



Scottish Council on Deafness

MENTAL HEALTH AND DEAF PEOPLE TASK GROUP

***Minutes of the 32nd Meeting of
the Mental Health and Deaf People Task Group
held at SAMH, 15 Carlton Court, Glasgow
on Friday 11th September 2009 at 10.30am***

PRESENT: Lilian Lawson (Chair)
Michael Davis, Counsellor
Frances Dolan, WSDCS
Deborah Innes, NHS Lanarkshire
Willie MacFadyen, BSMHD
Mandy Reid, SCoD
Linda Sharkey, HearingConcernLINK Scotland
John Speirs, Deaf Connections
Rachel Stewart, SAMH

IN ATTENDANCE: Dr Jane Morris (Royal Edinburgh Hospital), Jan Savage (NDCS Scotland), Andrew Dewey and Yvonne Strain (Sign Language Interpreters) and Linda Donnelly (Notetaker).

327 WELCOME & INTRODUCTIONS: LL welcomed everyone to the meeting. Dr Jane Morris, Consultant Child & Adolescent Psychiatrist from Royal Edinburgh Hospital was present to talk about CAMHS services. Jan Savage had been invited to observe the day's Meeting. Everyone introduced themselves for the benefit of the meeting.

328 APOLOGIES: Apologies had been received from Lesley Boyd (NHS Lothian), Judy Byrne (Hayfield Support Services), Delia Henry (RNID Scotland), Carolyn Roberts (SAMH) and Liz Scott Gibson (Deaf Action).

329 CHILDREN & ADOLESCENTS MENTAL HEALTH SERVICES: LL invited Dr Jane Morris to speak to the MHDP Task Group about her work.

Dr Morris gave an excellent PowerPoint presentation covering two main areas: what are the CAMHS services and how well do they serve deaf children and parents.

- a) CAMHS services consists of: outpatient services; day patient services; intensive outreach services and inpatient services. They also include those who need secure psychiatric services and who have a learning disability.
- b) CAMHS services deal with major psychiatric diagnoses:
 - Depression
 - Anxiety
 - OCD

- Bipolar affective disorders
- Psychoses (schizophrenia)
- Eating disorders
- Phobias
- Somatising disorders
- Autistic spectrum disorders
- ADHD

c) How well CAMHS serve Scotland's children?

Scotland has the lowest number of inpatient beds per million of the whole Western Europe (fewer than 8 per million – SE England has 24 per million).

CAMHS outpatient services are staffed inadequately compared with the “Getting the Workforce Right” document – and there are unfilled posts too.

However, there is commitment and concern, with some CAMHS teams providing high quality services regardless of resource.

On the other hand, there is low morale and little time for training because of clinical workload, so that some services are deteriorating.

d) How do people from any cultural minority find CAMHS services?

People from Chinese, Indian, Pakistani, African, Polish & Eastern European Communities and refugees from other countries have accessed CAMHS services. The main issue affecting these communities is related to languages. It is crucial to have a good interpreter who does not just have good language skills but must have knowledge and understanding of their cultures. Dr Morris said “cultural nuances are particularly important in psychiatry”.

Dr Morris said it might be easier for these people from ethnic minority groups to fit into groups and adapt to ward environment because they were “kids” and they could gradually learn English. Dr Morris accepted that this might not be so for deaf children.

e) How do deaf people in particular experience Scottish CAMHS?

Dr Morris identified the following issues:

- Lack of awareness of what is available
- Access & referral to CAMHS
- Communication – for both young deaf people and their families
- Isolation from peer groups
- Stigma

f) How do CAMHS professionals experience deaf people?

Dr Morris gave examples:

- Misunderstanding/misinterpreting deaf parents' communication (e.g. “shouting in sign language”)
- Difficulty of giving handovers and feedback by phone – CAMHS professionals have to think about using other means like fax, text and email

- Lack of CAMHS professionals with BSL skills
 - Not enough high quality BSL/English Interpreters who have been trained and have experience to work with mental health patients (Dr Morris gave two examples to illustrate good and bad BSL/English Interpreters)
 - Lack of CAMHS professionals who can lipread
 - Some CAMHS professionals have hearing problems too
- g) What might CAMHS do to improve things?
- i. Improve CAMHS all round
 - ii. Invest in training for working with people from all cultural minorities
 - iii. Raise awareness of particular vulnerabilities and strengths of people who are deaf

LL thanked Dr Morris for her excellent presentation and invited the MHDP Task Group to raise questions or issues with Dr Morris.

FD said that she was not surprised that Dr Morris had not seen many deaf children because when deaf children had left school, they were diagnosed to have mental health problems – late recognition of their problems. She said there was need for teachers of deaf children and educational psychologists to have mental health awareness and also there were not enough teachers who had good BSL skills.

WMacF supported the need for good quality BSL/English Interpreters but he said it would have been better if mental health professionals could acquire BSL and other communication skills so that they could communicate directly with deaf patients.

Some members spoke about telemedicine which could be used for accessing CAMHS services in England. Dr Morris advised the MHDP Task Group to bear in mind that legislation linking to education and mental health is different in England and Scotland. She also said that we would need more than just accessing a child psychologist or CPN.

LS spoke about lack of support for hearing children of parents with acquired hearing loss. Dr Morris said “interpersonal psychotherapy would help as it maps out all the people in the child's environment and also looks at transitions and losses”.

LL thanked Dr Morris once again for coming to speak to the MHDP Task Group and said that this item would be placed on a next meeting's agenda because the MHDP Task Group would need time to discuss how CAMHS services could be accessed by deaf children and adolescents and their families.

330 MINUTES OF THE 31st MEETING DATED 11th JUNE 2009: The Minutes of the 31st Meeting of the MHDP Task Group dated 11th June 2009, which had been previously circulated, were accepted as a true and correct record.

331 MATTERS ARISING:

331a Ref: 319a) Petition: LL informed the MHDP Task Group that a letter had been sent to Christine Grahame MSP, Convenor of the Scottish Parliament Health & Sports Committee raising concern about the Scottish Government's lack of progress with the Business Case. Christine Grahame MSP had replied saying that she had already written to the Scottish Government requesting for an update on whether a decision had been taken on the Business Case. The Scottish Government officials had advised the Health & Sports Committee clerks that Christine Grahame would expect to receive a response in mid September 2009.

LL also informed the MHDP Task Group that she had received a written reply from Paul Rhodes, eHealth Programme Director. Paul Rhodes confirmed that "when new IT systems are developed for NHS Scotland, the eHealth Directorate ensures that the needs and preferences of both patients and health professionals are fully considered, with specialist input from our clinical leads, and incorporated into the relevant commissioning/procurement documentation. For example, one of the eHealth Directorate's current priorities is the procurement of a national Patient Management System (PMS) which will be available for use by all NHS Boards in the secondary/acute care setting. The PMS requirements document includes a requirement for the application to provide a full patient alert capability and includes patients with special needs, and gives as an example patients in need of an interpreter.

Work is also underway to identify how deafness is recorded in GP electronic records so that it is easier for health professionals to identify communication needs and patients with special needs. This will improve the awareness of communication needs and ensure that these can be taken into account when patients attend their GP practice and when they are referred for other health care services. The way in which deafness might affect the impact of illness will also be made clearer."

Paul Rhodes mentioned in the letter that Linda Sharkey from Hearing Concern LINK had discussed the possibility of an awareness campaign to publicising this initiative once the "Read codes" becomes available to GP practices.

331b Ref: 319b: RNID Mental Health Research: LL read out Delia Henry's email which stated that the prevalence study and the returns from all of NHS boards had been complete. NHS Lothian had been very helpful and the researchers were still having problems identifying case studies from Glasgow. The MHDP Task Group discussed and agreed the researcher should contact Jac Ross at NHS Greater Glasgow & Clyde.

331c Ref: 319c: Making the Case: The Scottish Government would not reproduce the "purple" booklets in BSL. It had been noted in a Scottish Government publication that some service users had complained about the booklets because the written materials were too complex and used technical language that confused the reader.

- 331d** Ref: 319d: NHS Greater Glasgow & Clyde Mental Health SI Working Group: It had been reported that despite repeated reminders, NHS Greater Glasgow & Clyde had still not had arranged for this working group to resume after Gareth Greenaway's departure. Jac Ross emailed to LL saying that she would speak to David McCrae.
- 331e** Ref: 319e: Future of Mental Health and Deaf People Task Group: Owing to lack of time left for the rest of the day's meeting, it was agreed to defer this item to a next meeting for a full discussion.
- 331f** Ref: 319f: Criminal Justice and Mental Health: COSLA had responded saying that it was more appropriate for ASDW to deal with the issue and the letter had been forwarded to ASDW. The Scottish Prison Service had also responded saying that they would be pleased to have a meeting to discuss the issue further.
- 331g** Ref: 321: Audit Scotland's Overview of Mental Health Services: LL and MR had not yet had opportunity to follow this matter up.
- 331h** Ref: 320: Forensic Services: LL stated that she had recently received an email from the Forensic Network saying that the NSD was planning to establish a group to consider issues for deaf patients across a number of specialities such as access to staff who could sign. LL said that she would contact NSD for more information.
- 332** **MENTAL HEALTH REVIEW CONSULTATION:** MR gave some information about the mental health review consultation and asked the MHDP Task Group to give feedback to MR by mid October 2009. The consultation ends on 6th November 2009.
- 333** **BRITISH SOCIETY FOR MENTAL HEALTH AND DEAF PEOPLE:** WMacF stated that he had nothing to report as the BSMHD had not had a meeting since the last MHDP Task Group meeting.
- 334** **DEAF INTEREST GROUPS:** As LSG and LB were not present, there was no report on the DIG (Edinburgh). The DIG (Glasgow) had not met for several months.
- DI informed the MHDP Task Group about a new group called Scottish Clinicians Group consisting of mental health professionals who were currently working with deaf people who have mental health problems. It is a closed group aimed at peer support, discussing cases and research. LL welcomed this development.
- 335** **CROSS PARTY GROUP ON MENTAL HEALTH:** WMacF reported that the CPGMH met in June 2009 and the main agenda item was about Mental Health services within the Criminal system, looking at prisons. He said that he and MR raised the question of deaf people in prisons. MR said that she

had sent a copy of the Criminal Justice and Mental Health research report to the lady from the Scottish Prison Review Board. She had a reply saying that the issues should be fed into the Justice Disability Steering Group.

LL asked the MHDP Task Group to let her have any issue related to the prison service for her meeting with the Scottish Prison Service.

WMacF said the next CPGMH meeting would take place on 28th October 2009 and the main agenda item would be suicide prevention strategies.

336 AOCB:

336a Summit on 27th October 2009: WMacF gave information about a summit that was being organised to look at the diminution of social work services for deaf people in Scotland. MR said that she was currently carrying out an audit of social work services for the Forum of Social Work Service Providers in Scotland and BASW who would use the audit results for the summit.

336b Social and Emotional Development of Deaf Children Conference: FD asked if anyone in the MHDP Task Group would be going to this conference. FD said she was keen to attend and would speak to LL afterwards.

336c Register of Deaf Children: JS told the MHDP Task Group about a pilot register of deaf children with NHS Lothian.

336d Business Case: DI said that she had been asked by Colin Sloey, who drafted the Business Case, if she could represent NHS Lanarkshire in a group about deaf people with mental health problems. However, she had no more information because the group had not yet met.

336e Self Management Programme for Early Intervention for People with Acquired Hearing Loss: LS informed the MHDP Task Group that HearingConcernLINK Scotland was successful in securing funding from LTCAS for this programme which would run for two years.

336f Breathing Space: LL gave information about the new Breathing Space BSL Service which would be hoped to start running in late September and two Deaf BSL phone advisors had been recruited.

337 **DATE AND VENUE OF NEXT MHDP TASK GROUP MEETING**: Friday 11th December 2009 at 10.30am in Edinburgh.