Key Messages that support the need for major improvements to Deaf mental health services

Submission from the Coalition of Deaf Mental Health Professional

8/09/2021

Key information on mental illness in the Deaf community

* There are approximately 4.500 Deaf NZSL users in NZ[[1]](#endnote-1).
* 47% of deaf children who use NZSL in school identify as Māori[[2]](#endnote-2).
* Deaf children experience high levels of abuse and neglect which lead to mental illness as adults[[3]](#endnote-3).
* Deaf people face multiple barriers to equitable education, employment and
* healthcare,3,[[4]](#endnote-4) and have worse outcomes compared to the general population[[5]](#endnote-5) [[6]](#endnote-6).
* 30-40% of Deaf have a disability other than being Deaf[[7]](#endnote-7)
* General mental health promotion information does not reach the Deaf community. This limits their ability to engage in prevention and self-management of mental distress1,[[8]](#endnote-8)
* International and New Zealand research suggests Deaf people are 2-3 times higher than the general population3,6 in their need for mental health and addictions support. A 2015 report estimated 1500 Deaf people likely need mental health and addictions support[[9]](#endnote-9).

Discrimination and Stigma against Deaf

* There has been major historical oppression of Deaf language and culture[[10]](#endnote-10) and the ongoing impacts have resulted in collective trauma that must be recognised and addressed.
* Widespread *audism3* (a belief that hearing people are superior to Deaf) and *linguicism* (discrimination against users of NZSL) have had harmful impacts on Deaf causing isolation, distress and sign language suppression at both individual and community levels[[11]](#endnote-11),[[12]](#endnote-12).[[13]](#endnote-13),[[14]](#endnote-14).
* One harmful impact of audism is the acceptance by Deaf of the negative ideas about Deaf promoted by audism[[15]](#endnote-15). This is a colonizing process where hearing people *establish control over* Deaf and explains the psychological harm of negative Deaf-hearing interactions, such as the *Dinner Table Syndrome* [[16]](#endnote-16),[[17]](#endnote-17), where Deaf people are perpetually left out of conversations. Increasing the opportunities for the use of Sign Language is a protective factor creating resistance and resilience against audism

Deaf identity and Deaf rights

* For Deaf, cultural identity is always plural3 (e.g. Māori Deaf, Pakeha Deaf, Samoan Deaf, etc) and then with other communities of connection such as rainbow Deaf, Deaf refugee and Deaf plus). Deaf people want to choose where they get support, that considers the intersections of their identities.
* The cultural trauma caused by colonisation and sign language suppression10 has to be addressed and healed based on the restoration of Deaf and Māori Deaf cultural values and perspectives. Deaf and Māori Deaf approaches to trauma and healing must be defined, controlled and undertaken by Deaf for Deaf and Māori Deaf for Māori Deaf[[18]](#endnote-18).
* Effective mental health services depend on *co-design processes* with create an authentic Deaf presence, leading to self-determination and community empowerment. Māori must partner with Māori Deaf to create leadership roles, lead discussions and make decisons about service design that are shaped by Māori models of health.
* Deaf need to utilise current legislation and government obligations (e.g. the NZSL Act, the United Nations Convention on the Rights of People with a Disability, United Nations Universal Declaration of Human Rights, The Human Rights Act, the Code of Health and Disability Services Consumers' Rights, the Disability Strategy. The Enabling Good Lives Principles[[19]](#endnote-19)) to ensure human rights for Deaf relating to non-discrimination, education, employment, health, social security and housing are protected.
* A fundamental right that is often ignored by health professionals is the right to access NZSL interpreters1,3.

The need for a nationally coordinated Deaf mental health approach3

* The Deaf community is a cultural and linguistic community that requires a targeted and nationally coordinated response covering acute services, community support, counselling, telehealth, and residential and vocational services. Just making the mental health staff more Deaf aware and relying on interpreters will not be sufficient
* Being Deaf must be part of the health data base so that the outcomes for Deaf within the health system can be measure and improved over time
* There needs to be a nationally coordinated approach to building the capability and capacity of Deaf to become qualified in NZSL Support Roles and as health and mental health & addiction practitioners, counsellors, psychologists, etc. Such training would recognise the challenges Deaf professionals face at work (minority tax (burden of extra responsibilities placed on minority communities in the name of diversity), audism, linguicism and social barriers with colleagues) [[20]](#endnote-20),[[21]](#endnote-21),[[22]](#endnote-22) and provide strategies to minimising their risk of burn-out and struggles in maintaining boundaries.
* There needs to be a nationally coordinated approach to building the capability and capacity of hearing health professionals competent in NZSL
* There needs to be a national management structure for interpreters that builds the capability and capacity of interpreters skilled in mental health interpreting, including telehealth interpreting, Deaf interpreters, communication support roles and tri-lingual interpreters.
* There needs to be a nationally coordinated approach to building services for Deaf children and their carers that will prevent and address the trauma of abuse and identity formation that many Deaf have experienced growing up in New Zealand.
* The national funding support for Deaf with mental health must recognise that because of the cultural-linguistic barriers Deaf face they will require *Very High Needs* (VHN) funding to ensure an adequate level of service. The current community needs-assessment processes under the disability model does not have the flexibility for Deaf to gain access to services they need. Also, we need to remove the silo approach of MOE, MOH and MSD that creates commercial competition (come here, but can’t go elsewhere) and isolation (not sharing information, not promoting other services)
* Deaf need a nationally coordinated information service on how to get mental health support. A one-stop-shop centre for quick signposting and direction. Deaf experience a labyrinth of primary-tertiary services, are confused where and how to get help, and not knowing what is wrong with them. Deaf need more clarity on referral routes with self-referral recommended to bypass family GP for more confidentiality

Specifics issues for a Deaf mental health support services

* Deaf want a holistic, wrap-around, womb to tomb service [[23]](#endnote-23), with responsive (not reactive) networks for early support and reflecting Te Whare Tapa Whā, a Māori unified theory of health. Deaf want Deaf and Deaf-friendly Mentoring pathways and Allyship[[24]](#endnote-24),[[25]](#endnote-25).
* Family involvement is vital17 and the protective role of Deaf community as a second family must be recognised.17
* There is an urgent need for quality acute care for the Deaf in a culturally, linguistically appropriate environment to enable effective assessment-diagnosis-treatment-recovery. How Deaf can access these most specialised mental health services with New Zealand’s spread-out Deaf community needs to be solved.
* Deaf expect signing community support services including counselling (Deaf and interpreter supported), telehealth, and residential and vocational services.
* A strong Deaf friendly health promotion and general community psychoeducation programme aligned with Deafhood, creating a cultural toolbox and community capital for resilience and self-advocacy against audism and linguicism resulting in better individual and collective mental health wellbeing20,[[26]](#endnote-26),[[27]](#endnote-27). This could include *Deaf Ecosystems[[28]](#endnote-28)*, a directory of Deaf and NZSL accessible resources and services and/or an independent health promotion central hub for resources such as the UK SignHealth[[29]](#endnote-29) with Deaf interpretation, videos with real stories as examples
* Key elements for general Deaf health promotion are Healthy Relationships and Sex Education, and for children, identity formation in the school curriculum for positive psychosocial positioning in community and wider society[[30]](#endnote-30)

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