

Mental Health Services for Deaf People in Wales



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Introduction

The UK Government and the Welsh Assembly Government are both committed to improving mental health services for everyone and to reducing social exclusion wherever possible. One group of people who need special attention is those who are culturally Deaf and who are susceptible to mental ill health.

The Department of Health recently published best practice guidance in a report entitled *Mental Health and Deafness: Towards Equity and Access*. This document shows how mental health services for Deaf people can be improved using the template of the National Service Framework for Mental Health as a starting point. It provides practical examples of how access to services can be made easier and it brings into focus the needs of a group of people whose access to services has for too long, been fraught with difficulty.

It is important to recognise that there are different forms of deafness. This report encompasses all deafness using the broadest definition. However, the focus of the report is on services for culturally Deaf people whose natural language is British Sign Language. Many of the improvements suggested are specifically aimed at addressing services for this community – but will have a benefit among the wider deaf population and, indeed, the general population.

- Deaf – born Deaf, or becoming Deaf before acquiring verbal language. Many Deaf people whose natural language is British Sign Language (BSL) consider themselves to be a distinct cultural group or community. The term Deaf, with a capital 'D' is often used to refer to this group;
- deaf – when used with a small 'd' this term is used to refer to the full spectrum of deafness and hearing loss;
- deafened – born hearing but becoming deaf, either suddenly or over time; and
- hard of hearing – some hearing is possible, often associated with gradual hearing loss in later life.

Users of the health service are entitled to expect a culturally appropriate service, and this must apply equally to the Deaf community.

Background

Over the past few years serious concern has been raised about Deaf People's access to health services in Wales. Professionals, national organisations in Wales, and members of the Deaf community and their families have all expressed their concern. The absence of a clear pathway to specialist mental health facilities has been highlighted as particularly worrying.

The present situation has been brought about by a number of factors including the changing landscape of health service and social care commissioning. Referral pathways as a consequence have tended to be rather poor due to the lack of knowledge of secondary and tertiary providers. Also local health boards, with an

overall lack of resources, have tried to provide all services within their geographical area.

The former arrangement saw referrals being made to the specialist units in Manchester and Birmingham. The specialist service from London provided a monthly clinic in Bristol for Welsh patients.

- Deaf People visited the clinics for assessments;
- The Manchester unit operated a monthly outpatient clinic at the former East Glamorgan Hospital; and
- On occasions home visits were made by psychiatrists or CPNs.

With the change to these arrangements, mental health services for Deaf People in Wales became almost non-existent. The cost of one-off visits to Wales was prohibitively expensive, and referrals had to come via Health Commission Wales.

In 2003 an attempt to establish access to services was developed with the following strands:

- a. The issue of access was to be raised locally, particularly within Health Boards, NHS Trusts and Social Services Departments
- b. A review of awareness of the issue within the Deaf community was to be looked at
- c. Needs were to be highlighted within the Welsh Assembly
- d. An All-Wales Conference based on *A Sign of the Times* was to be planned

The approach was co-ordinated by the British Society of Mental Health & Deafness (BSMHD), and has seen a number of outcomes:

- A presentation was made to the Adult Mental Health Implementation Advisory Group;
- A series of meetings were held with colleagues at the Welsh Assembly Government at which areas such as the formulation of a pathway to services and the relationship with Health Commission Wales were discussed. This involved representatives from national organisations, local authorities and the Deaf community;
- In May 2004 the BSMHD organised an All-Wales Conference which was attended by Jane Hutt, then Minister of Health & Social Services. At this meeting the Minister agreed to receive a report from an External Reference Group. This report would detail recommendations on the development of future services. The document *Mental Health Services for Deaf People in Wales* is the product of this Reference Group.

Current Difficulties Experienced by Deaf People in Accessing Health and Care Services

Deaf people whose natural language is British Sign Language (BSL) currently face many barriers in accessing healthcare, some of which are highlighted below.

Most people with a mental health problem who seek professional help initially visit their GP. It is then for the GP to decide whether or not a referral is needed to a secondary mental health service. In approximately 90% of cases the patient is not referred on, and 'treatment' remains at this level. But this gatekeeping role is vital for people to get the correct service. This means that barriers to effective primary health care can have a big impact on access to all health services.

There are common barriers to health care which affect all settings. These include:

- having to book an appointment on the telephone
- reception staff "calling out" the patient's name
- communication between the clinician and patient not being clear. Evidence suggests that while many doctors do not feel there is a communication problem, this is not the impression of deaf patients
- doctors and nurses often using unfamiliar words, making appointments even more difficult;
- official letters often including jargon and being difficult to understand
- appropriate language facilitation not often being provided in a variety of settings. This includes the lack of provision of appropriately qualified BSL/English interpreters and Deaf advocates when making assessments under the Mental Health Act. Appropriate language facilitation is often not provided for various reasons which may include the dearth of qualified interpreters and lack of awareness on the part of the health service;
- access to counselling being very restricted for Deaf patients. It is highly likely that this leads to more Deaf patients being offered medication as the only treatment option
- Apparent evidence that deaf patients needing a specialist mental health service are not referred: it is not clear whether this is because referrers are not aware of the specialist services, or do not recognise there is a need.

Allied to this is a need for Deaf people to understand their rights. There are still many examples of Deaf people being interviewed without appropriate language facilitation.

Appendix B includes examples that illustrate these points and the particular problems in being able to access Deaf-aware services and being able to convince other professionals of the need to do so.

Overview of Mental Health Policy and Strategy

The Welsh Assembly Government's Adult Mental Health Strategy *Equity Empowerment Effectiveness and Efficiency* (September 2001) outlines the vision and plan for mental health service development over the next ten years. Extracts from the Strategy and key features include:

- The strategy aims for a model of recovery – based on the individual's assessment of need and how they wish to see services helping them
- Mental health services, whilst having a key role in their own right, will also have a vital function in helping to enable people to access ordinary community support and facilities
- The response to the mental health needs of people in Wales can no longer revolve solely around the notion of services: links must be made between the individual and the wider environment addressing the socio-economic determinants of poor health
- Quality of life is at the centre of this strategy with mental health services having a role in helping the individual to maximise and fulfil their life opportunities – through providing appropriate and timely care and support when needed and in helping to facilitate the persons integration into community life.

Six months after publication of the Strategy, the Welsh Assembly Government then published the National Service Framework for Adult Mental Health Services in Wales (April 2002), which outlined 8 standards, and 44 associated key actions. The development of services and care pathways within this framework are particularly targeted on those individuals who are identified as suffering with a severe and enduring mental health problem.

National Service Framework Standards:

Standard 1	Social inclusion, health promotion and tackling stigma
Standard 2	Service user and carer empowerment
Standard 3	Promotion of opportunities for a normal pattern of daily living
Standard 4	Providing equitable and accessible services
Standard 5	Commissioning effective, comprehensive and responsive services
Standard 6	Delivering effective, comprehensive and responsive services
Standard 7	Effective client assessment and care pathways
Standard 8	Ensuring a well staffed, skilled and supported workforce

Standard Seven and part of Key Action 37 have a particular reference to the needs of Deaf people who also have mental health needs:

“Some people need particularly responsive services and information. These include individuals with special needs, for example, those with physical disabilities and those with sensory impairments or suffering from the consequences of a traumatic brain injury with a concurrent mental illness. Protocols for management of such cases should be jointly agreed and in place in all Trusts and Local authorities.”¹
(*Raising the Standards*, October 2005)

The monitoring arrangements for this key action will be through the existence of protocols together with review arrangements in place.

Related Strategies/Targets include:

- Welsh Assembly Government Annual Service and Financial Framework (SaFF) Targets
- Audit Commission Losing Time report – 2002,
- Audit commission Losing Time review - 2004
- Health Social Care & Well Being Strategy.
- Everybody's Business – Child and Adolescent Mental Health Services Strategy
- National Service Framework for Children Services.
- Mental Health Policy Guidance – Care Programme Approach.
- Mental Health Policy guidance – Stronger in Partnership.
- Creating a Unified and Fair System for Assessing and Managing Care.

During the course of 2005 the Welsh Assembly Government commissioned and published the following reviews and reports on mental health services in Wales:

- Wales Audit Office Baseline Review of Adult Mental Health Services in Wales across the 22 Local Health Board/Unitary Authority areas – September 2005.
- *Raising the Standard* – The Revised Adult Mental Health National Service Framework and an Action Plan for Wales – October 2005.
- *Under Pressure* – Risk and Quality review of Mental Health services in Wales – October 2005.

Care Programme Approach (CPA)

Standard Seven & Key Action 29 of the *National Service Framework* addresses the implementation in Wales of the Care Programme Approach, which states:

“The Care Programme Approach has been introduced across Wales for all people with serious mental health problems and / or complex needs. CPA combines Care Planning and Case Management and is integrated with the Unified Assessment Process (UAP) to provide a framework for care coordination in mental health care”

¹ The authors of this report do not endorse the labels “special needs” and “sensory impairments”.

The Mental Health Policy Guidance – The Care Programme Approach for Mental Health Service Users – A Unified and Fair System for assessing and Managing Care – implemented in 2004 - includes the following key messages:

“Evidence and experience has shown the benefits of providing well coordinated care to those suffering with a mental health problem.”

“Mental health service users, particularly those with more complex and enduring needs, often require help with other aspects of their lives such as housing, finance, employment, education and physical health needs.”

“This places demands on services that no one discipline or agency can meet alone and it is therefore necessary to have an integrated system of effective care coordination for all services to work together for the benefit of the service user.”

The Care Programme Approach is highlighted by:

- A Health and Social Care Integrated Framework
- A Communication and Information System
- A Tool for Coordinating Care
- A Process which places the Service User / Carer and the Care Coordinator at the centre.

Service and Financial Framework

The Welsh Assembly Government has published the Annual Service and Financial Framework targets for 2006/07 in December 2005. These targets include the following:

Target 15

All Local Health Boards will strengthen mental health services within general practice to support whole system models of care, and specifically to provide additional Tier 1 mental health services in primary care in accordance with Welsh Assembly Government policy implementation guidance (to be issued by 31st March 2006) by ensuring:

- All GP practices should have access to psychological services either within or available to the primary care base. This should be available within a maximum wait of 12 weeks
- All GP practices must have a gateway worker provided by the CMHT who will provide
 - Screening
 - Assessment
 - Gatekeeping
 - Signposting to other tier 1 services e.g. voluntary sector mental health or other services such as CRUSE, Relate etc.
- Fast tracking to the CMHT cases requiring secondary care intervention
- GP's and practice staff receive training to help them diagnose and manage adults with mental health problems

(Target date 31st March 2007)

Population Profiles

Local Authority/Local Health Board areas

	Popula tion² (thousan ds)	Aged 0-15 (thousan ds)	Aged 16+ (thousan ds)	Estimated number of people who are deaf or hard of hearing³	Estimated number of people who are culturally Deaf BSL users⁴	Estimated number of culturally Deaf people with a mental health problem
North Wales Region						
Isle of Anglesey	68.4	13.0	55.4			
Gwynedd	117.5	22.5	94.9			
Conwy	110.9	20.0	90.9			
Denbighshire	94.9	18.2	76.7			
Flintshire	149.4	30.0	119.5			
Wrexham	129.7	25.1	104.6			
Total	670.8	128.8	542	117,391	235	117
Mid & West Wales Region						
Powys	129.3	24.5	104.8			
Ceredigion	77.2	12.5	64.7			
Pembrokeshire	116.3	23.3	93.0			
Carmarthenshire	176.0	33.7	142.3			
Swansea	224.6	41.4	183.2			
Neath Port Talbot	135.3	26.0	109.3			
Bridgend	129.9	26.0	103.9			
Total	988.6	187.4	801.2	172,996	346	173
South East Wales Region						
Vale of Glamorgan	121.2	25.3	96.0			
Cardiff	315.1	61.5	253.6			
Rhondda Cynon Taff	231.6	47.0	184.5			
Merthyr Tydfil	55.4	11.5	43.9			
Caerphilly	170.2	36.0	134.3			
Blaenau Gwent	68.9	14.1	54.9			
Torfaen	90.7	18.7	71.9			
Monmouthshire	86.2	17.0	69.2			
Newport	139.3	30.1	109.1			
Total	1278.6	261.2	1017.4	223,761	447	223
All Wales Total	2,937,9 91	577,40 0	2,360,6 00	514,148	1,028	514

² OPCS, mid-2003 figure for total population.

³ Calculated on the basis of 17.5% of the population being deaf or hard of hearing. Figures taken from Northern Specialist Commissioning Group.

⁴ Calculated on the basis that 0.2% of those who are deaf or hard of hearing will be culturally Deaf.

Commissioning Framework

There could be a number of service models for Wales. The model outlined in this document has been selected for the following reasons:

- The model easily improves access and improves pathways for Deaf people from primary level through secondary and, if required, tertiary care
- Equitable with services provided to hearing people
- Cost effective and justifiable
- Can be implemented within reasonable timescales
- Consistent for all groups within the Deaf community including ethnic and minority groups, children and deafblind people
- Consistent with the National Service Framework on Mental Health
- Would place Wales at the forefront of Mental Health care for Deaf people
- Significant cost efficiency savings for Local Health Boards.

Statutory duties for primary care providers

Access and equality for Deaf people at primary care level can easily be achieved at minimal cost. Indeed cost should not be an issue, for failure to implement recommendations leaves primary care services open to action under the 2005 DDA requirements. This places a general duty on GPs to eliminate discrimination and promote equality of opportunity for people with disabilities. All primary care facilities should include deaf awareness training and communication tactics training in their development criteria for front line staff. All staff within the health service should be required to attend an appropriate course. Surgeries should have an operational textphone for booking appointments, and internet/e-mail bookings should also be available. (see Appendix A).

Clear signage should be available for everyone and an interpreter booking service should be in place. These should not be seen as additional items or new costs but simply adaptations for disabled people in the same way as wheelchair ramps, Braille signage, wider doors, grab bars on paths and in disabled toilets. Many culturally Deaf people do not consider themselves to be disabled. However, they would argue for the same adaptations on the same grounds as Welsh, Somali or Chinese people who use their natural language, and whose cultures are valued. Deaf people have been excluded for far too long from the thinking of those responsible for equity and diversity (see Appendix B).

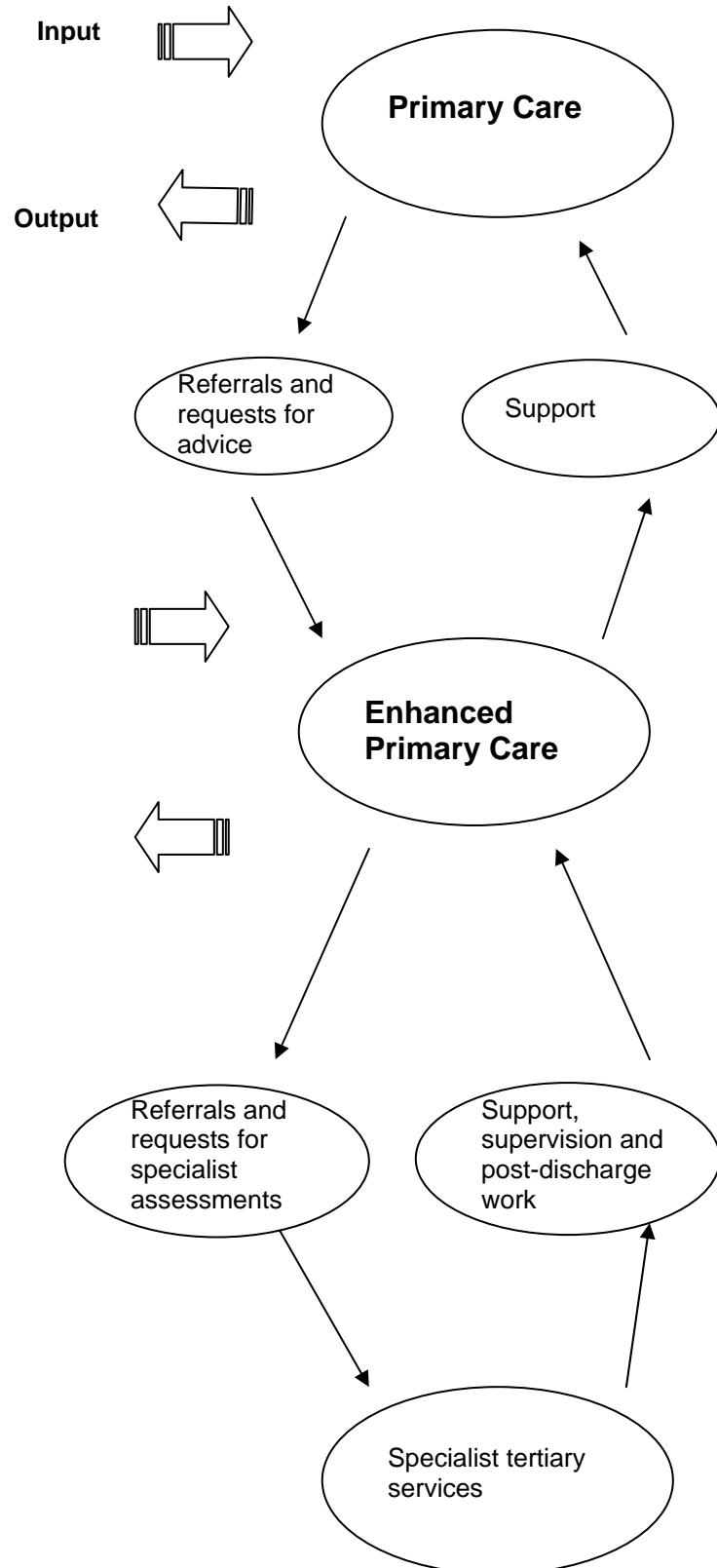
Service model – Adults and Older People

- Needs assessment of all groups: Deaf, deafblind, children, elderly, BME
- Deaf Awareness and Communication Tactics training
- Statutory adjustments, e.g. e-mail, signage, interpreter booking, loops, videophones.
- BSL/English translation software available

- Informed service delivery
- Services that are DDA compliant
- Services that all deaf patients can access and feel confident about using

- Interpreters
- Gateway workers/CPNs
- BSL training
- Sessions from staff with an interest, from different disciplines

- A full clinical network of services
- A team based in one practice, but covering a wide area, and drawing on staff based off-site
- Team members can co-work cases
- Team can advise and support others in primary and secondary care
- A vital link between local mental health services and the specialist tertiary services.
- A seamless link for the patient, throughout their care pathway



Service Model — Child & Adolescent Mental Health Service (CAMHS)

- Needs assessment of all groups: Deaf, deafblind, children, elderly, BME
- Deaf Awareness and Communication Tactics training
- Statutory adjustments, e.g. e-mail, signage, interpreter booking, loops, videophones.
- BSL/English translation software available

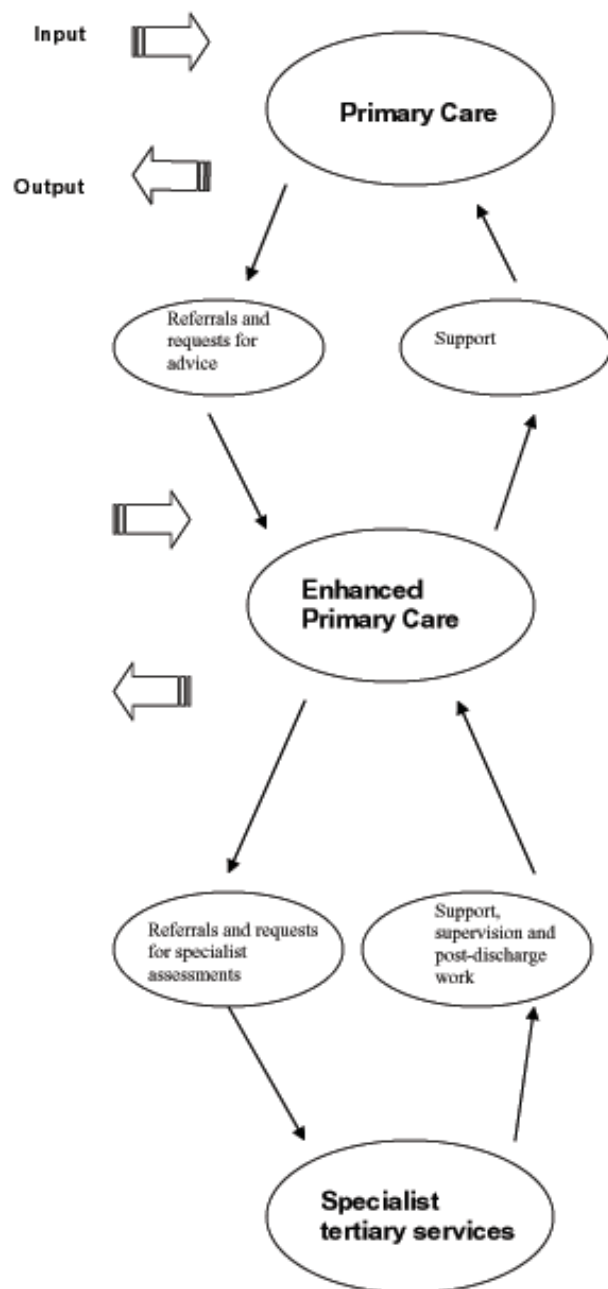
- Informed service delivery
- Services that are DDA compliant
- Services that all deaf patients can access and feel confident about using

- Interpreters
- Gateway workers/CPNs
- BSL training
- Sessions from staff with an interest, from different disciplines

- A full clinical network of services
- A team based in one practice, but covering a wide area, and drawing on staff based off-site
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Service Model

Detailing inputs/outputs and links



Narrative to the Service Models

Introduction

The Service Models draw upon best practice. Where Gateway Workers/Community Psychiatric Nurses have been employed there are significant health improvements, cost efficiencies and patient outcomes. Funding just three doctors with a special interest in Deafness and Mental Health would do much to improve care pathways.

The service model that is being recommended is not expensive or particularly difficult to implement and could become operational within a reasonable time-frame. What is required, however, is commitment, and a person with clear responsibility for its delivery and a willingness to ensure its future continuance.

Primary Care Services

As already stated, the expectations of Primary Care Services is for them to undertake their statutory duty of making all surgeries/health centres accessible to all groups in society. It should be made clear to them that Deaf people have the same rights as other groups who use their facilities. Simple measures like clear signage (which would improve access for everyone), deaf awareness/communication tactics training and options for booking appointments are simple changes but essential to Deaf people. Arrangements should be in place to book BSL/English interpreters as required, or use a videophone relay BSL/English interpreter. Use of the BSL/English translation software that has been adopted in England would immediately improve communication.

Unless Primary Care Services make their facilities accessible to Deaf people, mental health problems will still go unnoticed with tragic consequences for those who are affected.

Enhanced Primary Care Services

The suggestion of enhanced Primary Care Services is not new. Many healthcare facilities already run specialist clinics for diabetes, those with heart problems, asthma, pregnancy, etc.

An enhanced practice would have a clear, well defined role. This would be built on the following functions:

- To provide information and advice to healthcare staff within the area. This could involve clarifying queries from staff who are currently working with a Deaf patient who experiences mental distress.
- To provide consultancy and co-working
- To undertake specialist assessments

The team would comprise a consultant psychiatrist, clinical psychologist, a Community Psychiatric Nurse, Interpreter and Administrator (costs detailed in Appendix A).

What is being suggested here is that a facility in the South, one in Mid and West Wales, and one in the North should be sought out where a GP(s) and staff take an

interest in Deaf people and undertake some training in sign language. They will link with other Primary Care Services in their area offering support to GPs with Deaf patients.

From their surgery/health centre a Care Co-ordinator/Community Psychiatric Nurse would be based and also a BSL/English interpreter. Working closely with the GP(s), the Care Co-ordinator/Community Psychiatric Nurse would support health workers and deaf people across a number of Local Health Boards – also making contact with the secondary service providers and with the more specialist tertiary providers in England. There is much research to show the effectiveness of these workers is not only in reducing the incidence of serious mental health problems amongst Deaf people but also in being cost effective (see Appendix C).

Use of telemedicine links with the specialist providers could also reduce costs in the longer term, for ongoing assessment of a Deaf person's mental health can be undertaken without expensive travel and staff costs.

Secondary Care

The secondary tier consultant could be an extremely valuable resource and could certainly provide screening by undertaking early psychiatric assessments.

Tertiary Care

Health Commission Wales has arrangements with the specialist tertiary providers in Manchester, Birmingham and London. These will need reviewing in light of this service model. It should be noted that an in-patient bed at one of the specialist providers will cost in excess of £120,000 per year. Improved outreach with local provision and earlier interventions will greatly reduce the likelihood of these costs being incurred.

CAMHS

Children and adolescents clearly have to be looked at separately. Whilst this service model indicates some of the measures that could be incorporated, it is recommended that a more detailed review be undertaken that incorporates social services who usually have lead responsibility for child protection issues.

The Welsh Assembly may wish to refer to a report prepared for the Northern Ireland Mental Health & Deafness Forum, entitled *Developing mental health services for deaf children and young people in Northern Ireland (2005)*, which could be used as a template for this exercise.

There is now a NSF for Children in Wales which includes mental health services.

Recommendations

The recommendations in *Towards Equity and Access* that might be considered as pertinent to Wales are as follows:

1. *That consideration be given to conducting local Needs Assessments of the mental health of Deaf People.*

There is a need to establish the true extent of need on a local basis to inform planning and provision. This will best be done by local collaborations between health and social services, who share a responsibility for this group of people. Given the size of the population in Wales, there may be economies in carrying this out over a fairly large area with a number of Local Health Boards working together.

2. *Local Health Boards and Hospital Trusts to include Deaf Awareness/Equality training in their training and development curricula for all front line staff. Local voluntary groups and local authority social services departments are likely to be able to provide the appropriate expertise.*

This form of training seems essential if front line staff in primary and secondary care are to be able to respond appropriately and sensitively to the needs of Deaf people who need to use their services.

RNID, in its response to the Department of Health's *Choosing Health* consultation paper, recommends all staff undergo Deaf Awareness/Equality training as part of their curriculum in order to become more aware of the issues surrounding communication with Deaf people. The Council for the Advancement of Communication with Deaf People (CACDP) has worked with *Sign* and the Scottish Council on Deafness and NHS Education for Scotland to establish communication Tactics courses specifically aimed at health service staff.

It is acknowledged that Deaf Association Wales supports the teaching of Deaf Equality Training. This includes topics such as Deaf culture. Deaf Association Wales also object to the teaching of Communication Tactics. They argue that English speakers are not taught tactics to communicate with speakers of other languages, and the same should apply with BSL.

The importance and significance of this training to the NHS, is supported by the cost of missed appointments by deaf people. RNID's national report, *A Simple Cure* estimates the cost to the NHS of missed appointments to be £20 million a year. Furthermore, the report highlights confusion surrounding accurate diagnosis and dangers regarding medication dosages for deaf people.

Health organisations will also be made mindful of their new responsibilities relating to the Disability Discrimination Act 1995 to take all reasonable measures to make their services available to everyone, regardless of disability. It may well be practical to combine Deaf Awareness/Equality training with training initiatives to support compliance with the Act.

3. *A telemedicine pilot should be established between one of the specialist providers and a suitable remote site to explore whether further developments of this kind can be justified.*

Telemedicine is now commonly used to provide access to remote populations and to connect satellite services such as Minor Accident Units to better resourced centres. There could well be a role for this in allowing Deaf people and local service providers access to centres for consultation and advice that are aware of Deaf culture and language. This initiative could be combined with the initiative of developing a Psychiatric Resource in Wales.

4. *That the BSL/English translation software developed by SIGN is made available to primary and secondary care services as speedily as possible.*

A very recent innovation is some work done by the charity *Sign*. They have developed software which will translate questions and advice into BSL. The software will also provide patients with information and guidance. Given the shortage of interpreters, this could have a significant impact on access to primary care in a much shorter time span than training additional interpreters. Implementation of this recommendation has already started in England with the Department of Health paying for the software to be available in every Primary Care Service.

5. *Area Child Protection Committees should review local procedures, policies and training programmes to ensure that the needs of Deaf children are recognized and can be met.*
6. *There should be links developed between the National Deaf Service for Children and local CAMHS Teams for advice and consultation.*
7. *The use of video-links for this purpose should be piloted and proposals for a roll-out of this facility developed..*

Deaf children seem particularly vulnerable to abuse, particularly those with more severe communication difficulties or in poorly communicating environments. They need the same degree of safety as hearing children.

When Deaf children need specialised care, there is only one in-patient service nationally (South West London & St George's Trust) and a shortage of outpatient services. There is a scarcity of expertise in local Child and Adolescent Mental Health Services who are, in any case often feeling over-stretched.

The use of video-links is already operated by National Deaf Services for Children and this could be put to use effectively throughout Wales. This technology is used for both consultation and supervision as well as direct therapeutic work between clients and clinicians.

RNID, in *A Simple Cure*, highlights the need for BSL/English video interpreting to combat the shortage of BSL/English interpreters and also recommends the extension of visual displays in reception areas and consulting rooms.

8. *That Local Implementation Teams and CAMHS development teams make arrangements to access the data held by Local Authorities on Deafblind people as a starting point in considering how they might meet the needs of this group.*
9. *That consideration should be given to conducting a needs assessment of Deafblind people alongside any undertaken for Deaf People.*

Very little is known about mental health problems and treatment in this group although some do access the specialist Deaf services. People who are born deafblind may exhibit unusual behaviour, (including self harm and destructiveness) in an attempt to communicate.

Guidelines have been issued to local authorities on assessments and joint working.

10. *Every primary care facility should have appropriate means of communication (such as e-mail, minicom, text messaging, and fax) and a service agreement with a translation service that includes BSL.*

Such matters should have been implemented some time ago, certainly within the timescale of the Disability Discrimination Act. Local Health boards should check that such arrangements exist in each primary care facility.

11. *Consideration should be given to the potential role of Gateway Workers in guiding Deaf people with a mental health problem to the service most likely to be of assistance at that time.*

Gateway workers for hearing people are in operation already within Wales. Two or three fluent BSL Gateway workers operating in North and South Wales could be key to improving services for Deaf people.

12. *That specialist CPNs are recruited to those parts of the country with the greatest need for an enhanced service.*

There may be a case for recruiting a specialist CPN in addition to or instead of one of the Gateway workers. The CPN is linked to one of the specialist providers in England (London, Manchester, Birmingham) and provides essential outreach and aftercare support as well as coordination of any outpatient clinic(s) that may be established with Wales.

13. *Local Health Boards should consider working together to see if there is a practice within their boundaries which could develop a special interest in the needs of Deaf people.*

It would again be unrealistic to expect more than two or three 'enhanced' practices throughout Wales. However a practice where staff could develop their skills in working with Deaf people, providing a base for the Gateway workers and, indeed, for BSL/English interpreters, could lend to a much improved health service and opportunities for Deaf people to engage in the well-being activities that are presently available to hearing people, e.g. wellman clinics, diabetes clinics, ante-natal courses, etc. The enhanced service would link with other primary care services in its locality.

14. *In any needs assessment, attention needs to be paid to the implications of cultural and ethnic diversity.*

In considering how to meet their aspirations for race equality, NHS bodies need to be aware of groups with particular access needs.

Deaf people are often grouped together with an expectation that all their needs can be met by a single resource. However, this is not the case and it is recognised that Deaf people from cultural and ethnic groups can easily become detached from a health provision. Close attention to this matter is therefore required.

15. *Staff working in mental health setting should be encouraged to learn BSL and those in specialist services to acquire fluency that would allow them to carry out their professional functions.*

There are very few professionals in the health service with signing skills sufficient to equip them to carry out their work in BSL. Few Deaf people are employed in these services although those that do provide positive role models. Sometimes there is a waste of scarce resources, as well as unethical practice, such as social workers acting as interpreters or accompanying clients to general practice consultations. This recommendation, particularly if training packages and financial incentives are attached, would greatly improve Deaf people's access and pathways to care.

16. *Consideration should be given to how best to increase the pool of skilled interpreters, particularly those with specialist training in mental health.*

There are few registered/qualified sign language interpreters in Wales. The practice of using family members, often children, as informal interpreters is both widespread and unjustifiable in health care, particularly in mental health.

The shortage of interpreters is a serious barrier to access at all levels of healthcare and whilst this is not under the control of the health services in Wales, steps could be taken by the Welsh Assembly Government to improve matters.

British Sign Language

The Welsh Assembly Government has published a recommendation to increase dramatically the number of BSL/English interpreters based in Wales.

This is in response to pressure from voluntary organisations, pilot initiatives like RNID's Cymru Communication, and Communities First projects and developments in other parts of the UK.

The aim is to ensure that BSL users in Wales have access to essential services and are not socially excluded by due to the language they use. The end result will be that BSL users in Wales will have the same level of access to appropriately qualified sign language/spoken language interpreters as sign language users in similar European countries.

The announcement will lead to more opportunities for BSL users to work as qualified tutors, as the number of BSL classes is increased to give people more opportunities to learn BSL and train as BSL/English interpreters.

The recommendation to increase to 64 by 2009 the number of registered interpreters is included in a recently published Welsh Assembly Government report based on evidence gathered from RNID Cymru, Deaf Association Wales, Council for the Advancement of Communication with Deaf People, Association of Sign Language Interpreters (ASLI), and other deaf and disability organisations. The report recognises that there is a significant shortage of BSL/English interpreters in Wales and that BSL users are losing out because of it.

Whilst there is a need to increase the number of registered interpreters in Wales, it is vital that interpreters are trained in mental health interpreting as this is a specialised area which requires specific training. Additional consultation with ASLI is needed to ensure interpreters are supported and trained appropriately as there are currently very few interpreters in Wales who are trained in this field. Consideration will need to be given to supporting interpreters through their training, which may have financial implications.

Appendix A – Cost breakdown of service model

Local Health Boards making their services accessible to Deaf people

Training in Communication Tactics/Deaf Awareness (Recommendation 2)	£2,000 pa per LHB
Access for all Primary Care staff to SignHealth software (Recommendation 4)	£4,000 pa per LHB
Direct costs per LHB	£6,000 pa

LHB regional groups (3) funding enhanced services

Staffing costs (including on-costs) – Recommendations 11 and 12

3 wte CPN H grade (5 days)	119,130	(G Grade = £108,063)
3 sessions clinical psychologist B grade (point 47)	10,060	
3 Consultant sessions	15,873	
3 wte A&C 5	78,279	
3 interpreters	90,000	
Total	313,342	

Additional funding would be required for accommodation, travel, management costs, etc.

Direct cost per LHB 'group' would be £104,000 per annum.

Cost efficiency savings

Every missed appointment is estimated to cost £100.

An admission to one of the specialised tertiary providers costs in excess of £120,000 per annum.

Recommendation 2

— Deaf Awareness/Equality and Communication Tactics Training

Many health service staff have little awareness of the particular needs of Deaf people and their culture. This is not a criticism, but reflects the small population they are likely to encounter during their working lives. The Welsh Assembly Government has given a clear commitment to reduce inequalities and to improve access to effective health and social care for everyone.

Health service organisations will also be mindful of their responsibilities relating to the Disability Discrimination Act, which places a duty on them to take all reasonable measures to make their services available to everyone, regardless of disability. Deaf Awareness Training would support compliance with the Act.

In Scotland, and recently in England, the NHS has worked with the examination board for communication with deaf people (the Council for the Advancement of Communication with Deaf People – CACDP). They have developed an accredited Communication Tactics with Deaf People training pack, specifically aimed at staff in healthcare settings. It is strongly recommended that such an approach be followed in Wales.

Cost: Communications Tactics/Deaf Awareness/Equality training for LHB £2,000 pa

Recommendations 3 and 4

— Using Technology

Deaf people have benefited from advances in information technology. The wider availability of e-mail, websites, and mobile phones (sms), has opened up many opportunities. Textphones are now routinely used, although much less than they could be within the health service.

The charity *Sign* has developed software which will interface with family doctor computer systems and which translates questions and advice into BSL, and 12 other minority languages. Given the shortage of interpreters, this could have a significant impact on access to primary care. The software will soon be in operation throughout England.

*Cost: E-mail booking of appointments – nil
SMS booking of appointments – negligible
Minicom bookings – negligible
SignHealth software – £4,000 pa per LHB*

Scrolling signs are regularly seen at bus stops, railway stations and many other locations. For Deaf people they are vital components in the process of a visiting a doctor. All too often appointments are missed because the Deaf person has not heard their name being called.

Cost: Visual call system – £550 (one-off cost)

Recommendations 10 and 16

— Interpreters

There are only 168 members of the Register of Sign Language Interpreters in the UK.

The practice of using family members, often children, as informal interpreters seems both widespread and unjustifiable in healthcare, and particularly mental health.

The shortage of interpreters is a serious barrier to access at all levels of healthcare for Deaf people. There is the additional issue of there being a lack of specialist training for those interpreters who wish to work with mental health clients.

Given the requirements under the DDA, failure of any healthcare organisation to endeavour to book an interpreter for a healthcare consultation cannot be justified.

Cost: Most interpreters will charge a call out fee of two hours, at approximately £50 plus travel expenses. Additional costs will be incurred if booked via an agency, as agencies charge for administration.

Appendix B – Case histories

Case 1 *This case highlights the difficulties in accessing specialist mental health facilities.*

This case revolves around a young girl, now aged nine. In 2002, the child's social worker made a direct referral to a specialist service for Children based at a hospital. The social worker found their input extremely helpful. During 2003 the team from the hospital saw the social worker and the deaf child at their outpatient clinic four times and once for a clinical assessment at the Hospital. Full assessment reports and recommendations were provided to assist the child and family.

Help was sought again in 2004 as a foster placement had broken down due to the child's behaviour. However, the social worker was advised by the Mental Health Trust that an application would have to be made to the appropriate commissioning body for funding. This organisation was duly contacted and said that – in the first instance – a referral would have to be made to the local Child & Adolescent Mental Health Service (CAMHS). This route was followed. The social worker was then advised that if CAMHS were unable to provide a service then two Consultant Psychiatrists would need to sign a statement to this effect and make a recommendation to seek a specialist service elsewhere. Assurances were made that CAMHS would arrange this if they felt necessary.

Accordingly, a child psychiatrist from the CAMH service wrote to the social worker saying they could not provide a service as the child was deaf (and had not yet acquired language). He followed this by saying he had no knowledge of the specialist Child & Family Service at Springfield Hospital so was unable to recommend making a referral to them. The matter was taken up with the Child Health Development Manager at the local Child Health Board who promised to look into it and try to resolve the matter. That was in March 2005 and, although he has been contacted a few times since, a successful outcome is still awaited.

This case demonstrates the difficulties faced when trying to communicate the needs of Deaf people to other professionals.

In May 2005, a mental health team (MHT) contacted a social worker asking for assistance in communicating with a young deaf man who was experiencing paranoid delusions. The team requested this support because the young man's mother had made a fuss. The team said that providing this communication support would "shut her up".

Professionals from the mental health team had visited twice before and had "got by" by writing things down. They were amazed at the amount of information and the change in the young man when he was able to sign.

Case 2

The social worker informed the mental health workers that the young man had a legal right to an interpreter being provided.

During the signed conversation the young man said that during the previous month he had been arrested for a small incident and that no interpreters were provided by the police. His mother also informed the social worker that when her son had appeared in court, interpreters again were not provided so consequently she had had to interpret for him. The social worker had been unaware of the boy's existence until being contacted by the Mental Health Team.

Case 3 *This case demonstrates the difficulties a deaf young person from a minority ethnic group can face and the inappropriateness of some of the provision being considered.*

Martha⁵ was a culturally deaf 14-year-old living with her hearing family in Wales. She arrived in the UK as an Asylum Seeker with her two younger sisters, older brother, and mother in 1999. They were granted 'leave to remain' in the UK.

Martha did not have hearing aids before she arrived in the UK at the age of eight. This has had a severe affect on her speech and language.

She went to a special unit in a primary school and was educated orally. She seemed happy and progressed well. At eleven she began at a special unit attached to a mainstream secondary school. Martha's family were keen for her to use sign language to communicate although the school differed in opinion. Martha learnt sign language from other children.

During the summer holidays after her initial year at the school, Martha went to the country of origin with her family. She reported that while away she could not communicate with the children abroad at all because she did not share a language and they were not sensitive to her disability; she felt the full impact of her deafness. On her return to Wales, Martha seemed to become less able to cope.

September 2004

Martha initially presented with kidney problems needing to urinate extremely frequently. No medical reason was ever found for this.

October 2004

The school report stated that Martha seemed unhappy and was unwilling to discuss this openly.

November 2004

Martha disclosed to a school teacher that her mother had physically abused her. Martha was placed in foster care.

December 2004

Martha remained in foster care and was reportedly not happy about returning home and uncertain about having contact with her family.

January 2005

⁵ Not her real name.

Martha began to behave aggressively at her foster placement and decided she wanted to go home to her family.

February 2005

Having returned home Martha withdrew her allegations saying it never happened. She claimed never to have been in foster care and did not know who the foster family were. Her behaviour at school became increasingly aggressive and she was frequently involved in fights. Her behaviour at home was worse – pulling doors off their hinges and attacking her sisters.

February/March 2005

Martha was referred to the CAMHS service. Communication problems hindered any progress. She was prescribed anti-psychotic medication. Her behaviour was frightening for her sisters after she threatened them with a knife. She was referred to the Specialist national mental health unit for deaf children. At about the same time Martha was excluded from school following an incident. Martha refused to take her medication.

April 2005

Martha attended an appointment with a specialist from a specialist children's service. Advice was given to local services, but distance prevented any real help beyond the offer of a bed in the in-patient unit if the situation deteriorated.

Martha talked of being badly bullied at school. School reports stated that Martha was attacking other children with no provocation saying they called her names. She faced being excluded again.

May 2005

Martha remained in a situation where she could not fully access her local services. Her local mental health services did not understand deafness sufficiently and were not equipped to meet her needs. The only other services were a long distance away and expensive.

Without appropriate services Martha's situation was likely to deteriorate. If this happened then Martha might become an in-patient at the specialist unit in London, very far from all her support network. This could put additional strain on her already very delicate mental health making appropriate treatment more difficult.

NB. Please note that Martha is not the real name

Appendix C – Members of the Reference Group

The Reference Group had a broad range of participants, representing constituency groups interested in mental health and deafness.

Stakeholders were consulted on all aspects of the Strategy.

Voluntary Sector		
Catrin Fletcher	Director	RNID Cymru
Stephen Gratton	Operational Co-ordinator	Tai Trothwy Housing Association
Richard Jones	Director	Deaf Association Wales
Chris Leek	Manager of National Specialist Services	RNID
John Micklewright	General Manager	Sense Cymru
Norman Moore	Director	Wales Council for the Deaf
Jane Priestley	Director	North Wales Deaf Association
Steve Powell	Chief Executive	<i>Sign</i>
David Reader	Clinical Nurse Specialist	North Wales Mental Health Network
Julie Watkins	BSL Interpreter	ASLI (Association of Sign Language Interpreters)
David Heap	Chief Executive	National Deaf Children's Society Cymru

Healthcare Professionals		
Sally Austen	Consultant Psychologist	National Deaf Service – Birmingham & Solihull Mental Health Trust
Sally Cook	Service Manager	John Denamrk Unit - Bolton, Salford & Trafford Mental Health Trust
Sandra Cooke	Member	Board of Community Health Councils, Wales
Margaret du Feu	Consultant Psychiatrist	South & East Belfast Trust
Ray Jacques	Consultant Psychiatrist	Gwent Healthcare Trust
David Jenkins	Team Manager	Pembrokeshire County Council
Maddy Rowe	Specialist Social Worker	Pembrokeshire County Council

Social Services		
Nigel Bone	Senior Practitioner – Lead on Sensory Services	Newport City Council
Jane Hewitt	Social Worker with Deaf People	Bridgend Borough Council
Vernon King	Principal Officer	Bridgend Borough Council

Local Health Boards/Joint Commissioners		
Bernard Boniface	Deputy Head of Joint Commissioning	Monmouthshire County Council
Kate Crosby	Head of Service Modernisation	Newport LHB
Beverley Davies	Joint Commissioner	Monmouthshire County Council
Clive Ellis	BSL Interpreter	Cardiff Local Health Board
Dave Roberts	Partnership Strategic Manager (Mental Health)	Neath Port Talbot Local Health Board

Welsh Assembly observers		
Phil Chick	Director of Mental Health	National Assembly for Wales
Tracey Good	Regional Equality Manager	NHS Centre for Equality & Human Rights
Susan Thompson	Senior Assistant Commissioner	Health Commission Wales

Appendix D – BSL Interpreters – Wales

Equalities Minister Jane Hutt announced on Monday, 6 February 2006 that up to £2.7m was being made available for a scheme to increase the number of British Sign Language interpreters in Wales.

This is the first scheme of this size in the UK and is designed to benefit the 3,000 people in Wales who use British Sign Language (BSL) as their first or preferred language.

The funding would provide 36 posts for apprentice interpreters to train and obtain appropriate qualifications; it would also support an additional nine trainee interpreters with grants to access courses. This is the first scheme of its size in the UK.

BSL Futures is funded by £1.6m from the European Union's Objective One programme and £1.1m match funding from the Welsh Assembly Government. The partnership led by RNID Cymru, Deaf Association Wales and the Association of Sign Language Interpreters is already in the process of recruiting its first 10 apprentice interpreters.

The scheme will provide each apprentice interpreter with a bursary and an individually tailored, fully-supported training programme resulting in registration as a freelance professional interpreter.

It will also:

- Train more BSL tutors to teach the language at the highest levels;
- Support colleges across Wales to develop their BSL course provision
- Develop a postgraduate course in BSL/Spoken Language interpreting;
- Support public service providers in Wales to develop the capacity to deliver services in BSL.

References

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Mental Health Policy Guidance: The Care Programme Approach for Mental Health Service Users, Welsh Assembly Government, (February 2003)

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