the family. It doesn't matter how many times we assure him that everyone is equal; he knows we are different and he knows he 'hears' everything when we don't. He is carrying that little burden on his shoulders as a hearing child in a Deaf family, and it doesn't matter how many times I tell him not to, he still feels that is in his life plan.

Positive Psychology of Deaf People

Dr Paul Jacobs has lived with profound hearing loss since he was five years old. Dr Jacobs' Deaf-specific research has covered mental health, proactive thinking, social skills and advocacy by parents of children who are deaf and teachers of the deaf.

Dr Jacobs presented on how Deaf-specific research influences therapeutic and educational practice. Research tends to focus on the negatives and the problems. He argued that this is not helpful, because it does little to inform proactive courses of action. Research needs to focus on the positives that demonstrate how people living with deafness can socially and professionally participate. Dr Jacobs believes such research promotes healthy mental wellbeing.

Dr Jacobs explained that people often perceive the term 'mental health' as negative. Mental health means depression, suicidal thoughts, drug abuse and alcoholism, among other largely negative conditions. But mental health can be a positive thing. The word 'health' means life. It means enjoyment and happiness. Dr Jacobs spoke about the concept of positive psychology, and argued that the focus on negatives can influence poor self-perception and there is a need to consider positive psychology as a means of promoting positive self-image.

When Dr Jacobs explored this concept, he profiled famous Deaf people and their characteristics. One main theme he found was approach anxiety – the fear of approaching or being approached. It greatly affects people who live with deafness, as they are unable to predict what will happen next. Deaf people tend to seek out and learn a strategy to enable them to predict what could happen if they were approached or they had to approach someone. There is nothing more intimidating to a Deaf person than being approached randomly by someone talking about something that is out of context.

Dr Jacobs stated that when we talk about mental health and deafness, we focus mostly on the medical model: 'fixing' deafness and dealing with 'loss' of hearing. However, he argued that if society just removed the barriers and allowed Deaf people to participate fully and equally, then there would be a positive change in mental wellbeing.

Research on the effect of being Deaf

Dr Anthony Hogan's work addresses issues of social identity and wellbeing across a variety of settings. Dr Hogan has completed projects on hearing and social identity, stigma and mental health, disability and employment, and the social wellbeing of children with hearing loss.

Dr Hogan has done extensive research on the life effects of being Deaf. He argued that the oppression of Deaf people due to audism is affecting the lifespans of Deaf people across Australia. He believed that the challenge is that the larger society has what he calls "unconscious bias". This is a way of saying, 'I realise I'm doing the wrong thing, but I am going to do it anyway'.

He argued that one of the challenges for deaf individuals is to come to the realisation that they need to stop internalising the oppression, self-blame and anxious feelings, and come to recognise that it is actually the other person who needs to change the way they interact with them. The Deaf individual is not at fault; it is the inaccessible environment that is at fault.

This internalisation leads to people trading in their own identity, who they truly believe they are, for an identity that they think other people will want and accept. This brings on depression, anxiety and associated negative feelings.

One of the big problems we have in Australia is that our major intervention for adults is primarily focused on devices: hearing aids and cochlear implants. The very first professionals, whom we deal with from an early age with our deafness, and throughout our lifetime, are not equipped to work with us on our psychosocial wellbeing.

Our physical or mental wellbeing is our sense of belonging and connectivity, not our level of hearing. Our confidence and ability to manage our hearing loss is closely related to our quality of life:

The other thing that we found is that all of those negatives and knocks and the anxiety, the approach anxiety, the anticipation, is related to the accumulation of depression. If you go to the audiologists, for example, they

will tell you – face people, ask them to look at you, speak slowly and clearly, 'It will all be great'. Well, it's not, is it? All that does is set you up to be more stressed. Because you know inside that the other person is not going to do it ... We don't actually work as a family or a social unit to renegotiate the rules of how we will communicate. If my cholesterol was off the charts, and me being the cook in my house – everyone is going to be on a low-cholesterol diet, we would all change. If we had people coming over for dinner and were worried about being gluten free or high sugar levels. But are we worried about auditory inclusion? Do we talk about it or negotiate it?

– Anthony Hogan, 17 November 2015

While we continue as a public to fund audiology services alone, things will not change. The provision of hearing aids and specialist services to children is vital and should continue. Specialist services for kids should continue. However, we need to develop a model that is inclusive of mental health and whole-of-wellbeing services.

Current Mental Health Model in the United Kingdom.

Dr Brendan Monteiro presented on the current mental health model for Deaf people in the United Kingdom. Dr Monteiro has been a psychiatrist for Deaf people since 1987 and has established three specialist Deaf services for Deaf people.

Rampton Hospital is a high-security hospital based in Nottingham. It has ten beds for Deaf patients in one ward. It has a high fence, which means it has highly secure conditions. Deaf people there receive a range of services. There are also medium- and low-security services at St Andrews in Northampton (developed in 2001 with four beds), St Maoris (four beds) and All Saints (six beds). They provide medium-security Deaf-specific services. Lastly, St Mary's has four Deaf beds in a ward of sixteen hearing and Deaf patients. Another option is open hearing wards with visiting Deaf services.

Deaf people come in with varying types of communications needs. Some prefer to speak, some prefer to sign and some prefer a combination of both. There is a critical phase of language development and acquisition. Lack of access to language during this period has a lifelong impact on a person's ability to develop their language skills. This is a situation that arises for many Deaf people.

Quite often, problems arise when Deaf people leave the security of home to enter the world as adults and suddenly find they are lonely and cannot engage properly with the hearing world. This impacts in particular on forming relationships, getting jobs and pursuing further education. There are numerous situations where they may experience discrimination and mental health issues.

In other cases, there are some causes of deafness that can also cause learning disabilities, including poor emotional environments and deprivation. In this context, 'deprivation' means deprivation of language and communication. It causes a domino effect: if you are deprived of language and cannot speak to your parents, siblings or peers, then you cannot be educated properly using conventional language systems. When that happens, you wind up not being able to absorb age-appropriate concepts. This makes it difficult to make sense of the world as an adult and so to participate appropriately.

In terms of literacy, there is plenty of scope for misunderstanding. There is plenty of scope for the treating professional to get the construct of the communication wrong and thereby conclude that the Deaf person is paranoid. An example of this:

Remember Maggie Thatcher? [In 1985] there were lots of cuts and very strict fiscal policies [in the UK]. Disability was sort of ignored. I saw this guy who came into the outpatient clinic. He said that the government is very cruel. I said, 'I agree with you to a certain extent'. He said, 'No, they are specifically cruel because they are breaking ducks' legs and putting them on ice'. I thought that this sounded psychotic. I'm trying to explore this further and my consultant John Denmark was in the next room. Otherwise he seemed perfectly sane, communicating very well. But he said the government is breaking ducks' legs and putting them on ice. My consultant said, 'Where did you get this from?' He said it was in the newspaper. The headline was: 'Government puts lame duck policy on ice'. So this is the way even somebody who has training in the field, somebody who has some understanding, can go around and misunderstand situations.

– Brendan Monteiro, 17 November 2015

When instances of misdiagnosis of intellectual impairment occur during assessments of Deaf people, this is largely due to misperception and lack of awareness about deafness. If a Deaf person is assessed

by a psychologist who does not have Deaf awareness and does not understand sign language, and the assessment is conducted with intelligence tests that are based on verbal and performance tests, the Deaf person may underscore due to not understanding the words. If the Deaf person is given performance tests, they tend to score according to their performance ability.

In the UK system, performance tests are taken as indicative of a person's true innate intelligence. Due to this incorrect assessment, Deaf people are often misdiagnosed as being intellectually impaired, which is one factor in the higher reported incidence of intellectual impairment in the Deaf population.

So, how do the doctors in the UK system communicate effectively with Deaf people who are mentally ill?

- In the very first instance, assess their first mode of communication: are they more comfortable hearing/ speaking or signing?
- Do not ask vague questions about anything you can't make sense of. Ask very specific questions: How is it affecting you? Why are you angry? Why are you upset?
- Often you do not get an appropriate time line with Deaf people who are using particularly minimal sign language.
- Clarify name signs right from the beginning.
- Use a qualified interpreter; often there are times where something might not make sense in the context, but interpreters are qualified to pick this up. This could mean the difference between diagnosing someone as having a mental illness or their just being misunderstood.
- Always check understanding, because Deaf people are known to nod even when they don't understand.

Dr Monteiro mentioned that it is also critical to understand the family dynamic. There are instances where families reject or try to overprotect or blame. The Deaf person has different relationships with peers too and all that needs to be explored. Sometimes what appears like a mental health problem such as anger, aggression or acting out might actually be because the person is upset and does not have the emotional vocabulary to describe it, for example:

I was upset with my brother because he took my Xbox and played with it, and I wanted it and couldn't get it so I punched him.

Assessments of Deaf people on an intellectual level need to be done by psychologists who are Deaf aware and can communicate using sign language. When you are working with Deaf people who have minimal sign language, you also need Deaf relay interpreters. Deaf relay interpreters assist to break the language down even further.

Deaf people suffer from the same range of problems as hearing people. However, maladjustment, anxiety and depression, and stress-related issues are far higher in the Deaf population compared to the hearing population. This is because their lives can be far more stressful. Anything that is likely to be environmentally determined – stress, difficulty in adjustment, discrimination, problems of finding employment, problems in relationships – is likely to be higher in the Deaf population than in the hearing population.

When doing risk assessments of Deaf people, it is important that a number of other issues are taken into account. When you do formal risk assessments of Deaf people, there are items like the history of early employment; Deaf people might not have the employment history, but you cannot put that down as a risk factor. There are also items such as the history of anger problems and temper tantrums; you cannot put that down as a risk factor because it might be part of their developmental phase. So there are a number of things that you have to be cautious about, and this has to be reflected in the report in order to make an accurate assessment.

In Deaf people generally, personality disorders and behavioural adjustment problems are higher in incidence. That's not surprising, because many of the environmental factors are stressors and are factors that can be naturally difficult for Deaf people. Their personalities can take a slightly different pathway. They can appear antisocial, paranoid, isolated and uncooperative. The difference between a Deaf person with those personality characteristics and a hearing person with those personality characteristics is that the Deaf person is often treatable. Often their personality has changed because of environmental issues. You can bring about improvement by changing the environmental barriers. However, in hearing people, who have had greater opportunities, those characteristics are deeply ingrained in their personalities and are very difficult to change.

In a Deaf treatment model, Dr Monteiro talked about the ‘habilitation’ approach that is used, rather than a ‘rehabilitation’ approach. Habilitation is the concept of developing new skills in people that are lacking. Rehabilitation is where people have lost skills for some reason and they are taught to regain the skills. In the UK model, most Deaf people come in without the skills. Habilitation means the person has gaps in their knowledge, and the service tries to fill in these gaps. The professional identifies the source, whether it is emotional or psychological, and tries to develop the skill areas that are lacking. Developing various cues, looking at the person’s weaknesses and providing nurturing can achieve this.

To do this, Dr Monteiro said that first, the professional needs to educate the patient about terms, the meaning of signs, their knowledge of the world, etc. Then they move into specific types of management i.e. anger, trauma, substance abuse, sex abuse, violence etc. Then they move into recovery programs and relapse. It is important to note that these stages are not fixed. People can move up and down between stages. So you might get to recovery and then the person doesn’t understand something about sex offences, so you go back to management.

All assessments are completed in the Deaf person’s preferred language and at their level of communication. The staff all use sign language to some degree, although not everyone is absolutely fluent. The program uses cognitive behaviour therapy approaches and psycho-education. All of these programs, sex offender treatment, group or individual, substance misuse, are adapted for Deaf people.

As mentioned previously in the section about audism (see page 4), the treatment of Deaf people costs more and takes longer. In the UK, the Government has sex offender programs that need to be completed within nine months to a year. For Deaf people, this program can last between three and five years.

The environment is very important. The UK services are run from a Deaf cultural perspective. It is not sufficient to have hearing psychiatrists and professionals working with sign language interpreters when providing a Deaf service. It is very important that staff can sign and have good Deaf awareness. In the UK system, all staff participate in an induction course that include a week of Deaf awareness, in addition to receiving varying levels of sign language training. There is a signing policy in the hospital, with a fine that goes to a Deaf charity if staff do not use signs or if hearing people speak to each other in corridors.

It is also essential to employ interpreters with expertise in mental health, because there are particular signs that can be used to explain a concept and need expert translation. However, even with interpreters, it is still important that all staff and people in the treatment environment use sign language themselves.

The UK Government often says, ‘Why don’t we send them to a hearing hospital with sign language interpreters?’ That is what we call a ‘pseudo team’: what you have is a range of professionals who understand nothing about deafness, who have no idea of the range of problems they are going to have, and you are putting in an interpreter and expecting the interpreter to solve it all. That gives the impression that you are treating the person. It actually does not mean real treatment.

A real team is like the team you can have in a Deaf service where everybody working there has an understanding of deafness, can communicate at a particular level, can understand the variations of minimal sign language to highly eloquent sign language, and can gain understanding of the patient’s individual experience. This is a highly effective team, which has been recognised by the UK government and funded for the past twenty-two years. Three services have been developed in that time and a lot of lessons have been learnt.

Guidelines for working with Auslan Interpreters- Ryan Tuema

Dr Ryan Tuema is a psychologist who has established a private practice called Vitalogy Consulting devoted to the Deaf and Deafblind community. He regularly works with the Victorian Deaf Society, Queensland Deaf Society, Deaf Association New Zealand and Able Australia. He has spent the last four-and-a-half years working at the Victorian College for the Deaf in collaboration with Deaf Children Australia and the Victorian Deaf Education Institute.

Using his knowledge, Dr Tuema has developed a list of best practice principles for mental health clinicians when working with Level 3 NAATI-qualified interpreters.

Strategies and guidelines for effective communication in forensic interviews with Deaf clients: for assessing mental health clinicians

- a. Talk to the interpreter before you meet in person about your experience or lack of experience of working with interpreters. Ask the interpreter about their experience of facilitating mental health assessments.
- b. Request all previous, if any, psychological, psychiatric, correctional and educational assessments.
- c. With the client’s consent, talk to relevant caseworkers, doctors, teachers, parents and extended family members to gain as much information as possible about the client’s general functioning and their communication strengths and weaknesses.
- d. Be aware that most psychometric assessment tools are not standardised for deaf populations. To avoid misdiagnosis, liaise with your local Deaf society about ways to ensure your testing is relevant and accessible to the client, and conduct a literature search on psychological assessments of deaf persons.
- e. On the day of the assessment, meet with the interpreter beforehand and discuss the nature of the assessment, the topics to be covered, the language to be used, and potential risks and sensitive information.
- f. Set the room up so that you, the interpreter and the client have clear sight of each other. Ensure the room is well-lit and private from onlookers, and has good ventilation, comfortable chairs and a table at a height that is practical for all concerned.
- g. Do not shout at the client; be aware of your facial expression at all times. Speak clearly and at an even pace. Regularly check in with the interpreter to see if you are speaking too fast or too slowly. Pay attention to your pitch and choice of language, as there are many words in the discipline of psychology that do not have an Auslan equivalent. However, having said this, a competent interpreter will bridge the gap by interpreting the meaning or intent of what is being spoken where necessary.
- h. Ensure that you explore with the client their experience of mental health assessment. Take time to build rapport and trust. Explain slowly and clearly what your role is and what you want to achieve. Explain why you have been asked to provide a psychological assessment. Ask the client if they have any questions before you start getting personal.
 - i. Explain to the client your experience in working with Deaf people. If it is extensive, this will greatly add to the client’s sense of ease and comfort. If it is limited, be upfront about it. Ask the client to assist the process by seeking clarification and providing advice as to where you can improve.
- j. It is essential to conduct a basic language assessment and explore how they best communicate, such as sign language, lip-reading, use of hearing aids, gestures, reading, or being oral (using whatever intelligible speech they have.) If they wear glasses, ensure they are wearing these during the assessment. If they are wearing hearing aids, check if these have been adjusted to suit the environment.
- k. Explore the client’s perception of their Deaf identity and sense of connection with Deaf culture. It is not uncommon for a deaf person to be uncomfortable about their deafness. When conducting a genogram, ask if they are the only deaf person in their family. Explore their Deaf role models. Explore whether other family members sign fluently. Explore how they communicate with their family members who are not deaf.
- l. Explore their education in detail. It is not uncommon for a Deaf child to be placed in mainstream schools with hearing children. Ask whether they were subject to bullying or ridicule because of their deafness. Explore their social circle and if they have Deaf friends. Where did they go to school, how was their relationship with their

teachers and who helped them with their homework?

- m. If the client does not respond to a question or seems to be having difficulty comprehending, try to rephrase the message instead of repeating it exactly.
- n. Avoid abrupt topic changes and explain when you are changing the topic or the focus of enquiry.
- o. Use visual aids wherever possible. Have a large notebook and thick markers so you can write down key words to guide your enquiry. If the client cannot read at all, draw a picture in simple style. There are a number of pictorial cards that depict emotions, feelings, events and behaviours, which can be found on the internet. These learning aids are concrete, clear and highly visual.
- p. Schedule breaks every thirty minutes and check in with the interpreter on how the client comprehends the information. Discuss with the interpreter whether your pitch and vocabulary are too high or too low, or whether you are talking too fast or too slowly. Explore with the interpreter whether they feel comfortable with the level of detail and whether there were any confusing or ambiguous questions or responses.
- q. If it is a forensics interview, it is sometimes useful to explore details of an offence after you have gathered information about social and development background: Deaf culture and identity, psychosexual development, drug and alcohol history, suicide and self-harm behaviours, issues with aggression and violence, for example. This allows the client to feel they are being understood as a person, not as a criminal. On occasion, the client may not want to start the interview with the offence. In this situation, be guided by the client and then return to the offence after you have gathered all relevant background information, to clarify specific details.
- r. Learn about a healthy psychological Deaf presentation in contrast to a healthy psychological hearing presentation. In general, it is uncommon for hearing practitioners to be exposed to a healthy psychological Deaf presentation, simply because the Deaf population is a minority in Australia. This exposure could occur through contact with various Deaf conferences and workshops provided by your state Deaf society or Deaf organisation. Learn about possible Deaf adolescent mental health issues, for example:
 - Loneliness as a result of being left out of social interactions
 - Social isolation
 - Inferiority and feeling like a lesser person than hearing people
 - Frustration from not being understood or listened to
 - Aggressive behaviours
 - Fear of rejection
 - Low self-esteem
 - Shame resulting from being taught to behave and act like a hearing child
 - Depression and despair that life will always be a struggle
 - Trauma from sexual abuse, rape, bullying or ridicule
 - Poor self-expression because of overly controlling parents
 - Sexual development problems from delayed, confused and poor sex education, and Deaf gay/lesbian issues
 - Suicide and self-harm – it is very hard to spot warning signals and there is potential for high incidence.
- s. When formulating a diagnosis for a client, for example: depression, obsessive compulsive disorder, post-traumatic stress disorder; do not rely on the DSM-IV (Diagnostic and Statistical Manual for Mental Disorders) as it is culturally biased towards the Western hearing population. Misdiagnosis can lead to a number of problems including inappropriate treatment plans, inaccurate medication regimes, client confusion and frustration, and further trauma to the client. Inaccurate forensic assessments have the potential to significantly disadvantage the Deaf client. For example, overestimation of the risk of reoffending or overestimation of the danger to the community may see Deaf people detained in higher security cells unnecessarily and imprisoned for longer.
- t. Learn some basic signs such as 'Hello, how are you?' 'Would you like a break?' 'Toilet break?' This will demonstrate to the client that you respect them and have taken a basic step to understand their language. If you make a mistake, be prepared to laugh at yourself and learn from the client and the interpreter (Farrugia 1988).

RECOMMENDATIONS

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

It is clear from many speakers that support for people who are Deaf in the current mental health system in Australia is lacking. Systems are designed for people who are hearing and adjustments are not readily made for Deaf people who need mental health support.

It is recommended that:

1. Research needs to be conducted to identify best practice community-based support models for Deaf mental health support throughout the world.
2. Continuing consultation needs to occur with key stakeholders in Australia to identify the needs and improvements required for effective Deaf mental health support.
3. From data collected, a report needs to be drafted with key recommendations for the development of a community-based response to Deaf mental health in Australia.

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

It is clear that interpreting and communication support for Deaf mental health support is a specialised field.

It is recommended that both training and support be developed around this field to increase the skills and awareness of communication support people who work with Deaf people receiving mental health support. This includes interpreters, relay interpreters, Deafblind interpreters and so on.

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

It is clear that many of the available mental health resources, both printed and online, are not accessible for people who are Deaf. Plain-English versions and Auslan versions of printed material are required. Online videos need to be captioned and Auslan versions developed.

It is recommended that accessible resources be developed across the spectrum of mental health support, including, but not limited to:

- Domestic violence
- Substance abuse
- General mental health information, such as details about beyondblue and other websites, and printed information.

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

It is clear that there is a lack of awareness among mainstream mental health professionals such as psychiatrists, counsellors, nurses and other support people, surrounding the specific issues of the Deaf population in relation to mental health support.

It is recommended that this be addressed through the development of both training and resources to increase their awareness of the requirements of Deaf people who are accessing mental health support.

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

Evidence was presented that suggests Deaf people are subject to many negative stereotypes around 'cures' and 'fixing'. This stereotyping can lead to poor self-concept.

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

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