

The Consequence of Decisions: Deaf Mental Health

Deaf Mental Health Development Group Report

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Kites Trust
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The views of this report do not necessarily reflect on the opinions of Kites Trust or the Deaf Mental Health Development Group.



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Due to the Privacy Act (1993), we cannot individually name the clients involved in this report, however without their shared experiences of the system, this report would not have been completed. This report is for you.

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Introduction

In 2010, Hutt Valley DHB as the lead District Health Board (DHB) for the central region of DHBs decided to close the specialised regional Deaf Mental Health service. It is unclear how and why this decision was made however at the time the DHBs stated they were confident that the needs of people who were Deaf and experienced mental health problems would be met within existing mainstream mental health services. The funding for the Deaf Mental Health service was absorbed back into DHB services, at the time it was unknown what the impact of this decision would have on the deaf clients who used the specialised service.

Local DHB's and the Ministry of Health have requested more evidence of need before committing to any financial contribution to meeting needs of Deaf people who experience mental health problems. The Wellington Deaf Mental Health Development Group (DMHDG) is interested to identify the gaps left by the closure of the Wellington regional Deaf mental health service and to ensure the needs of the Deaf people are being met within the Mental Health sector. In order to do this, the authors approached the Deaf community and engaged in a discussion where the consumers (People who are Deaf and experience mental health problems) and mental health professionals could share their experiences and provide advice on what was needed and how best to meet needs and invest resources in going forward.

The report first discusses the history of Deaf mental health in New Zealand (with particular focus in Wellington) before exploring the known limitations of this research and acknowledgements to stakeholders for their involvement and contributions to the final copy of this report. Following this, the report discusses the clients' perspectives based on the questionnaire developed (see Appendix, No 1) before moving onto the professionals' responses based on a separate questionnaire (see Appendix, No 2). The conclusion provides a summary of the clients and professionals' viewpoints on Deaf mental health that then shape this report's recommendations.

Background

This section explores the history of Deaf Mental Health in New Zealand from 1994 to present day.

1994 the Mental Health Steering Committee was established by the Deaf Association of New Zealand. The purpose of this committee was to identify, plan and cost the service required and oversee the implementation of the service.

1995 saw the Bridgeman Report: *The Mental Health of Deaf People: a Preliminary Assessment of the Needs* that gave recommendations to the development of a pool of mental health professionals competent in New Zealand Sign Language (NZSL), and for the development of NZSL resources for those using the service.

1998 The proposal for a National Deaf Mental Health Service was introduced and the joint operation between Deaf Association and a local hospital in Auckland to develop a team offering a range of services for Deaf people with mental illness. Within the proposal it was suggested that similar services could be established in Christchurch and Wellington.

2001 an agreement was reached between Deaf Association (now called Deaf Aotearoa NZ), Richmond Fellowship (now called Richmond) and the Framework Trust for the provision of Deaf Services. A Ministry of Health contract was given to the umbrella group of Synergy Healthcare, a joint venture between Richmond and Framework Trust. At the time, Deaf Aotearoa had stressed that for the needs of Deaf people to be met, staff who are fluent NZSL, awareness of Deaf Culture and the use of trained mental health NZSL interpreters was essential. The agreement saw four staff employed. A communicator, a team leader and two community support workers.

2003 Deaf Mental Health Service sat within Richmond NZ infrastructure alongside other Mental Health Services. 'Synergy' was a joint initiative between Richmond NZ and Framework Trust

A Memorandum of Understanding was developed between the Deaf Association and Synergy Healthcare.

2004 Additional funding was received to establish the Wellington base. Two more Community Support Workers were employed. Team Leader based in Auckland provided leadership for the Auckland and Wellington offices.

2005 Synergy disbanded and services moved to Richmond

2007 Central Region Deaf Mental Health Service became operated by Richmond NZ. A restructure disestablished the Service Manager role and created clinical advisers and operations managers. A proposal was made to Richmond NZ that the Deaf Mental Health Service was unique and required leadership - it was hoped that a clinical adviser could fulfill this role and the opportunity existed with a qualified and experienced person from England here in New Zealand at the time but this approach was not successful.

Auckland and Wellington Deaf Mental Health Services separated. New Service Delivery Managers were appointed to manage each DMHS independently. In Auckland one of the staff members became a Service Manager for the Auckland based service covering Northland, Auckland and Waikato. Wellington brought in a hearing Service Delivery Manager which was followed by the resignation of the two Deaf Community Support Workers.

The Auckland Service relied on social networks to know what was happening in relation to their counterparts in Wellington.

2008 Further restructuring reduced the number of Service Delivery Managers and the Auckland Deaf Mental Health service was reduced to the two Community Support Workers.

The Deaf Mental Health Service is no longer a stand-alone service.

2010 Central Region Deaf Mental Health Service operated by Richmond NZ closes.

The “Deaf Way” Report commissioned by Deaf Aotearoa

2011 Wellington Deaf Mental Health Development Group is established with the aim of improving responses for people who are Deaf and experience mental health problems.

The coalition of Deaf Mental Health Professionals (CDMHG) was developed by Deaf/Hearing people in Auckland. CDMHG are now an independent legal entity.

2012 Meeting held with the Clinical Director of C&C DHB to discuss issues of concern for Deaf mental health consumers. Specific stories from Deaf consumers citing examples of problems with access to mental health services were requested and provided.

2013 Wellington Forum held in June – *Improving access to mental health services for Deaf*. This forum was attended by approximately 50 people and results can be found at http://www.kites.org.nz/index.php?deaf_mental_health2014

This report has been commissioned by Kites Trust with the assistance of a COGs grant to explore the impact of the closure of the Wellington region Deaf Mental Health services has had on Deaf consumers.

Limitations of the report

The extent of this report was limited by the resources available to undertake the research. The number of consumers and health professionals interviewed was small and they were identified through current networks. All of the consumers had used the specialised Deaf Mental Health Service in the past.

It is essential to understand the challenges in providing mental health services for people who are Deaf. An individualistic approach which places the person at the centre is required due to the diverse needs within the Deaf mental health community. Variations include the degree of understanding and use of New Zealand Sign Language, different modes of communication-many of which are technology based, the range of mental health problems and distress, geophysical locations, accessibility to services and supports, education (understanding and retaining key information), relationships and understanding of mental health.

Consumers' perspective

All consumers interviewed reported they are not currently accessing specialised mental health services including DHB and NGO clinical mental health services. The reasons, cited were relationship breakdown [as no communication] between the provider and the clients. This was described as resulting in undue stress on the consumers and their families. When consumers have tried to access specialised mental health services, they reported it was unhelpful due to deficiencies in understanding of Deaf culture. Within the service, none of the staff have any knowledge of sign language interpreting services. It should be noted that all consumers have reported they have accessed services provided outside Wellington region, going as far as Palmerston North, Hamilton and Auckland.

Recognition of official language

The consumers had mixed responses of whether NZSL Interpreter was provided or not. A consumer had to prompt the provider to get an NZSL Interpreter which often saw delays in

getting treatment. The consumer explained how he was required to check every time he was going to get an NZSL Interpreter. Another consumer reported a similar experience, the staff at the mental health service did not know how to book an interpreter and exhibited no knowledge about the service of interpreters. The consequence of this saw the consumer having to take up the responsibility to book the interpreter and ensure payment was met. The impact of the increased responsibility was said to have a negative impact of the consumer's wellbeing.

Consumers interviewed had no issues on understanding "who pays" [NZSL Interpreters] as it was assumed there was not any problems associated with the process of payment for providers.

Lack of Information

Since the closure of the specialised Deaf Mental Health service in Wellington, those interviewed reported feeling left in the dark. They described how the lack of information has left them waiting longer for something that may not come, which caused them to feel significantly disadvantaged. The following terms were used to describe how they felt about the closure; "sad", "depressed", "worse off", "lost", "breakdown", "confused" and "couldn't find anything"

Consumers reported that no communications about the intended plan after the closure of the service. All consumers interviewed stated they did not have any understanding of what plans there were in place to refer to or access to an alternative mental health service where they would be supported.

Ongoing challenges

The feedback from the consumers is that it has been harder [since the closure of the Deaf mental health Service] highlighted a common theme that is found within the Deaf community. Issues of barriers, breakdowns, not the same person [case manager], no information, lack of cultural awareness, inconsistent service, little or no understanding of booking interpreters, fear of going mainstream, barriers to accessing information (both, digital and print) and therefore being extremely difficult to understand, no help to get

support after the closure which consequently saw and left them feeling in the dark about their own needs.

All consumers have strongly pleaded to see the Deaf Mental Health services restored with better transparency of information that is Deaf-friendly and accessible for Deaf people.

Communication

The consumers expressed the need to have better communication between service providers and consumers. There was a strong desire to see more medical professionals having Deaf awareness training, including learning how to sign. One consumer pointed out that while hearing people have 24/7 access to help such as Lifeline and Youthline Deaf people have NZ Relay which only provides telecommunication service during limited hours. Upon being asked what would resolve the difficulties in accessing help, consumers suggested reintroducing the Community Support Worker (CSW) service.

It was strongly stated the mainstream service should not take the responsibility of any Deaf clients unless there is a clear evidence of their understanding of Deaf culture, the use of NZSL and the specific needs of the Deaf community. The final suggestion was for the interpreters to have more mental health literacy training as some are not specialist or qualified in Mental Health area.

Need for a Specialised Services and Responses

The importance of specialised Deaf Mental Health service was expressed as important by all consumers. The profound reason why this was the case was because the consumers felt more comfortable expressing themselves through NZSL which gave them better access to help. All consumers reported they felt safer using this specialised service compared to a general mental health service because there was a good level of understanding, better collaboration between CSW and service providers and ensuring the Deaf consumer was fully participating in the process. Taking into consideration the limited literacy skills across the Deaf community, the CSW would enable a better individualised approach to understanding the information at hand.

If there continue to be no Deaf services, the consumers felt that the mental health services could do with general feedback about what is helpful for Deaf people. The predominant answer was to have face-to-face interaction by means of using NZSL. Central to NZSL, also saw suggestions of;

- NZ Relay Service VR
- text services
- more Deaf awareness training,
- more professionals to try and sign/express in sign language.

Consumers interviewed asked why it is not part of the professional development for those working with Deaf consumers.

Support for family whanau and friends

All consumers supported the notion that the mental health support should also be extended to their partners and families who are dealing with their daily struggles, and navigating the mental health system. This would ensure a more consistent understanding for the wider community about mental health. However the consumers expressed concern about the potential implications of this as the Deaf community is very small and privacy is very important. Privacy is a strong prevalent issue associated with the need of an autonomous service such as Deaf Mental Health Service.

Upon being asked who the consumers would contact in an emergency when experiencing distress or feeling low or suicidal, one client uses an organisation's identification card that details how to best help the user. Surprisingly, others had no idea who to call/contact. According to a general consensus, it was thought that ideally, it would be to contact on duty Deaf CSW, if the option was there. A consumer, who had previously had the experience of accessing a CSW, said that the CSW referred the client to the most appropriate service at the time. When asked since the closure of such service, what was the current means of accessing help, the consumer said there was no effective way to seek assistance. Currently all consumers rely on text/emails to whoever. This was a key concern of the authors, which we discuss in depth further into this report (see recommendations).

Wider Community

Drawing from a wider community perspective, the consumers felt that the Deaf community would benefit from having general information about mental health. It was suggested that during mental health week, Deaf people should be included. Providing a workshop at the local Deaf club about general information on mental health was thought to benefit everyone positively. This would also see a decrease in alienation and the negative social stigma surrounding mental health in the community. It is important that the wider Deaf community has some knowledge of mental health so there is more respect and better attitudes towards those that use mental health services. Care is needed so that any information normalises distress as part of the human experience and does not increase stigma in any way. The key focus is ensuring and enabling Deaf people understand and knowing how to access/approach the services offered.

It was strongly reinforced by the consumers that mainstream practitioners would benefit from more Deaf awareness and access to deaf advisors. In relation to this it was believed there should be some form of guidelines for all practitioners to ensure consistent services for deaf. The consumers expressed a need for a wider scope on deaf friendly buildings, to be more accessible for deaf people. For example, public announcement, fire alarms are not currently Deaf-friendly.

Consumers felt there should be a “one stop shop” at the hospital for the needs of Deaf people. Due to the high value consumers place on privacy they did not want the Deaf community to know they have mental health issues or use services. However it should be interesting to note the consumers also wished to see more Deaf trained professionals. There is a growing need from the consumers to be able to access the information independently without reliance on others.

The consumers questioned why there are specialised mental health services for other cultural-linguistic minority groups such as Maori, and Pacific but not for Deaf.

In reference to improvement of information, all the consumers interviewed currently had no understanding of what their medications do, or the potential side effects or even what medications they are currently on.

They also believe there should be a more flexible consultation times with Deaf people due to the time delay in interpreting from NZSL to English or vice versa. Where consultants are booked for 30 minutes or 1 hour, Deaf clients feel they really only have 15 minutes or 30 minutes of meaningful interaction.

The consumers reported there was no clear understanding of what the complaint procedure was. It should be noted that all consumers bought this up without prompting. The consumers felt the lack of information about complaints is a breach of HDC ethics and a lack of professionalism.

Those interviewed felt the CSW should have some relevant background in mental health or equivalent. The requirement is the CSW must be knowledgeable in NZSL and have some understanding of Deaf culture to improve communications between all stakeholders.

All consumers reported that the constant change of case manager/health worker was detrimental and affected the service they received. This was due to having to re-educate every time there was someone new, which in turn delayed effective treatment and establishment of trust was difficult.

Some consumers suggested there should be a support group for Deaf mental health users. Lastly the consumers interviewed believe that their option of using NZ Relay was hard to effectively use when the interpreter is not trained in the mental health area or the service provider is not recognizing NZ Relay.

Professionals' perspective

The authors gathered perspective's from mental health professionals, to ensure that all

points of view had equal opportunities to explain their side of the story regarding the barriers and what it's like for them when they meet a Deaf consumer. These perspectives were collected during interviews and workshops with health professionals from DHBs and NGOs.

The most common and major problem is the lack of effective communication as most mental health professionals who cannot sign and have limited understanding of the Deaf culture. Many are unaware of "how to book an interpreter" or even know that there are several interpreting services available. All mental health professionals agreed that they do not have right information with a visual picture or appropriate resources for the Deaf community due to limited funding. Many of the professionals were not aware that literacy would be a problem for the Deaf community. Most of the health professionals did not understand how an interpreter works and what their role specifically is.

There were several comments that have been brought to our attention as barriers, and whilst not specific to mental health services their inclusion is warranted as mental health consumers may access these services. For example, the environment being unsuitable whilst performing tests e.g.: dark theatre, wearing masks and positioning when Deaf consumers are having an x-ray, or examination and the staff having to be behind a protective screen. With hearing people you can talk over the microphone and tell them where to change the position but with Deaf people you cannot do this.

When a Deaf Consumer is going for an assessment, there is a risk that the specialists may misinterpret behaviour that is not understood, for example, when a Deaf person sign's or uses facial expressions that may come across as intimidating. Additional concerns are the lack of knowledge of a Deaf person's behavior, understanding of the Deaf Culture or background such as: education, family and employment.

Most of the health professionals interviewed were aware Deaf consumers may lack of understanding of medical terms as many cannot read or write. Consent forms are a big issue because of the language, terminology and general jargon.

The lack of appropriate resources in residential and respite services raises safety concerns.

Most do not have a Deaf fire alarm especially in the kitchen, bathroom or bedroom or have the right equipment essentials, such as door bell, computer to call NZ Relay Service and specialist alarm to wake the patient if there were a fire, earthquake or any sort of disaster. The major problem is funding issues and they are unsure where they can get funding to provide this essential equipment.

Many health professionals reported having problem's booking interpreter's at short notice especially in an emergency and for rapid response such as Crisis Assessment Treatment (CATT) services. It has been a major crisis for both health professionals and the consumers, which lead to both parties to act under increased pressure and stress.

Systemic Challenges

Regarding the Health and Disability Commission code of rights, consumers can complain about the service if they are not providing or meeting their needs, however the code does not extend to services closing such as the Deaf Mental Health service. Problems with access to services and funding issues are also out of their jurisdiction.

Areas of challenge and difference between the health professionals and consumers are accessing and understanding between the two language and cultures.

Deaf people view the hearing world as the other culture and language (including associated protocols and systems.) Written English is largely inaccessible to a high proportion of Deaf people due to English being a second language.

Due to limited exposure to the Deaf community, there is a general lack of understanding and knowledge about Deaf culture, language and the needs of Deaf people by the hearing population. This leads to distorted perceptions about what it is to be Deaf. Hearing people often view the Deaf community as disabled, incompetent, incapable, separate etc. This can reinforce negative stereotyping resulting in more barriers being erected. When Deaf people develop problems with their mental health, this can compound their feelings of isolation and separateness.

In dealing with the authorities and social systems, the culture and language difference can

often result in Deaf people feeling overwhelmed, confused, and disempowered. They are at risk of having their rights undermined especially in the case of mental health users.

At the same time for Mental Health professionals, they can feel overwhelmed, fearful, and powerless too. They are at risk of their rights and responsibilities as providers being undermined.

Consideration also needs to be given to Deaf people who are from multicultural backgrounds or have additional disabilities. What about the Deaf people who are in prison and have a mental health problems? What about the Deaf children, teenagers, and older people?

The health professionals interviewed believe that something needs to be done to improve responses to Deaf who experience mental health problems. Suggestions include

- two roles; a hearing or Deaf navigator or CSW and a Deaf educator/advisor
- an educator and advisor who could provide on-going education, not a one off because of change over staff
- someone who they can call on to give advice and support especially when it comes to sharing information,
- use of interpreter and referral to appropriate service if they are unable to support the Deaf consumer.

Conclusion

Consumers interviewed report the closure of the specialised Deaf mental health service has had a negative impact on them. Feedback strongly suggests Deaf mental health consumers are experiencing inequality as a result of mental health services being unable to adequately accommodate their needs. Communication problems and lack of understanding of Deaf culture are the major barriers that need to be overcome. This report raises serious concerns about the health and wellbeing of Deaf consumers given all consumers interviewed reported having no understanding of the medication they take, barriers to accessing services, especially when in crisis and the potential to be misunderstood.

The issues raised by consumers are supported by health professionals and despite good intentions the barriers to accessing interpreters which means good communication between health professional and consumer are compromised.

The combination of issues highlighted within this report has potential to have serious consequences for Deaf consumers. Dissatisfaction and mistrust of services alongside the stigma toward people with mental health problems within the Deaf community may result in isolation and reluctance to seek help and support when needed. Mental distress can therefore be exacerbated.

The District Health Boards of the central region made the decision to no longer fund the specialised Deaf mental health service and felt confident that mainstream mental health services could provide effective treatment and support. The findings in this report suggest this has not been the case and action is required to ensure people who are Deaf and experience mental health problems have the same opportunities to mental health treatment and support as hearing people as the United Nations Convention on the Rights of Persons with Disabilities, Human Rights and Health and Disability Commission have stated.

Recommendations

The recommendations draw from both the Deaf consumers and the professionals that work with the Deaf consumers.

Establish Deaf or hearing Navigator and support roles. For these roles to be effective they;

- Must be able to use NZSL and understand the Deaf Culture
- Support Deaf clients in mainstream service
- Provide clear communication understood by both cultures
- Work collaboratively with mainstream services, other health professionals and Deaf educators and advisors
- Support Deaf clients understand their medication/legal rights

- Ensure information is Deaf friendly and accessible for Deaf consumer
- Facilitate referral and navigation to appropriate services
- Undertake needs assessment
- Must have equivalent MH qualification or working knowledge of mental health sector and community

Establish Deaf educator/advisor role within mental health services:

The purpose of this role(s) is to

- Provide ongoing education session with health workers and Deaf community
- Develop and provide accessible general information to both consumers and health services
- Provide a list of interpreter services
- Provide advice and referral to appropriate services
- Collect and provide data information to ensure responses are evidence based
- Develop appropriate resources for all parties
- Explore the development of h a Deaf consumers support group
- Explore options for Deaf consumers to have any training or leadership development, for example, peer recovery education workshop
- Undertake systemic needs assessment to identify how to best meet the needs of the community

Other essential recommendations:

Due to limited funding we were unable to approach as many consumers as we would have liked as well as other relevant organisations who could inform this work. To further this project, we need to have:

1. Funding to support the work of the Deaf Mental Health Development Group
2. Research into areas of excellence for responses to meet need of Deaf Mental Health consumers.
3. Expansion of responses to include across all walks of life, age, ethnicities etc.
4. Create a book of stories about people who are Deaf and share their journeys through mental illness.
5. Encourage mental health services to collect data for analysis, for example, record if



someone is Deaf.

You have to be Deaf to understand

What is it like to "hear" a hand?
You have to be deaf to understand.

What is it like to be a small child,
In a school, in a room void of sound-
With a teacher who talks and talks and talks;
And then when she does come around to you,
She expects you to know what she's said?
You have to be deaf to understand.

Or the teacher thinks that to make you smart,
You must first learn how to talk with your voice;
So mumbo-jumbo with hands on your face
For hours and hours without patience or end,
Until out comes a faint resembling sound?
You have to be deaf to understand.

What is it like to be curious,
To thirst for knowledge you can call your own,
With an inner desire that's set on fire-
And you ask a brother, sister, or friend
Who looks in answer and says, "Never mind"?
You have to be deaf to understand.

What it is like in a corner to stand,
Though there's nothing you've done really
wrong,
Other than try to make use of your hands
To a silent peer to communicate
A thought that comes to your mind all at once?
You have to be deaf to understand.

What is it like to be shouted at
When one thinks that will help you to hear;
Or misunderstand the words of a friend
Who is trying to make a joke clear,
And you don't get the point because he's failed?
You have to be deaf to understand.

What is it like to be laughed in the face
When you try to repeat what is said;
Just to make sure that you've understood,
And you find that the words were misread-
And you want to cry out, "Please help me,
friend"?
You have to be deaf to understand.

What is it like to have to depend
Upon one who can hear to phone a friend;
Or place a call to a business firm
And be forced to share what's personal, and,
Then find that your message wasn't made clear?
You have to be deaf to understand.

What is it like to be deaf and alone
In the company of those who can hear-
And you only guess as you go along,
For no one's there with a helping hand,
As you try to keep up with words and song?
You have to be deaf to understand.

What is it like on the road of life
To meet with a stranger who opens his mouth-
And speaks out a line at a rapid pace;
And you can't understand the look in his face
Because it is new and you're lost in the race?
You have to be deaf to understand.

What is it like to comprehend
Some nimble fingers that paint the scene,
And make you smile and feel serene
With the "spoken word" of the moving hand
that makes you part of the world at large?
You have to be deaf to understand.

What is it like to "hear" a hand?
Yes, you have to be deaf to understand.

Willard J. Madsen, associate professor at
Gallaudet College and a graduate of the Kansas
School for the Deaf.

Appendix

Information sheet

You are invited to be part of a survey of the services you have used in Wellington region. We are looking to learn about:

- How you found the process
- What you found unhelpful and,
- Identify what service(s) support you best
- Identify how to best meet the service and the needs of the deaf mental health community.

Kites Trust is keen to learn about your experiences with the process and the support you have received. Zachary Best and Lynnen Allen have been contracted by Kites Trust to do the survey.

Who can take part?

Deaf people who have used (or continue to use) the services provided by the mental health organisations.

You do not have to participate. Whether you choose to participate or not will not affect the services you receive.

Why is this important?

Accessing quality mental health services is important and we can all learn from what has worked and what has not.

What will I have to do?

Zachary or Lynnen, on behalf of Kites, will contact you to arrange a time to meet and interview you about your experiences of the mental health services. We will have a number of questions and you are welcome to discuss it in whatever way you are most comfortable with. Your answers will be kept confidential.

You are welcome to have someone with you of your choice, if you wish.



What will happen to my information?

Your information will be kept anonymous. It will be used and stored securely in the Kites office for a period of one year after which it will be destroyed securely.

Once we have everyone's information, it will be summarised into a report for the Deaf Mental Health Development Group (DMHDG) (Wellington).

You will receive a copy of the information you give us and the summary of the report to the DMHDG.

What else do I need to know?

You may stop participating at any time, without giving any reason.

You are able to withdraw any information you provide up to one week from the date of providing it.

Thank you

Your perspective and experience is highly valued and we really hope that you will take part.

Contacts

If you have any questions or would like to discuss the study further, please email:

Marge Jackson
Kites Trust
margej@kites.org.nz



Consent form

I have read the information sheet and have had details of the information sheet explained to me.

My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

By signing this form, I agree to:

- Participate in the survey under the conditions set out in the information sheet.

Full name

Signature:

Date:

Witnessed by:

Questionnaire (clients)

- Have you used any Mental Health services in the last 5 years?
- Have you used any Mental Health services outside of Wellington?
- Did you have an interpreter with you?
- Do you feel since the closure of the Deaf Mental Health services, it has been harder to access information or services?
- How has it been harder?
- Can you suggest any improvements to access better Mental Health services?
- Do you think it is important to have a Deaf Mental Health services?
- What skills do you think the Mental Health services should have to better help you?
- Do you think the support should be extended to the client's family/friends if wanted wider involvement?
- If you needed Mental Health help urgently, who do you contact?
- Do you think that it would be useful for the Deaf Community to have better access to information about Mental Health?
- Do you feel that mainstream practitioners could benefit from more Deaf Awareness and Deaf advisors?
- Do you think that a formal set of guidelines for all practitioners to use would be helpful to support good services for Deaf people?
- Is there anything else you feel that we should include in the report that we have not discussed today?

Questionnaire (professionals)

- Are you are aware of DMHS closed?
- Have your service work with a Deaf consumer? If yes, how is that? If not, why do you think Deaf people are not using your service? About how many consumers?
- Do you know how to book an interpreter and understand their role?
- What are the main barriers that affect the mental health care of Deaf people in Wellington?
- What is the most difficult part for your service dealing with Deaf consumer?
- Do you think it is important to have a specialist service for Deaf people with mental health needs and why?
- What skills do you think your staff could have when working with Deaf consumer?
- Do you think that mainstream practitioners could benefit from more specialist training and guidance?
- Do you think that a formal set of guidelines for all practitioners to use would be helpful to support good practice with Deaf people?
- Any recommendation for your service?