Metro South Health

Metro South Addiction and Mental Health Services

Guidelines for working with people who are Deaf or hard of hearing

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Queensland Government

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Introduction

Persons who are deaf and use sign language to communicate also belong to a culturally and linguistically diverse community simply referred to as the Deaf community. They share similar struggles with access issues as those from a Culturally and Linguistically Diverse (CALD) background. Persons who are hard of hearing tend to identify with the dominant hearing culture yet face difficulties with full inclusion in daily life. A deaf person's identity may be fixed or vacillate according to his or her various life stages. By viewing deafness as a vast continuum of diverse individuals, service providers are able to appreciate the heterogeneity of deaf people and aim to deliver services that respect individual needs.

According to Access Economics[1], one in six Australians experience some level of hearing loss. Research suggests that people who are Deaf or hard of hearing experience restricted or delayed access to health information and health services[2-6]. Researchers have discussed the need for (hearing) health professionals to be more aware of Deaf culture and the communication needs of deafness[7-9]. The need for culturally and linguistically accessible health information and services continues to be unmet. These guidelines serve as a step towards addressing this gap, giving professionals access to relevant and reliable information.

These guidelines provide clinicians with up-to-date, evidenced based information about Australians who are Deaf or hard of hearing. In line with the National Practice Standards for the Mental Health Workforce 2013[10], these guidelines support clinicians to understand and meet the holistic needs of people and families living with deafness or hearing loss.
The guidelines are separated into five main sections, each with subsections:

Background information
Communication
Mental health
Criminal justice system
Resources

Hearing loss and deafness is a broad and complex area. The information provided in these guidelines is specifically tailored for (mental health) clinicians and the (mental) health context. For more detailed information please see the resources section of these guidelines. We use the term Deaf, to refer specifically to people who identify with Deaf culture. The term hard of hearing is used to specifically refer to people who identify as hard of hearing. The phrase 'Deaf and hard of hearing' is used to collectively refer to both groups, while the term deafness refers to the physiological experience of having no, or reduced, hearing. It must be noted that individuals with a

hearing loss have various ways of defining themselves and clinicians must respect each individual's choice.

These guidelines aim to highlight the communication, social and systemic barriers that give rise to isolation and exclusion which can impede, at every life stage, an individual's access to health promotion and care.

How to use these guidelines

Throughout these guidelines hyperlinks (text in underlined in blue) are used to help the reader find more information about relevant topics.

In the resources section of these guidelines you can find a series of Quick facts that provide a brief summary of each section. These pages can be printed for quick reference. At the top of each section is a link to the relevant Quick fact sheet.

In the resources section of these guidelines you can find a series of checklists that professionals may find useful. These pages can be printed for quick reference. In the relevant sections there will be hyperlinks to the checklists.

Background information

Deaf culture | Coda | Hard of hearing | Indigenous deaf Australians | Deafblind | Audiological information

Deaf culture

Quick Facts

Deaf people are a culturally and linguistically diverse (CALD) minority group who share common experiences, beliefs, attitudes, history, norms, values, traditions, and art[11]. Unlike other ethnic cultures, Deaf culture is not associated with a native land, but as a global culture and the culture is not typically passed down from parent to child. The majority of Deaf people are from hearing families who find the Deaf community later in life, often after having struggled to fully assimilate in a hearing society.

The word Deaf is used with a capital 'D', referring to individuals with a hearing loss or deafness who identify as culturally Deaf and have a strong identity in the Deaf community. Within Deaf culture, deafness is considered normal and as a cultural identifier. Personal choice defines whether a person is Deaf, and is not reliant on hearing status. The word deaf, using lowercase 'd' refers to an audiological condition.

Deaf identity

Only a few Deaf people acquire their cultural identity from family. As more than 90% of deaf children are born to hearing parents[12], who frequently do not learn sign language, socialisation into Deaf culture and their Deaf identity develops through meeting other Deaf people in school or in the community[13]. Deaf people can sometimes feel alienated and/or isolated from their family and the hearing world, due to language and communication issues, which can impact on their social and emotional well-being and general identity development[14-18].

Language

Barriers to communication between Deaf and hearing people are often associated with differences in language. Deaf people regard their native language, **Auslan** (Australian Sign Language), as their first language and for some, English as their second. Auslan is a visual-spatial language that has developed organically over time, with sentence structure, grammar and vocabulary distinct from English[13]. There is no written form of Auslan. Sign languages are comprised of signs, facial expression and use of space. Auslan is a living language that is continuing to develop in response to Auslan being used in areas (e.g., employment, education, health, legal) that it has never been used before.

There are sometimes strong emotive behaviours utilised in sign language that are a feature of the language. When Deaf people interact with others, they can appear to exert emotive behaviours while signing, such as anger, fear and elation. The expression of these emotions does not necessarily reflect current emotions, rather it articulates how they, or another person, was feeling or behaving. When conversing about a person, they can take on the persona of that person and this is a key element of sign language that is known as role shift. Deaf people are also highly vigilant to the way others interact with them, paying particular attention to the use of expression on the face and body language.

Deaf people will often adjust their signing style to match the language status of the people they are with[19]; either switching between languages or using a variety of sign language. This sophisticated technique to conserve communication is known as code switching[19, 20].

History
Deaf Australians have their own unique history. This history includes important events such as the Australian Deaf Games (since 1964) and festivals where Deaf people can gather together in one place to socialise and celebrate Deaf culture. Attempts to cure deafness, the evolution of welfare organisations[21] and the suppression of sign languages are significant parts of Deaf history[22]. The oralist movement, particularly evident in the education of children living with hearing loss or deafness[22], and more recently the application of Cochlear Implants to eradicate (or cure) deafness[23], represent instances of the oppression of Deaf culture and sign languages. Historical events and relations between hearing and Deaf people have created an ongoing deep sense of mistrust of hearing people.

Deaf education is also an important part of Deaf history. Deaf education shapes the succession of Deaf culture and Auslan as well as children's language development and skill and subsequent social and employment opportunities[24, 25]. Decisions about deaf education have been informed by three main approaches, and largely been made by hearing educators[22, 26]. Deaf education in Australia initially adopted manualism, the use of signed communication and finger-spelling, until 1880, when oralism became mainstream. Oralism is informed by the redefinition of deafness as a medical condition that results in people being isolated from the hearing community, and the belief that exclusive use of oral methods of communication would lead to Deaf people being able to assimilate into the hearing community[22]. The oralist education philosophy has had a lasting impact on Deaf culture (globally) and Auslan and Deaf-hearing relations (see [21-23]).

Bilingual deaf education was first suggested in the 1970's[26-28] but was only implemented in Australia during the 1990's[26]. Bilingual education involves the use of two languages to provide education, in this case English and Auslan. The majority of children continue to be educated in mainstream (oralist) schools[27, 29], with assistance from Visiting Support Teachers, Educational Interpreters, and Auslan Language Models.

Values and beliefs
Generally, Deaf people have a strong cultural identity. Deaf culture (values, customs and information) is passed on to members of the community, who include family members i.e. Coda's (Children of deaf adults), friends and Auslan interpreters, through social gatherings. Culturally Deaf people value deafness and sign language. Deaf people believe in their right for equal access to society through communication.

Behaviours and customs
Tactile and visual methods are often used to gain the attention of others. This includes touching people on the arm or shoulder, raising your hand to speak in a group situation, waving hands at people, banging on surfaces, stomping feet and flicking lights on and off. These behaviours should not be mistaken for aggression or rudeness. Eye contact is also an important feature of the Deaf community. Keeping eye contact indicates continued attention to the person while they are speaking; a lack of eye contact indicates disinterest[30]. Sitting or standing to face each other and allowing for personal space, is also typical in Deaf culture, so that people can see others more easily. The Deaf nod, which is often assumed to be an indication that the person understands the

message, is typically a strategy used to avoid appearing ignorant[31-33] and should not be seen as an indication of understanding.

Greetings within the Deaf community include personal details such as family name and school. These details are used to establish where a person 'fits' within the community and to establish credibility. Hearing people who sign are often asked where they learnt Auslan and from whom.

Children of deaf adults

Quick facts

Children born to one or both Deaf or hard of hearing parents are often called codas (children of deaf adults). Typically this term refers to hearing children of Deaf adults. Where a Deaf child has Deaf parents, the phrase 'Deaf of Deaf' is typically used. The term koda (kids of deaf adults) is sometimes used to specifically refer to children under the age of 18 who have one or both Deaf or hard of hearing parents.

Culture

Codas typically grow up in a Deaf culture environment and learn to sign before they learn to speak[34]. Deaf parents usually involve their children in Deaf activities and events, embracing a Deaf way of life. Some Deaf parents will choose for their child who has a hearing loss or deafness to use hearing augmentation. Codas who are hearing will also function as part of the hearing world. They go to hearing schools, usually grow up with hearing friends and participate in hearing activities and events. Therefore, most codas are regarded as bilingual and bicultural[34].

Common experiences for hearing codas

It is common for Deaf parents to rely on their hearing children from a very young age to communicate for them when in the presence of a hearing person, on the phone or conveying news reports from the TV etc. With greater recognition of professional interpreters and the availability of technology (e.g., captioning, National Relay Service), this practice is now discouraged.
Some hearing codas choose to become professional interpreters as adults.
Some hearing codas are not able to communicate in sign language and may have communication issues with their Deaf parents. This is usually only if one parent is Deaf and one is hearing and/or sign language is not affirmed and valued within the family.

Mental health considerations

When working with codas (as children or adults), clinicians can equip themselves with an understanding of this group and consider questions such as:

- What is the preferred language? Will you need an interpreter?
- Is there effective communication with the coda and their parent/s or caregivers?
- Is there a common understanding of concepts relating to the mental health area?
- Are the parents aware that the child has a mental health issue, or vice versa?
- Has everyone been involved in plans (i.e. recovery plans) and have a common understanding of the key elements?
- Family members are a valuable support, however, are they speaking for or on behalf of Deaf parent/s?
- Do the parents have access to programs and services (with interpreters) that could assist them in supporting their child? Is there school involvement or intervention?
- What parenting skills are evident and working well?
- Have the Deaf parents 'missed out' on the incidental learning surrounding parenting, can this be acquired now?
- Has the coda taken on adult responsibilities or a mediator role early in life?
- Have the roles of parent and child reversed? Is there a power shift?

Hard of hearing

Quick facts

Identity
Hard of hearing individuals are either born with a hearing loss or lose some or all their hearing over time or at some point in their life. Some individuals may classify themselves as deaf or as having a hearing loss; however this depends on how they view their own identity, which can be informed by audiological advice (e.g. degree of hearing loss) and the personal meaning they attach to their experience(s). Hard of hearing people generally have a hearing loss that is less than profound, rely on hearing augmentation such as hearing aids and cochlear implants to assist communication, and use spoken language.

Communication strategies
Hard of hearing individuals will still require behavioural and environmental adjustments[4] in order to achieve social inclusion including:

- direct face to face communication
- seating arrangements to optimise visibility
- good lighting
- reduced background noise
- clear speech (not exaggerated or loud)
- written information or captioning

Social and emotional implications
Hard of hearing people will likely view their deafness as a deficit and or a disability. Hearing loss is associated with social and emotional consequences such as stigma, identity concerns, denial[35, 36], social withdrawal and isolation. Relationship issues are also common which likely result from problems with communication resulting from the hearing loss[37].

The following psychological stresses, associated with deafness, can appear[38, 39]:

- stress
- depression
- loneliness
- shame
- low self-confidence
- loss of security
- anxiety
- anger
- grief

Speech
People who identify as hard of hearing generally use speech to communicate rather than sign language. Residual hearing, with or without the assistance of hearing augmentation, enable the hard of hearing person to develop and/or maintain speech. For young hard of hearing children, it can take many years of extra speech and language intervention to develop effective verbal /oral communication. For late-deafened adults, speech has already been acquired but they may have difficulty regulating the loudness of their own voice.
Clarity of speech can depend on:

- when the hearing loss occurred
- the degree of hearing loss
- the process of habilitation or rehabilitation therapy

Aboriginal or Torres Strait Islander Deaf or hard of hearing people

Quick facts

“Indigenous Australians have a wide range of lifestyles, and social, cultural, educational and family backgrounds”[40]. An estimated 30% to 80% of Indigenous children of school age have a hearing loss in Australia; and by adulthood hearing loss can be present in up to 70% of Aboriginal people[41]. The Australian Bureau of Statistics (2012-13)[42] reported Aboriginal and Torres Strait Islander people were significantly more likely than non-Indigenous people to have diseases of the ear and mastoid and/or hearing problems (rate ratio of 1.3).

Hearing loss in the Indigenous population is largely due to a higher prevalence rate of middle ear disease and conductive hearing loss[43]. Ear disease, particularly otitis media (OM) and associated hearing impairments are significant public health problems[44]. OM, also known as glue ear, pus(sy) ear, ear trouble, etc., in Australian Indigenous communities, is an inflammation of the middle ear, which can lead to perforation of the eardrum if treatment is not sought early[45]. It often begins in childhood and causes mild to severe hearing loss. For Australian Indigenous children, OM can be persistent and last longer, and tends to be chronic and recurrent[46]. For Aboriginal infants, OM rarely exhibits symptoms such as fever, irritability or inflammation of the ear which means the illness goes unnoticed by parents and is thus untreated[47]. Those living in the rural and remote regions are particularly susceptible to OM[41].

Social implications

The social consequences of hearing loss in Australian Indigenous people include greater frustration and stress during communication in noisy contexts, which can contribute to family violence and reduced social and emotional wellbeing. Additionally, hearing loss can constrain intercultural communication[48].

Vanderpoll and Howard’s[49] investigation into hearing loss in the Northern Territory Correctional Services found that a significant portion of the Indigenous population who were incarcerated had a hearing loss that they were previously unaware of. Hearing loss was also found to have likely contributed to violent altercations due to misunderstandings.

Involvement in the criminal justice system may be the end product of a cumulative link, whereby hearing-related social problems contribute to low educational standards, unemployment, alcohol and substance abuse, these being the more obvious antecedents of contact with the criminal justice system. A defendant with hearing loss or a history of hearing loss requires unique consideration at each stage of the criminal justice process including arrest, bail, questioning and confessions, fitness to plead, communication with counsel, communication in court, and sentencing and parole[48, 50]. Further information can be found in the criminal justice system section of these guidelines.

Cultural implications

In the Indigenous community, not being able to hear may cause shame for the person with a hearing loss and consequently, they may be reluctant to seek support from service providers or even avoid mental health services due to stereotyping and stigma from others[51].

An Indigenous person or community may attribute hearing loss to supernatural causes or past wrong doings. Therefore, individuals must be aware of relevant cultural factors in mental illness, such as cultural behaviours that may mimic symptoms of mental illness. It is also important to identify sources of support for culturally appropriate responses to mental health problems. These may include community members, support groups and men's or women's groups[52].

Culturally relevant communication tips and tips for engaging with an indigenous person who uses sign language are provided in a communication with an Aboriginal or Torres Strait Islander Deaf person checklist

Deafblind

Quick facts

The term Deafblind is an umbrella term. It does not always mean totally deaf and totally blind. Deafblind people may have varying degrees of combined hearing and vision impairment[53]. Also referred to as 'dual sensory loss'. The major causes of deafblindness include congenital Rubella Syndrome, premature birth, Usher's Syndrome and other viruses such as Meningitis[54]. There are two distinct groups of people with dual sensory loss, those born deaf who lose their sight in adulthood, and those born blind who lose their hearing in adulthood[54]. There are also people who become deafblind later in life due to Usher's Syndrome Type 3, illness or trauma. According to a report by Access Economics, people living with a dual sensory loss represented 1.4% of the Australian population in 2005[55]. The same report projected the number of Australians living with a dual sensory loss to increase to over 3.5% by 2050[55].

A person with deafblindness uses residual vision and/or hearing, touch, smell and taste, to make sense of the world. There are a range of literacy issues that are associated with living with a dual sensory loss[54]. The communication modality used by an individual depends on the degree of sensory loss, their communication ability and personal preference. A deafblind interpreter is often needed to facilitate communication between hearing and sighted professionals and deafblind consumers.

Independence is an important issue for deafblind people; however barriers to communication, information, and mobility can hinder daily living and lead to serious emotional and social consequences[53, 56]. Many will require one-to-one support, in formal and in informal situations, but without this; they may be susceptible to feelings of anxiety, depression, reduced self-esteem and isolation[53, 56]. Deafblind people don't like to feel they are a burden, and therefore by having some control in their lives, being interdependent allows them to become "vital contributors to their communities"[53].

Since the development of cochlear implants (CI) a number of deafblind recipients have benefited through improved social interaction and communication. Evidence shows they are better engaged and more responsive to their surroundings therefore providing them with a better quality of life[57].

The impact of dual sensory loss can include difficulties with[54]:

- communicating with others
- orientation and mobility
- access to information and everyday experiences
- independence and daily living skills
- education and training
- relationships
- financial access to aids and equipment
- employment

This can result in feelings of[54]:

- grief and loss
- isolation and loss of independency
- frustration
- fatigue
- low confidence and self-esteem

Audiological information

Quick facts

This section contains basic information about the hearing system and various types and causes of hearing loss or deafness. More detailed information can be sourced from medical text books.

The hearing system

The ear has three main parts: the outer, middle, and inner ear.

Figure 3.1 – How the ear works[58]

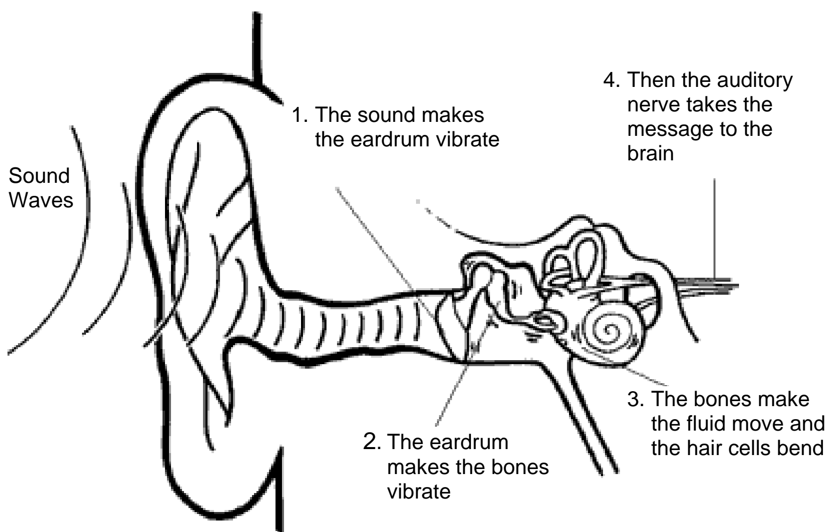


Image source: www.hearing.com.au

Types and causes of deafness

Type	Definition	Possible causes
Conductive	A conductive hearing loss may be acquired or congenital. It typically results from damage to outer and/or middle ear and leads to a loss of loudness. Conductive hearing loss can often be remediated by medical or surgical treatment.	• blockages of ear canal due to wax, objects etc. • outer ear infection • 'glue ear' – middle ear infection • perforated ear drum • otosclerosis- bony growth around the stapes • partial or complete closure of ear canal
Sensorineural	Sensorineural hearing loss may be acquired or congenital. It typically results from damage to, or the malfunction of, the cochlear or the hearing nerve in the inner ear and leads to loss of loudness and clarity. Hearing augmentation devices provide varied benefits.	Acquired: • the aging process • excessive noise exposure • diseases such as Meningitis and Meniere's • viruses, such as mumps and measles • drugs which can damage hearing • head injuries Congenital: • inherited

		• premature birth • damage to unborn baby from viruses such as rubella • jaundice
Mixed	Mixed hearing loss occurs when there is problem in both the conductive pathway (outer or middle ear) and in the nerve pathway (inner ear) Blockages of ear canal due to wax, objects etc.	An example maybe a conductive loss due to middle ear infection combined with a sensorineural loss from excessive noise exposure.

Degrees of deafness

Hearing is measured in decibels (dB). The severity of the hearing loss is graded as:

Mild	Moderate	Moderately severe	Severe	Profound
(26-40 dB)	(41-55 dB)	(56-70 dB)	(71-90 dB)	(90 dB)

Deafness may remain the same throughout an individual's lifetime (stable hearing loss), change from time to time (fluctuating hearing loss) or become more severe over time (progressive hearing loss).

Onset of hearing loss can be:

1. before speech is usually present (pre-lingual hearing loss)
2. after the usual time of development of normal speech (post-lingual hearing loss)

Deafness can affect either one ear (unilateral hearing loss) or both ears (bilateral hearing loss). It is possible for the severity of hearing loss to be different in each ear or to be able to hear some sounds clearly, and other sounds not as clearly.

Communication

Interpreters | Hearing augmentation |Language and literacy | Communication technology

Interpreters

Quick facts

This section provides clinicians with information about the role of an interpreter, the credentialed and qualification process for interpreters, 'best practice' for how clinicians and interpreters can work together to provide an accurate and equitable service for sign language users, and generic tips for working with interpreters.

Auslan/English interpreter: a person who is not Deaf, who is assessed to have a high level of linguistic ability in both English and Auslan, and who is credentialed to interpret between these two languages.

Deaf interpreter: a Deaf person assessed to a have high level of linguistic ability in communicating with clients whose language use is non-conventional, idiosyncratic or not fluent. A Deaf interpreter is engaged alongside an Auslan/English interpreter for clients who use non-conventional sign language (or who have minimal language skills)[19]. An Auslan/English interpreter will render the spoken English into Auslan, and the Deaf interpreter will then convert the Auslan message into a form of the language most easily understood by the client. When the client responds, his or her message will be converted from non-conventional sign language into Auslan by the Deaf interpreter and then the Auslan/English interpreter will interpret the Auslan message into spoken English.

The role of an interpreter

The role of an interpreter is to act as a linguistic and cultural bridge between parties who do not share the same language; in other words, to facilitate communication. For the purposes of this document, "communication" typically refers to communication between a non-Deaf, non-signing clinician and a Deaf sign language user. Interpreting is not reproducing a message in English by producing a word-for-sign match from Auslan, or vice versa. Rather, it involves conveying the meaning of a communication exchange comprehensibly and accurately between two languages.

Clinician

- will conduct all aspects of the assessment and treatment
- will need to explain and conduct the clinical session

Auslan/English interpreter

- has expertise in the language and culture of Deaf people; and how it differs from the culture of people who are not Deaf
- can provide useful insights on the language use of the Deaf client
- can provide cultural and linguistic information that may affect the assessment or treatment plan
- cannot comment on the mental health of the consumer

Interpreter credentialing and qualification

Qualified and accredited interpreters have been deemed, by the National Accreditation Authority for Translators and Interpreters (NAATI), to be knowledgeable about the cultures of Deaf and non-Deaf people, and skilled in English and Auslan. There is currently no requirement for interpreters to have any specific mental health qualifications. Although there is a shortage of NAATI accredited interpreters with experience in the mental health setting in Australia[59], it is of paramount importance that suitably experienced NAATI accredited interpreters are sourced to work in the mental health context[60]. NAATI accredited interpreters are obliged to adhere to a code of ethics which will, in most cases, ensure a standard of professional practice a clinician can depend on. Para-professionally accredited interpreters have a lower level of cultural knowledge and linguistic skill than do professional interpreters, which may adversely impact the episode of care, should a para-professionally accredited interpreter be employed.

Best practice

Interpreting is a complex activity requiring a set of specialist linguistic and interpersonal skills. Be mindful that if friends or relatives are enlisted as interpreters instead of a qualified interpreting practitioner, communication can become distorted, due to lack of competence in one or both languages, lack of proven ability to interpret accurately between both languages, and an inability to remain impartial[61-63].

Where possible, a pre and post assessment meeting should be held with the clinician and interpreter alone[64]. This meeting may be difficult to arrange as the consumer may be uncomfortable with the clinician meeting with the interpreter without them being present. To minimise the consumer's discomfort, the clinician could explain, through the interpreter, what they will be discussing with the interpreter. The working with interpreters checklist provides a list of the things clinicians and interpreters should discuss pre and post assessment.

Generic tips for working with an interpreter can be found in Interpreters Quick facts
Queensland Health staff can book Auslan/English interpreters by using the Interpreter Service Information System (ISIS) via QHEPS. See the Resources section to find information about organisations offering interpreting services.

Hearing augmentation

Quick facts

This section contains basic information about various hearing augmentation devices. Specific information about a particular device can be sought from professionals, hearing augmentation websites and device users.

Hearing aids

A hearing aid is basically a miniature public-address system such that it amplifies sounds. A hearing aid consists of a microphone, amplifier and speaker. Sound is processed naturally in the body's auditory system.

Hearing aids do not cure hearing loss. It is important to be mindful of the following limitations; a hearing aid:

- is expensive to purchase and maintain. Subsidies vary between private insurance and government requirements.
- is battery operated (battery life is affected by level of usage)
- is easily damaged by dust and moisture
- microphones do not discriminate between the sounds they pick up. Accessing communication in noisy environments remains extremely cumbersome

Cochlear Implant

A cochlear implant (CI), also known as the Bionic Ear, is an artificial hearing device, designed to produce useful hearing sensations by electrically stimulating nerves inside the inner ear. CIs consist of the implant package and electrode array (receive-stimulator) located inside the skull and the speech processor and headset which are worn externally.

Sophisticated though it is, the cochlear implant does not fully reproduce the sounds experienced by someone with full hearing. The effectiveness of the CI varies considerably. Examples of factors that determine the benefit recipients will gain include[66-68]:

- age at implantation
- whether they developed spoken language before going deaf (people who have learned to speak usually benefit most)
- the time since deafness first occurred
- the environment in which they live, an encouraging home, school or work environment will help the person achieve their full potential

Potential limitations of the CI include the following:

- the cost of purchasing and maintaining the implant

- the externally worn speech processor is battery operated (battery life is affected by level of usage)
- the speech processor can be damaged by dust and moisture

Assistive technology

Assistive technology varies from physical equipment to smart device applications. Some technology is able to link in with hearing augmentation devices where other technology makes use of visual and tactile senses. Various technology has been developed to facilitate access to the classroom, work space and home. A range of information about available technology and user reviews can be found at www.techfinder.org.au or www.hearing.com.au (Australian Hearing).

The following are commonly recognised symbols to indicate public assistive listening devices:

hearing loop

volume controlled phone

closed captioning

Language and literacy

Quick facts

In the health sector, low health literacy, cultural barriers, and limited English proficiency have been coined the "triple threat" to effective health communication[69]. This section provides a brief summary of the language and literacy skills of people living with hearing loss or deafness, including Auslan users and people using cochlear implants (CI).

Deafness is a heterogeneous condition; as such social and educational experiences are highly varied, as are communication preferences, literacy levels and fluency in sign language[70]. A common experience for deaf and hard of hearing children is a lack of incidental learning opportunities. Incidental learning refers to the acquisition of information through passive exposure to events witnessed or overheard[71]. Where hearing people have access to everyday communication (radio, TV, overheard conversations, announcements, family and relationship communication), deaf and hard of hearing children often have a lack or reduction in access to these learning opportunities[72], consequently impacting aspects of their development such as their general knowledge and social skills.

The literacy skills of Deaf adults and children living with hearing loss or deafness are typically lower than their hearing peers[73-75], and this is recognised as a serious problem[76], having implications for employment and social opportunities. Internationally, the average reading age of Deaf adults is said to be at fourth grade level[74, 77]. Luckner and his colleagues[77] explain that there are a variety of reasons why students who are deaf or hard of hearing struggle with literacy, including experiences in early childhood and delayed or obstructed access to language(s). Children who are deaf or hard of hearing are also at a disadvantage when trying to learn or acquire a spoken (and written) language; the spoken form of the language is often not fully accessible resulting in limited prior familiarity with spoken languages and potentially delaying early language access[78, 79].

Some Deaf adults who use Auslan as their preferred language may also have difficulties with written English comprehension, similar to the experiences of people who have a (spoken) language other than English as their first language. In many cases, people who are Deaf or hard of hearing don't have access to the primary form of English (spoken language) and learning the secondary form of the language (written) is mediated through a completely difference language (Auslan). This requires a strong first language base in order to develop English to a native like level.

Evidence suggests that children who have a CI, who are then able to have auditory access to spoken language[80], show improved auditory speech perception skills[73]. However, the reading comprehension skills of CI users continue to lag behind their hearing peers[73].

Communication technology

Quick facts

Technological advancements have given the Deaf community greater access to communication and information. Smart devices such as smart phones and tablets, along with the large range of apps now available, make it possible for Deaf people to access information in appropriate formats and to communicate in sign language via video.

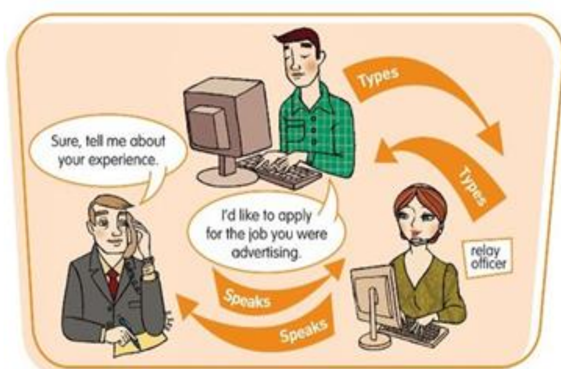
In the clinical setting, communication with deaf consumers can be greatly enhanced by using such technologies. The following are some examples of communication technologies and how they may be used when working with Deaf consumers.

Email/SMS

Email and SMS should be used when arranging appointments or for short messages. Caution must be exercised as these modes of communication rely on written English which can be difficult for some Deaf people to comprehend. Please see language and literacy.

National Relay Service (NRS)

The NRS is a Commonwealth Government initiative allowing Deaf and hard-of-hearing individuals to make and receive phone calls through a range of devices, from computers, tabelts, mobile phones, ordinary phones or a Teletypewriter. Clinicians can use the relay service to make standard phone calls to their clients who use the NRS. As this system is mostly text-based, caution should be exercised as some Deaf people struggle to comprehend written English. Please see language and literacy.



A diagram showing how an Internet Relay call works. http://relayservice.gov.au/making-a-call/internet-relay/

Video Relay

Video Relay, a service provided by the NRS, allows Deaf people to make and receive phone calls in Auslan. A phone call is relayed through Skype by an Auslan/English interpreter. This service

enables Deaf people to communicate freely in their own language. This service can only be used for phone calls and cannot be used in place of booking interpreters for appointments and, unlike other NRS services, it operates on limited hours.

A diagram showing how a Video Relay Call works. http://relayservice.gov.au/making-a-call/video-relay/

Video Remote Interpreting (VRI)

VRI is a video communication based service used for meetings. The Auslan interpreter is usually based at a remote location (eg; Deaf Society) and through video technology supports a meeting between a Deaf person who uses Auslan and the hearing person(s). VRI is a fee for service arrangement.
http://auslanconnections.com.au/services/video-remote-interpreting/

Skype or other video chat apps

Skype and other video chat apps can be used much like a telephone. Clinician and consumer can see each other and communicate directly in Auslan. These options can also be used for clinical appointments, provided internet speeds are high enough to accommodate video transmission. Although a clinician with conversational Auslan skills may use these video chat options for brief interactions, any communication that is clinically significant, such as in a clinical appointment, would still require an accredited interpreter.

Telehealth

Queensland Health's Statewide Telehealth Service is a sophisticated network of videoconference units throughout Queensland. These videoconference units provide high quality video conferencing and can be used in much the same way the above consumer-level video chat options may be used. For information on how to book and use a Telehealth videoconference unit:
https://www.health.qld.gov.au/telehealth/ or
https://www.humanservices.gov.au/health-professionals/services/medicare/mbs-and-telehealth

Mental health

Prior to reading this section, we recommend being familiar with the following sections:

- Deaf culture
- Hard of hearing
- Communication

Mental health | Barriers to access | Assessment considerations | Mental State Examination | Therapy considerations

At a minimum, Deaf people experience a prevalence of mental illness equal to that of the hearing population[81-84] with some evidence suggesting children with hearing loss are one and a half to two times more vulnerable to mental health problems compared to hearing children[12]. However, there continues to be a lack of psychiatric/mental health specialists and facilities that specialise in the needs of people who are Deaf or hard of hearing[59]. Even for clinicians who are experienced in the area of deafness, an interview or assessment can be extremely challenging, and can potentially result in poor outcomes for the consumer, their family and community, as well as the service itself.

Summary of literature and prevalence

There is limited, and mixed, research on the prevalence rates of psychosis, mental distress and various mood and behavioural disorders; however, there is consistent evidence to suggest that at the very least, Deaf and hard of hearing people experience rates of mental illness(s) comparable to that of hearing population(s)[81, 82, 85-87]. Black and Glickman[85] report deaf patients, in a speciality deaf inpatient unit, were more likely to be diagnosed with a mood, anxiety, personality or developmental disorder than a substance misuse or psychotic disorder. There is no evidence to suggest there is a causal relationship between deafness or hearing loss and mental illness[81].

Known barriers to accessing mental health support

Quick facts

Barriers to access

Deaf and hard of hearing people experience a range of barriers to accessing mental health services, including:

- difficulties arranging an appointment[4, 5]
- difficulties communicating with the clinician[4, 5]
- issues with interpreters[4, 5]
- mental health care education and information[89, 93] not being provided in an accessible format for Deaf and hard of hearing people
- mental illness being highly stigmatised in the community[94]
- types of therapy being inaccessible, including group therapy, due to issues with communication[8]

Clinicians experience a range of barriers to providing accessible mental health service, including:

- lacking awareness, training and experience with deafness related issues[4, 88, 90, 91]
- the lack of research available on mental health interventions and outcomes for Deaf and hard of hearing people
- the diagnostic and treatment process being complicated by linguistic and cultural differences[4, 90, 92]
- having to make use of inappropriate assessments[2, 5, 81, 85, 88, 89] that:
    - have not been normed on, or adequately translated for, Deaf people[88, 90]
    - assume or require certain level of English comprehension and knowledge of vocabulary[89]
    - use phrasing of items that assume 'hearingness'[81]

Language and the diagnostic process

For many reasons there is a huge extent of variation in the language (spoken or visual) ability and literacy within the Deaf and hard of hearing population(s). A person's language and communication skills are greatly affected by their deafness (pre-lingual, post lingual, bilateral etc.) and opportunities to acquire a language. The absence of early auditory stimulation and delay in (spoken or signed) language acquisition seems to affect neuro-cognitive processing domains, such as auditory and visual working memory, attention and inhibition[81].

Persons with language and learning challenges, exhibiting language dysfluency along with developmental, behavioural, mood and personality disorders, can present like persons with psychotic disorders to an untrained clinician[95]. Glickman[95] warns that assessments based on written or verbal language (dys)fluency should be used with extreme caution.

Diagnosis complications

Researchers and clinicians are continuing to explore how deaf people experience mental illness; how symptoms manifest and how consumers can be best assessed, treated and managed. However, clinicians should be careful not to:

- mistake deafness for intellectual impairment[95]
- assume that a Deaf or hard of hearing person's illness will manifest itself in the same way as a hearing person[95]
- assume that engaging an interpreter will address the shortfalls of current assessment tools and therapy styles for Deaf and hard of hearing consumers[95]

In addition to utilising interpreters, clinicians also need to be mindful of other cultural and clinical factors which are summarised in these guidelines.

Recommendations

Deaf people experience considerable barriers to accessing services, treatment and support. There are a few things clinicians can do to improve the accessibility of their service which are listed in the improving the accessibility of your service checklist.

Mental health assessment considerations

Quick facts

Pre-assessment considerations and recommendations:

Currently, interpreters are considered best practice to interpret assessment tool questions and answers during an appointment. However, clinicians should be mindful that during the process of interpreting an item from English to a visual language, the meaning may be lost or become self-evident to the consumer, affecting the responses. Furthermore, that when an interpreter is used, the assessment tool still lacks psychometric validity and reliability.

The use of an interpreter may also introduce potential threats to the therapeutic alliance as the consumer will focus their visual attention largely on the interpreter[59]. Engaging an experienced and qualified interpreter may help to mitigate against this threat[96].

To minimise the risk of misdiagnosis, prior to conducting an assessment we recommend completing the mental health pre-assessment checklist.

The mental health assessment:

It is important the assessment amplifies the persons' strengths, values, coping strategies, and goals, in support of a recovery orientated mental health service[97]. The areas listed in the mental health assessment checklist are likely to be relevant and should be included in the persons' mental health assessment.

Post-session considerations and recommendations:

The considerations outlined in this mental health post-assessment checklist are largely similar to those that need to be considered in the criminal justice system context.

Mental State Examination

When conducting a Mental State Examination, we recommend considering the following ten factors:

Physical appearance

- extreme language deprivation and or mental illness can have enormous affects on psychosocial aspects (e.g., grooming, clothing, hygiene, build etc.)
- deafness as part of a genetic syndrome in some, may accompany other visible physical abnormalities, for example facial asymmetry, skin tags, blindness, and or cognitive abnormalities or disorders

Behaviour

- when engaging an interpreter**,** the Deaf person will give more eye contact to the interpreter than the assessor. This is not unusual, and is a necessary part of communication. This can have a significant impact on the development of a therapeutic relationship, building of trust etc. The assessor should direct their eye contact towards the Deaf person.
- Auslan is a visual language which utilises signs and facial expressions. In retelling a story or situation the Deaf person takes on the persona (emotion, behaviour) of the people in their story. This should not automatically be mistaken as a response to non-existent external stimuli. An interpreter will aid you in your understanding.
- eye contact is extremely important. Hearing people often talk to each other with comparatively little eye contact, but within Deaf culture, avoiding eye contact can be seen as rude. When someone is signing to you, maintain eye contact. Be mindful of the intersection of Deaf culture with a person's ethnic culture (e.g., Aboriginal and Torres Strait Islander).
- Deaf people may use language that can appear to be blunt or abrupt. This is a normal aspect the highly visual orientation of Deaf culture and Auslan.
- Deaf people can often thump on tables or floors to gain another person's attention, in the same way as hearing people call a person's name or shout. While this behaviour can appear aggressive to hearing people, it should usually be understood as normal Deaf cultural behaviour.

Mood

- a professional interpreter with mental health experience will convey mood

Affect

- in sign language, although facial expressions can represent emotions, they also have specific linguistic functions[81]
- the interpreter will express the meaning of the person's facial expressions

Speech/expression

- rate, flow and volume will be displayed in the signing. For example, pressured speech may be displayed by signing very quickly and larger signs may indicate loudness
- saying little may not indicate poverty of speech, but may be an indication of lack of language skills, word knowledge or dysfluency; Lack of speech may be interpreted as a cognitive deficit[98]
- echolalia/echopraxia may be displayed by repeating signs that the interpreter has used[60]

Thought

- poverty of thought could depend on the age of access to language, possible lack of incidental learning, education standards and literacy skills. Poverty of thought or lack of language could be displayed in slow signing
- language dysfluency presents as limited vocab, lack of reference to time and subject, lack of sequential organisation of stories, inappropriate or absent syntax and excessive use of gesture, mime and "home signs" – this should not be readily attributed to psychosis[60]
- there are similar communication changes in Deaf with dementia to that of hearing with dementia. For example, repeatedly asking the same question, sign finding issues (same as word finding), impairment in abstract thinking, and or judgement and impulse control[99].

Perception

- Deaf people may have more visual and tactile hallucinations
- Deaf and hard of hearing people can experience auditory hallucinations[100]

Orientation

- instead of knowing the English or hearing culture name, Deaf people may have name signs or home signs for cultural and historical figures or events
- Deaf and hard of hearing people may not share common knowledge due to a lack of incidental learning opportunities

Insight/judgement

- consider the effects of delay and or disruptions of language acquisition in early childhood development. For example the relevance of theory of mind (the ability to put yourself in someone else's shoes)[92].

Memory

- in the pre-brief session discuss short and long term memory items with the interpreter so that they can use appropriate signs. The Interpreter will also be able to assess the cultural relevance of the long term questions (e.g., a wrong answer as to the name of a past prime minister may be the result of lack of vicarious learning rather than a memory issue).

In relation to psychiatric phenomenology, Glickman[100] discusses behaviours that may point a diagnosis toward thought disorder rather than language deprivation. These include:

- inappropriate (for Deaf culture) facial and emotional expression
- bizarre language content, the looser the connection between thoughts the more suggestion of thought disorder
- non-verbal behaviours suggesting hallucinations (preoccupation with phenomena unseen by clinician)
- guardedness, suspiciousness and volatility. A feeling the patient is "not there" or "ready to explode"
- worsening of communication skills from a previous baseline
- appearance/behaviour of psychotic persons is often striking and abnormal for their cultural context - self-care is poor e.g., winter clothes in summer
- language improvement with psychiatric medication

Therapy considerations

Quick facts

The purpose of this section is to provide a summary of information and recommendations for those delivering counselling or psychotherapy to Deaf or hard of hearing people. Counselling with Deaf people will include cultural considerations.

Background

Deaf people are likely to enter therapy with the same problems as their hearing counterparts, although historically the Deaf community has experienced the effects of oppression similar to that of other minorities[101]. This can, and has, resulted issues with substance abuse, un/underemployment, social isolation, and depending on family communication circumstances, isolation from parents and other family members[101-103].

Globalisations and generalisations, whilst not always helpful, may be useful to ponder, before working in the therapeutic context.

- more than 90% of deaf children are born to hearing parents, who have little or no previous experience with deafness. Consider the impact of this on the child and their family
- there are two dominant models of deafness, the medical model which views deafness in audiological terms and has a corrective focus. The second is a cultural model, which highlights ability and accepts difference
- it is common for people who are Deaf or hard of hearing to have been viewed as disabled, or incapable. Negative views such as this can have detrimental effects on a Deaf persons' self-identity

Recommendations

Mental health interventions should be culturally sensitive. The following recommendations, drawn from Munro, Knox and Lowe's[88] work, are made in relation to counselling and psychotherapy with Deaf people:

- story telling, externalising and using metaphors as counselling tools have been identified as culturally sensitive interventions and as intrinsic parts of Deaf culture and sign language
- Deaf people want to be able to communicate with a therapist using their first language; where this is not possible, they want a skilled sign language interpreter
- Deaf people want therapists to recognise them as part of a cultural group and not as disabled
- Deaf people appreciate therapists having prior awareness and understanding of Deaf culture

In Australia there are few mental health professionals who are Deaf or who have Auslan as a first language[88]. Sign language interpreters are necessary in most cases, and are a very valuable part of the multidisciplinary team.

In relation to counselling or psychotherapy, it will be necessary to consider the role and impact of an interpreter on the therapeutic alliance and process[104], including considering the following:

- the impact of information being relayed back and forth between two languages and (at least) two cultures
- the varying languages requirements that may need to be catered for (e.g., mixed hearing and deaf families)
- issues of confidentiality and safety (small Deaf culture) as it pertains to group therapy with Deaf consumers and the appropriateness of the interpreter (existing relationships)
- the use of interpreters in reflective team therapy[88]
- if the therapist is mobile, lines of sight and visibility of the interpreter need to be considered. For example, experimental therapies, chair work, mindfulness activities where people are walking around. If visual resources are being used (drawings, genograms, timelines) the drawing and the interpreter need to be visible at the same time

Therapists should also be mindful of the following phenomena[104], which are common to therapy with all people. Deaf specific considerations may include:

- *transference/counter transference* - interpreters can easily become part of these mechanisms. Interpreter pre and post session briefs and professional supervision is important to support the interpreter
- *coalitions and alliances* - high risk situations in the mental health setting include, circumstances when an interpreter is unfamiliar in the mental health setting, but knows the consumer from other interpreting situations or other social scenarios
- *learned helplessness* – a linguistically sensitive and culturally affirmative service, will help to empower consumers, their families and carers, in areas of advocacy, self-management and responsibility

Victims of crime | Assessing fitness for trial

Criminal justice system and deafness

This section presents some considerations for Deaf consumers in the forensic or criminal justice system context. The information is provided for forensic mental health clinicians, staff from various advocacy and support services, court liaison and prison mental health service staff. Similar to the mental health context, there is a need for professionals to have an increased knowledge and awareness to better accommodate Deaf and hard of hearing people within the criminal justice system[105].

Victims of crime

Quick facts

Deaf and hard of hearing people confront numerous barriers when protecting themselves against being a victim of crime, and reporting crimes to law enforcement agencies[106]. Research suggests that children who are deaf or hard of hearing are at increased risk of being abused, and are less likely to report abuse[107]. When reporting a crime, research has also found that Deaf people report having concerns about[106]:

- not understanding the reporting and investigation process
- being perceived as less credible
- being blamed for being a victim, or their disability as causing the victimisation
- law enforcement not understanding their disability
- law enforcement being unresponsive to their (communication) needs

Suggestions for law enforcement and clinicians[106]:

- provide an interpreter or real-time captioning
- provide victims with time to talk and share details about their story
- ask probing questions about the incident
- keep the victim informed via email or text (SMS)

Assessing fitness for trial of Deaf and hard of hearing defendants

Quick facts

The content from this section is largely drawn from Davidson et al.'s publication[105]. Historically all Deaf people were deemed unfit for trial due to deafness alone, as they could not hear or speak. Today a minority of Deaf defendants will be permanently unfit for trial. It is important, that in determining fitness for trial, the rights of Deaf and hard of hearing individuals who face criminal charges are suitably met. Specifically, individuals must:

1. understand the charges, trial process and the roles of participants in the trial
2. be able to follow the trial and understand evidence given
3. understand the social purpose, possible outcome and consequences of the legal proceedings and
4. be able to communicate effectively with their counsel and put forward their version of the relevant facts

When developing an opinion regarding a Deaf or hard of hearing person's fitness for trial, the assessment focus should include areas of understanding, reasoning, decision-making and communication. Assessing fitness for trial of a Deaf person is a complex and specialised area. Similar to a mental health assessment, it will be lengthy, requiring more time and resources. When assessing fitness for trial of a Deaf or hard of hearing person, consider the factors listed in this assessing fitness for trial considerations checklist.

When conducting an assessment of fitness for trial, consider the listed in this fitness for trial assessment recommendations checklist.

Assessment:

This assessing fitness for trial checklist provides recommendations for conducting an assessment and is broken down into three stages, preparation, during and post assessment.

The use of assessment tools must be made with the knowledge that they may be invalid, unreliable and in some cases completely inappropriate (culturally and linguistically) unless they have been validated for the population. Forensic mental health clinicians should also be mindful that there are very few Auslan interpreters in Australia who have experience in legal interpreting. Interpreting in legal settings requires specific knowledge of Auslan as well as the legal system. There are also very few clinicians with sufficient knowledge of Deaf culture or experience with Deaf consumers.

See Mental Health Examination for additional considerations and for further information and support contact the Deafness and Mental Health Service.

Resources

Resources for clinicians

Indigenous Deaf and hard of hearing information and programs	
Deafness and Mental Health – Indigenous Social and Emotional Wellbeing site.	https://metrosouth.health.qld.gov.au/mental-health/services/deafness-and-mental-health/indigenous-deafness-and-mental-health
The Indigenous Ear*InfoNet* - is a web resource and yarning place (electronic network). This is a useful resource for people working, studying or interested in addressing ear health and hearing loss among Indigenous peoples. The electronic yarning service encourages information sharing and collaboration between health and education workers.	http://www.healthinfonet.ecu.edu.au/other-health-conditions/ear
Deadly Ears is Queensland Health's State-wide Aboriginal and Torres Strait Islander Ear Health Program for children.	https://www.health.qld.gov.au/deadly_ears/
Ear Troubles offers fact sheets and resources relevant to hearing loss in Australian Indigenous people.	www.eartroubles.com

Interpreter	
National Auslan Booking and Payment Service (NABS) provides NAATI interpreters and Deaf Relay Interpreters free of charge for 1. all public and private health related appointments involving an Indigenous Deaf client 2. All public health related appointments involving a non-indigenous Deaf client	www.nabs.org.au 1800 24 69 45
Auslan Connections is an interpreting service that specialises in Auslan interpreting.	www.auslanconnections.com.au 1300 010 877

Child and youth	
Queensland Hearing Loss Family Support Service (QHLFSS) is a statewide team of family support facilitators who provide family-centred counselling and support to families of children diagnosed with a permanent hearing loss.	https://www.health.qld.gov.au/healthyhearing/pages/family.asp 1800 24 69 45
Deaf Children Australia provides information and services for children and young people who are deaf or hard of hearing, and their families.	http://deafchildrenaustralia.org.au/
Hear For You is a youth mentoring program providing workshops, information and support to young children who are Deaf or hard of hearing.	http://hearforyou.com.au/
Aussie Deaf Kids is an organisation that provides online support for parents and information and resources for families raising a deaf child.	http://www.aussiedeafkids.org.au/
Deaf Student Support Program at Griffith University customises support and activities for Deaf or hard of hearing university students.	https://www.griffith.edu.au/student-equity-services/support/deaf-and-hard-of-hearing-program
Parents of Deaf Children Queensland Support group is a group based in Queensland that provides an opportunity for parents to meeting and provide information and support to other parents with a deaf child.	Email: pod.qld@gmail.com
Child of Deaf Adult International Support Network Kids of Deaf Adults – Australia provides support for 7-12 year olds in the form of camps	http://www.coda-international.org kodaaustralia@gmail.com

Programs and services	
The Australian Government Hearing Services is a program run by the Office of Hearing Services within the Australian Government Department of Health. The office of hearing services aims to support access to quality hearing services for eligible clients,	http://www.hearingservices.gov.au 1800 500 726 hearing@health.gov.au

provide better targeted hearing services, and support research into hearing loss prevention and management. The website contains useful information about program eligibility, the National Disability Insurance Scheme, service providers, factsheets and forms.	
Australian Hearing is the nation's leading hearing specialist and largest provider of Government funded hearing services. The website contains information about hearing loss and hearing solutions.	www.hearing.com.au
Able Australia is a leading non-for-profit organisation that provides information and person-centred services to support people with multiple disabilities and other complex needs, including deafblindness.	http://www.ableaustralia.org.au
Better Hearing Australia (BHA) is a national organisation for all people in Australia with hearing loss or impairment. BHA is an independent advocacy organisation that provides consumer advice. There is a BHA branch in each state.	http://www.betterhearingaustralia.org.au/
Deafness Forum of Australia advocates on behalf of people who are Deaf, deafblind, the families of these individuals and the various organisations and services that support these individuals; providing information and advice to the Government.	http://www.deafnessforum.org.au/index.php
Deaf Services Queensland is a not for profit organisation providing services and programs for Deaf and hard of hearing adults including lifestyle support, community engagement, education and interpreting services.	http://www.deafservicesqld.org.au/
Sign For Work is a free employment service, is part of Deaf Children Australia, helping people find work, including people who are Deaf or	http://signforwork.org.au/

hard of hearing.	
Australian Communication Exchange is a national not-for-profit organisation that provides communication products and services for people with diverse communication needs.	http://www.aceinfo.net.au/index.html

Private mental health practitioners

Please contact the Deafness and Mental Health Service for information regarding private practitioners, available in your local area, specialising in deafness and mental health.

Assessment tools

Outcomes Rating Scale (ORS) and Session Ratings Scale (SRS), Auslan version

Auslan resources	
Auslan Dictionary: Signs of Australia: a new dictionary of Auslan (the sign language of the Australian deaf community). Edited by Trevor Johnston, North Rocks, N.S.W. : North Rocks Press, 1998. Reprinted 2010.	
Green Door Auslan offers flexible learning within all range of Auslan skills, with one-to-one or group tutoring, workshops and professional development.	www.greendoor-auslan.com.au/
Auslan Signbank is a language resource site for Auslan. The website provides an interaction dictionary, information on the Deaf community and links to Auslan classes.	www.auslan.org.au/
Auslan Tutor app is a basic learning tool for 150 common Auslan signs	www.ridbc.org.au/ridbc-auslan-tutor

Captioning services (for fee)	
Bradley Reporting	Captioning and Subtitling International
Red Bee	Caption It
Ai-Media	The Captioning Studio

Communication technology	
National Relay Service is an Australia-wide phone service for people who are deaf or have	http://relayservice.gov.au/

a hearing or speech impairment. The service is available to anyone who wants to call a person with a hearing or speech impairment.	
Telehealth is the delivery of health services and information using telecommunication technology.	https://www.humanservices.gov.au/health-professionals/services/medicare/mbs-and-telehealth For booking information with the Queensland Health Telehealth Support Unit see: https://www.health.qld.gov.au/telehealth/
Techfinder is a go-to information source about available technologies	www.techfinder.org.au

Resources for interpreters

This section aims to help interpreters become aware of the issues and challenges they may face when interpreting in mental health settings, and how they may approach these complexities so that the goals of this setting are achieved as far as it depends on the interpreter.

The mental health setting

The professionals you may interpret for in the mental health setting can include psychiatrists, psychologists, counsellors, mental health nurses, social workers and occupational therapists. However mental health interpreting can arise even in situations you may not expect such as in general practitioner appointments, in the education setting, in the workplace or in other generic community appointments.

Challenge - role of the mental health interpreter

Sign language interpreters are generally comfortable working within their role boundaries as informed by the code of ethics outlined by the Australian Sign Language Interpreters Association (ASLIA)[108]. However in the mental health setting, there will often be a need to ‘step outside’ these usual role parameters[19]. It is common for mental health professionals to have little to no knowledge or experience of the Deaf community, their language and their culture and this is critical information that a qualified interpreter (should) possess.

This information is critical to mental health professionals “because language, thinking, culture, emotions, and behaviour are so closely related”[64]. Being aware of the goals of the therapy, assessment or treatment episode will guide the interpreter to make the best decision about what information to share so that these goals are not compromised by the traditional application of ethics[109]. This way the deaf client should receive appropriate and equitable care and services. The types of information the interpreter possesses that would be valuable to the mental health professional include:

- the differences between Auslan and English
- information on the interpreting process; for instance how a message in the source language may be adapted to make sense in the target language
- educational levels of deaf people
- the fact that poor English skills do not necessarily mean low intelligence[65]

The interpreter should exercise caution not to give their opinion on the mental health of the client, nor share information learned in other interpreting assignments specific to the client[110]. For a more in depth analysis of how the ASLIA Code of Ethics may apply to interpreting in mental health settings, please see ASLIA’s *Guidelines for Interpreting in Mental Health Settings*[111].

Challenge – linguistic issues

Due to the scarcity of deaf mental health professionals in Australia, there is very limited Auslan vocabulary for mental health terminology. This leads to interpreters having to use expansion techniques and to explain concepts[19]. This requires the interpreter to be knowledgeable on the topic of mental health and for there to be extra time allowed.

When using these techniques, the interpreter may unwittingly sabotage a clinician’s line of questioning or assessment items by producing a good translation that is full of meaning and accessible to the deaf client.

At times, the client may have dysfluent language due to mental illness. In these instances, what the client is saying and how they are saying it are vital clues to allow the clinician to make a proper diagnosis. If an interpreter repairs this language by making a nice, sophisticated interpretation this actually conceals important information from the clinician and a diagnostic opportunity may be lost[64].

When interpreting for dysfluent clients, it may be best to veer away from the usual mode of interpreting in first person by including descriptions of what you are seeing in the client's language. If the language is so disturbed that little to no sense can be made, a mixture of description and glossing, or literal word-for-sign interpretation may be necessary[64].

Challenge - vicarious trauma

Mental health interpreting will expose interpreters to very confronting material. Although interpreters strive to be neutral and impartial, it is a natural psychological reflex to feel empathic pain when we observe and interpret the discrimination a client is subject to, the abuse they have suffered or the mental anguish they endure.

Trauma is contagious, so an interpreter must learn to shield themselves from the possibility of becoming vicariously traumatised[112]. To achieve a healthy empathic stance, Harvey[112] suggests balancing the emotional and cognitive components of empathy. Being aware of your feelings of sadness, grief and alliance with the client, while at the same time being aware that although you may be conveying the thoughts and feelings of another person, you are a separate individual with your own identity and feelings. This balance requires regular self-monitoring across separate mental health interpreting assignments.

Recommendations for interpreting in mental health context:

- ask for a pre and post session brief with the clinician to assist you to prepare for and ensure a successful communicative environment for the client, clinician and interpreter. These opportunities for discussion can also foster mutual trust and a better working relationship between interpreter and clinician[104]
- in the pre-session brief discuss the clinician's goals, review any assessments and therapeutic tools the clinician intends to use and any language or cultural issues that may arise
- in the post-session brief discuss any concerns about the session. This includes sharing language and cultural insights with the clinician that could not be shared during the session[64]. If you are struggling to cope with the linguistic demands of the assignment a Deaf interpreter should be engaged to work along with you
- disclose any interpreting decisions with the clinician during the pre or post debriefing session
- it is good practice for an interpreter to seek regular professional supervision, often with other experienced interpreters. In these sessions any issues with empathic pain or vicarious trauma should be discussed
- if you are struggling after an interpreting assignment, you could ask the therapist for some time to talk about your feelings, or even arrange to visit a counsellor yourself, be it privately or through the interpreting agency who engaged you, to manage these feelings in a constructive way
- preparing as best you can prior to the assignment is an excellent way not only to increase your effectiveness as an interpreter, but also to fortify yourself

Quick facts

Deaf culture

Coda

Hard of hearing

Aboriginal and Torres Strait Islander Deaf and hard of hearing people

People who are deafblind

Audiological information

Interpreters

Hearing augmentation

Language and literacy

Communication technology

Barriers to mental health services

Mental health assessment considerations

Therapy considerations

Victims of criminal justice system

Assessing fitness for trial

Deaf culture

Terminology:

deaf, using lowercase ‘d’ refers to an audiological condition

Deaf, using a capital ‘D’, referring to individuals who identify as culturally Deaf

Culture:

Language: Australian Sign Language (Auslan). A visual, spatial language separate from English.

Values: deafness and sign language. Equal access to society through communication. Story telling.

Behaviours: visual and tactile methods of communication. Strong eye contact. The Deaf nod (not an indication of agreement or understanding). Greetings ad farewells which are lengthy and detailed.

Identity: Deaf identity and socialisation into Deaf culture is typically delayed, occurring through contact with Deaf people outside of the immediate family. Language and communication issues within the immediate family can impact on a Deaf persons social and emotional well-being and general identity development

History: Events and gatherings where Deaf people can socialise and celebrate Deaf culture are important aspects of Deaf history. Equally significant, are historical (and continued) efforts, typically perpetrated by hearing people, to cure deafness and suppress sign languages. The history of Deaf education has had a lasting impact on Deaf culture and sign language development. Historical relations between hearing and Deaf people continue to influence an ongoing sense of mistrust of hearing people.

Coda

Terminology:

Coda (Children of deaf adults) typically refers to hearing children of Deaf adults.

Deaf of Deaf is a Deaf child of Deaf parents

Culture:

Codas typically grow up in a Deaf culture but they will also function as part of the hearing world.

Language: They typically learn Auslan and spoken English.

Values: Deaf culture

Common experiences:

1. It is common for codas to act as mediator between their Deaf parents and hearing people (e.g. teachers, doctors).
2. Where there is one Deaf parent and one hearing parent, and sign language is not affirmed within the family, some codas may have communication issues with their Deaf parent.

Hard of hearing

Terminology:

deaf, using lowercase ‘d’, is often used to refer to an audiological condition.

hard of hearing refers to individuals who are either born with a hearing loss or lose some, or all, of their hearing over time.

Considerations:

Identity: individuals use a combination of their knowledge of audiological information and the personal meaning they attach to their hearing loss in order to develop a sense of identity related to their hearing loss.

Communication: behavioural and environmental adjustments are required to facilitate communication, which are typically oral methods of communicating. Adjustments include reducing background noise, good lighting, clear speech, providing written information and seating arrangements

Values: hearingness and hearing norms are valued. Being able to operate successfully in a hearing environment is important to people who identify hard of hearing.

Technology: it is common for people who are hard of hearing to use hearing augmentation devices such as cochlear implants and hearing aids. Real-time captioning is also used to facilitate communication.

Implications: it is common for people who are hard of hearing to experience stigma, identity concerns, denial, social withdrawal and isolation, anxiety, grief and depression.

Aboriginal and Torres Strait Islander Deaf and hard of hearing people

Terminology:

Indigenous is used here to refer to people who identify as Aboriginal or Torres Strait Islander.

deaf, using lowercase ‘d’ refers to an audiological condition.

Deaf, using capital ‘D’ refers to individuals who identify as culturally Deaf.

Hard of hearing refers to individuals who are either born with a hearing loss or lose some, or all, of their hearing over time.

Considerations:

Indigenous Australians have a wide range of lifestyles, and social, cultural, educational and family backgrounds.

Hearing loss in the Indigenous population is largely due to a higher prevalence rate of middle ear disease and conductive hearing loss.

Identity: individuals use a combination of the personal meaning they attach to their indigenous heritage and culture, and their hearing loss, as well as audiological information to develop a sense of identity related to their hearing loss.

Social implications: hearing loss can result in greater frustration and stress during communication in noisy contexts, which can contribute to family violence and reduced social and emotional wellbeing, and constraints on intercultural communication. There is an increased rate of incarceration that is likely linked to violent altercations resulting from misunderstandings.

Cultural implications: hearing loss may be attributed to supernatural or past wrong doings. Not being able to hear may cause shame for the person with a hearing loss and they may be reluctant to seek support from service providers or even avoid mental health services.

People who are Deafblind

Terminology:

Deafblind is an umbrella term for people who have a combination of deafness and blindness.

Dual sensory loss: is another term for Deafblind people who have combined hearing and vision impairment.

Deafblindness can be a consequence of a range of disorders such as one eye, low vision, pinpoint vision, glaucoma, muscular, ageing etc.

Considerations:

A person with deafblindness uses residual vision and/or hearing, touch, smell and taste, to make sense of the world.

Identity: there are two distinct groups of people with dual sensory loss, those born deaf who lose their sight in adulthood, and those born blind who lose their hearing in adulthood. There also people who become deafblind later in life due to illness or trauma.

Communication: a deafblind interpreter is often needed to facilitate communication between hearing and sighted professionals and deafblind consumers. The communication modality used by an individual depends on the degree of sensory loss, their communication ability and personal preference .

Technology: some people who are deafblind make use of cochlear implants, hearing aid/s, Frequency Modulators, QWERTY keyboard or Braille.

Implications: living with deafblindness can result in issues communicating with others, orientation, mobility, independence, relationships and employment. People who are Deafblind can experience feelings of grief, loss, isolation, frustration, fatigue, low confidence.

Audiological information

The hearing system:

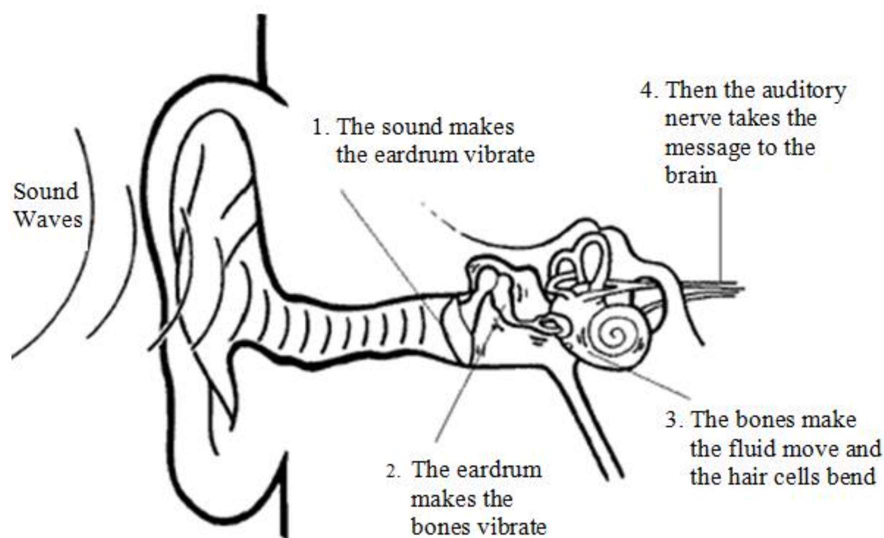


Image source: www.hearing.com.au

There are a number of type and causes of hearing loss that can affect either one ear or both ears.

Deafness can be stable, fluctuate from time to time or become more severe over time

Onset of hearing loss can be:

1. Before speech is usually present (pre-lingual hearing loss)

2. After the usual time of development of normal speech (post-lingual hearing loss)

Hearing is measured in decibels (dB). The severity of the hearing loss is graded as:

Mild	**Moderate**	**Moderately severe**	**Severe**	**Profound**
(26-40 dB)	(41-55 dB)	(56-70 dB)	(71-90 dB)	(90 dB)

Interpreters

Auslan/English Interpreter: a person, who is not Deaf, who is assessed to have a high level of linguistic ability in both English and Auslan and who is credentialed to interpret between these languages.

Deaf interpreter: is a Deaf person assessed to have a high level of linguistic ability in communicating with clients whose language use is non-conventional, idiosyncratic or underdeveloped. A Deaf interpreter is engaged, alongside an Auslan/English interpreter, for clients who use non-conventional sign language (or who have minimal language skills).

The role of an interpreter

The role of an interpreter is to act as a linguistic and cultural bridge between parties who do not share the same language; in other words, to facilitate communication. The meaning of a communication exchange, rather than word-for-sign, is conveyed between two languages.

Best practice

Interpreting is a complex activity requiring a set of specialist linguistic and interpersonal skills in which an interpreter has been trained to perform. Accredited interpreters have been assessed as competent in these specialist skills. Where possible, a pre and post assessment meeting should be held with the clinician and interpreter alone.

Generic communication tips

- speak normally and directly to the client (and remember the interpreter will speak in first person i.e., as though they are the client)
- avoid private conversations as everything heard by the interpreter will be conveyed in sign language and vice versa
- speak in plain English, avoid using jargon
- take cues from the Deaf person and interpreter about appropriate positioning and lighting
- regularly check for understanding, preferably using open ended questions rather than closed questions e.g., “Can you explain to me…” rather than “Do you understand?”
- provide a short break every hour
- make use of visual tools such as whiteboards, pictures, calendar print outs, family trees etc.

Hearing augmentation

Hearing aids

A hearing aid amplifies sounds. Sound is processed naturally in the body's auditory system.

The following are limitations of hearing aids:

- expensive to purchase and maintain.
- battery operated
- easily damaged by dust and moisture
- microphones do not discriminate between the sounds they pick up

Cochlear implant

A Cochlear Implant (CI) electrically stimulating nerves inside the inner ear to produce useful hearing sensations. CIs do not fully reproduce the sounds experienced by someone with full hearing. The effectiveness of the CI varies considerably.

The following are potential limitations of the CI:

- cost of purchasing and maintaining the implant
- externally worn speech processor is battery operated (battery life is affected by level of usage)
- speech processor can be damaged by dust and moisture

Assistive technology

Assistive technology varies from physical equipment to smart device applications.

Language and literacy

Incidental learning:

Incidental learning refers to the acquisition of information through passive exposure to events witnessed or overheard. Deaf and hard of hearing children commonly experience a lack of incidental learning opportunities impacting aspects of their development.

Literacy skills:

The literacy skills of Deaf adults and children living with hearing loss or deafness are typically lower than their hearing peers, having implications for employment and social opportunities. Internationally, the average reading age of Deaf adults is said to be at fourth grade level.

Deaf adults who have Auslan as a first language may also have difficulties with written English comprehension, similar to the experiences of people who have a (spoken) language other than English as their first language.

Hearing augmentation:

Children who have a CI have auditory access to spoken language, and evidence shows that their auditory speech perception skills are improved significantly. However, the reading comprehension skills of CI users continue to lag behind their hearing peers.

Communication technology

When using any communication technology caution must be exercised, considering the language and literacy skills of Deaf and hard of hearing people

Email and SMS:

Email and SMS should be used when arranging appointments or for short messages

National Relay Service:

The NRS is a federal government-funded initiative allowing Deaf and hard-of-hearing individuals to make and receive standard phone calls.

Video Relay Service:

Allows Deaf people to make and receive phone calls in Auslan. A phone call is relayed through Skype by an Auslan/English interpreter. This service enables Deaf people to communicate freely in their own language. Please note this service can only be used for phone calls and cannot be used in place of booking interpreters for appointments.

Video Remote Interpreting (VRI):

VRI is a video communication based service used for meetings between Deaf and hearing people. The Auslan interpreter is usually based at a remote location.

Skype and video chat:

Skype and other video chat apps can be used much like a telephone.

Telehealth:

Telehealth Service is a sophisticated network of videoconference units which provide high quality video conferencing.

Barriers to mental health services

Barriers commonly experienced by Deaf and hard of hearing people:

- difficulties arranging an appointment
- difficulties communicating with the clinician
- issues with interpreters (e.g. availability, cost, skill)
- mental health care education and information not being provided in an accessible format for Deaf and hard of hearing people
- mental illness being highly stigmatised in the community types of therapy being inaccessible, including group therapy, due to issues with communication

Barriers commonly experienced by clinicians:

- lacking an awareness, training and experience with deafness related issues
- the lack of research available on mental health interventions and outcomes for Deaf and hard of hearing people
- the diagnostic and treatment process being complicated by linguistic and cultural differences
- having to make use of culturally and linguistically inappropriate assessments

Language and the diagnostic process:

Persons exhibiting language dysfluency can present like persons with psychotic disorders to an untrained clinician.

Common pitfalls to avoid:

Clinicians should be careful not to:

- mistake deafness for intellectual impairment
- assume that a Deaf or hard of hearing person's illness will manifest itself in the same way as a hearing person
- assume that engaging an interpreter will address the shortfalls of current assessment tools and therapy styles for Deaf and hard of hearing consumers
- use standardised delivery of assessment tools and based diagnoses on tests not normed for Auslan users

Mental health assessment considerations

Pre-assessment considerations and recommendations:

Prior to conducting an assessment, consider:

- allowing additional time or multiple appointments
- communication needs of everyone in the appointment, including the consumer's interpreter preference, and the arrangements need to be made
- usefulness of assessment tools
- how to strengthen the rapport and therapeutic alliance with the Deaf or hard of hearing consumer
- implementing useful visual tools such as whiteboards, pictures, calendars, family trees etc.

The mental health assessment:

The mental health assessment should amplify the persons' strengths, values, coping strategies, and goals, in support of a recovery orientated mental health service.

Post-session considerations and recommendations:

After conducting an assessment, consider:

- debriefing with the interpreter
- consulting with professionals who have relevant expertise
- the limitations of the assessment session

Therapy considerations

Deaf people are likely to enter therapy with the same problems as their hearing counterparts; however specific skills are required when working with Deaf or Hard of hearing people.

Common mental health experiences include:

- issues with substance abuse
- stress, anxiety and/or depression
- issues experienced as part of a minority group
- social and economic circumstances affecting mental well being

Contextual information:

- more than 90% of deaf children are born to hearing parents, who have little or no previous experience with deafness.
- in Australia, there are few mental health professionals who are Deaf or who have Auslan as a first language

Considerations:

- the role and impact of an interpreter on the therapeutic alliance and process
- the impact of information being relayed back and forth between two languages and (at least) two cultures and the varying language requirements that may need to be catered for (e.g., mixed hearing and deaf families)
- issues of confidentiality and safety (small Deaf culture)
- lines of sight and visibility of the interpreter
- transference and counter transference in relation to interpreter
- coalitions and alliances between the interpreter and consumer
- the person's own explanatory models of illness, distress and wellness
- the impact of the practitioner's own language, cultural beliefs and values on the therapeutic relationship

Recommendations:

- mental health interventions should be culturally and linguistically affirmative
- practice in person centred, holistic, recovery-oriented models of care
- consider a person's cultural identity, as the basis for understanding how they see self, kinship and relations with the broader community
- document concerns and request support Deafness and Mental Health Services 3167 8383

Victims within the criminal justice system

Deaf and hard of hearing people confront numerous barriers when protecting themselves against being a victim of crime, and reporting crimes to law enforcement agencies.

Deaf people report having concerns about:

- not understanding the reporting and investigation process
- being perceived as less credible
- being blamed for being a victim, or their disability as causing the victimisation
- law enforcement not understanding their disability
- law enforcement being unresponsive to their (communication) needs

Suggestions for law enforcement and clinicians:

- provide an interpreter or real-time captioning
- provide victims with time to talk and share details about their story
- ask probing questions about the incident
- keep the victim informed via email or text (SMS)

Assessing fitness for trial

In determining fitness for trial, the rights of Deaf and hard of hearing individuals who face criminal charges must be suitably met.

Fitness for trial requires a Deaf or hard of hearing person to:

1. understand the charges, trial process and the roles of participants in the trial
2. be able to follow the trial and understand evidence given
3. understand the social purpose, possible outcome and consequences of the legal proceedings and
4. be able to communicate effectively with their counsel and put forward their version of the relevant facts

Assessments of fitness for trial:

The assessment focus should include areas of understanding, reasoning, decision-making and communication. Assessing fitness for trial of a Deaf person is a complex and specialised area that is lengthy and requires more time and resources.

Assessments must be made with the knowledge that they may be invalid, unreliable and in some cases completely inappropriate (culturally and linguistically). There are very few Auslan interpreters in Australia who have experience in legal interpreting as it requires specific knowledge of Auslan as well as the legal system.

Checklists

Communication with an Aboriginal and Torres Strait Islander Deaf person

Pre and post assessment meeting with an interpreter

Service accessibility considerations

Mental health assessment considerations

Fitness for trial considerations

Fitness for trial assessment recommendations

Assessing fitness for trial

Mental health pre-assessment

Mental health post-assessment

Communication with an Aboriginal and Torres Strait Islander Deaf person

Checklist

Prior to conducting an appointment with an Indigenous Deaf person, complete the following checklist:

Item	Check
I am mindful of the diversity of Aboriginal and Torres Strait Islander experiences, culture and values and the processes. Western service models and responses can be culturally inappropriate for Aboriginal and Torres Strait Islander people.	
I am aware that interpretations of mental health and wellbeing, and mental illness are the vital first steps in achieving culturally competent and safe practice.	
I am able to adhere to the local cultural communication protocols when planning meetings, passing on information and seeking feedback. Indigenous people with hearing loss will find communication even more difficult when faced with unfamiliar cultural processes.	
I am mindful of building rapport through yarning about who I am, where I am from, my family and my role.	
I know the importance of welcoming and working with family and/or community.	
I have booked an Auslan/English interpreter when it is appropriate, and if possible, an Indigenous Deaf Interpreter, suitable to the person.	
I have allowed time for the interpreter(s) to engage with the Deaf person before the formal communication takes place.	
I am aware that Indigenous Deaf people have different levels of proficiency of English and this could impact on service delivery.	
I have sought the advice and guidance from Aboriginal and Torres Strait Islander health and mental health practitioners and where appropriate, relevant Elders and representatives.	
I am aware of using culturally sensitive and appropriate communication behaviour (e.g. eye contact).	

For additional information see:

http://qheps.health.qld.gov.au/metrosouthmentalhealth/metspen/metspen_indigenous.htm

Pre and post assessment meeting with interpreter

Checklist

When conducting any type of assessment with an interpreter, complete the following checklist.

Pre-session

Item	Check
The interpreter has explained his or her role.	
I have explained the overarching purpose of the session to the interpreter.	
I have explained the key principles and concepts of the treatment or therapy to the interpreter.	
I have shared the relevant facts of the client's case for the purpose of accurate interpretation.	
I have provided the interpreter with a copy of any assessment items I plan to use.	
the interpreter has highlighted areas of the assessment that they forsee may have linguistic or cultural difficulty.	
I have provided an opportunity for the interpreter to calibrate to the language that I will use in the assessment or treatment. Calibrating refers to the process of adjusting to the language level, patterns and idiosyncrasies of each individual in the communication exchange. Calibrating is an important part of maintaining the integrity of the meaning intended in each communication exchange.	

Post-session

Item	Check
I have clarified with the interpreter any linguistic or cultural concerns that were raised in the session.	
I have checked if the interpreter had any difficulties in translation or has any culturally relevant information that may influence my diagnosis or recommendations.	
If the client and myself are happy with the interpreter, I have established whether it is possible to book the interpreter for regular appointments.	

Service accessibility considerations

Checklist

To improve the accessibility of your service, complete the following items.

Item	check
Have I made use of available advice and resources that are available online at QHEPS? e.g. 'communication kit for Deaf /hard of hearing'	
Are there simplified visual resources I could use? e.g. diagrams, calendars	
Have I turned on captioning on any televisions in the waiting room?	
Is it possible to implement an online booking system or email/SMS communication system for my consumer(s), their carer and/or family?	
Have I accommodated my consumer(s) communication needs? The mere presence of hearing aids or cochlear implants is not enough to make an inference in relation to a person's communication needs.	
Have I ensured that the relevant staff know to book and engage an interpreter?	

Mental health assessment considerations

Checklist

During and assessment, consider the individual's:

Item		Check
Deafness and developmental history	Onset of deafness	
	Level of deafness	
Modes of communication	Exposure to sign, spoken, written language	
	Extent of sign, spoken and written language	
Family of origin	Deaf or hearing?	
Identity development		
Family environment	Supports	
	Strengths	
	Family culture	
Educational experiences	Type of school	
	Level achieved	
	Literacy skills	
Social supports and roles	Involvement in Deaf community	
	Friends and colleagues	
Intellectual and cognitive ability and how this might relate to experiences of abuse	Academic skills	
	Physical or cognitive disabilities	
Past psychiatric history (including suicide and self-harm)	Precipitating events	
	Experiences	
	Coping strategies	
	Supports	
Forensic, drug and alcohol history	past behaviour	
	Past habits	
	Goals	
Risk assessment	Personal goals	

Fitness for trial considerations

Checklist

When assessing fitness for trial, consider the following:

Item	Check
Deafness can have far-reaching effects on social, emotional and cognitive development.	
Language deprivation, sign language fluency and variations in language literacy have very real implications when considering a deaf individuals' fitness for trial. Deaf people may not understand legal terminology or concepts, the charges or even the process they are going through.	
People with limited language ability can experience difficulty with abstract concepts such as time, and have poor comprehension of verb structure.	
There is currently no standardised test for Auslan development for Deaf adults, rendering the task of determining sign language ability/comprehension challenging.	
The degree of audiological loss does not equate to a standardised level of communication ability or hearing functioning.	
Utilising hearing augmentation devices does not give the user 'normal hearing'.	
There are limited formal signs for the sophisticated terminology used in legal settings. Extra time will be needed for explanation and in many areas, teaching, and this will often have extra time and cost implications.	
The developmental disabilities or neurological conditions that sometimes co-occur with deafness may have a direct or indirect psychological effect on a persons' mental state.	

Fitness for trial assessment recommendations Checklist

Prior to assessing an individual's fitness for trial, it is recommended that you consider the following:

Item	Check
Determining the person's preferred mode of communication prior to any appointments by directly asking the person. All efforts should be made to locate a suitable qualified and experienced professional interpreter. Particularly in the legal setting, using family members as interpreters should be avoided as much as practically possible.	
Arranging communication provisions prior to any appointment, for any and all communication (formal and informal).	
Clinicians have a right to an interpreter as well as the consumer.	
A skilled and well qualified Auslan/English interpreter or Deaf interpreter can be crucial in gaining an understanding of sign language ability.	
Those relying on hearing augmentation must have provision to ensure they are functioning adequately prior to an appointment, including access to batteries, back up equipment etc.	
Allowing extra time for any appointments, or multiple appointments	
Facilitating communication through the use of visual resources such as picture cards, emotion scales, calendars, time lines.	
Being flexible in your approach to communication, making use of resources online and services available for Deaf or hard of hearing people.	
Ascertaining reports and information on the consumer's use of language and educational level to gain insight into their ability to understand and their reasoning and decision-making skills.	
Understanding the familial and social context a Deaf or hard of hearing person lives in to gain insight into the person's language and social learning opportunities, or lack there of.	
Regularly checking for understanding during your conversation by asking the consumer to repeat back what you have said using their own words.	
Understanding that English is a second language for most Auslan users.	
Being aware of a possible reduced capacity for the consumer to be educated about relevant legal matters including the trial process.	
The suitability of tools for assessment.	

Assessing fitness for trial Checklist

When conducting an assessment of fitness for trial, we recommend completing the following checklists.

Stage 1 - Preparation

Item	Check
I have an understanding of Deaf culture.	
I have sought the involvement or expertise of professionals with relevant experience, including advocates or helpers from Deaf services in my State.	
I have allowed time 2-3 times longer for the appointment or arranged multiple appointments.	
I have elicited the consumers preferred mode of communication and confirmed appropriate arrangements.	
I have completed a pre session brief with the interpreter.	

Stage 2 - During

Item	Check
I have obtained a detailed Deaf history of the consumer, including cause of deafness to discern any possible developmental, neurological, or learning disabilities.	
I have obtained a detailed developmental history: age and use of language from early childhood onwards, including education and work history.	

Stage 3 - Post

Item	Check
If it was possible, I have debriefed between with interpreter.	
I have made note of the interpreter’s comments and considerations before formulating an assessment and report.	
I have enlisted the expertise from a range of clinicians or professional staff before making any reports or recommendations.	
My recommendations and reports highlight any limitations in the assessment, suitability of measurement tools, as well as resource issues i.e. availability of interpreters.	

Mental health pre-assessment Checklist

Prior to conducting a mental health assessment, check that you have completed the following:

Item	Check
I have an understanding of Deaf culture.	
I have sought the involvement and advice from professionals with relevant experience, including enlisting advocates or helpers from Deaf Services in my State.	
I have knowledge and experience of healthy Deaf people.	
I have allowed 2-3 times longer for the appointment or for multiple sessions.	
I have allowed time to explain who I am and what I am doing.	
I have elicited the consumer's preferred mode of communication and made appropriate arrangements (e.g. interpreter, captioning etc.).	
I have considered my own communication behaviours and how they can be altered to best facilitate communication between myself and the consumer.	
I have gathered information on support networks, community supports and programs relevant and available for Deaf and hard of hearing people.	
I have considered the cultural and linguistic assumptions behind any assessment items/questions, or sought advice from the interpreter.	
I am mindful of over emphasising a consumer's deafness to the detriment of not addressing the person's presenting concerns.	
I have completed a pre-session brief with the interpreter.	

Mental health post-assessment Checklist

After completing a mental health assessment, and prior to completing any reports or recommendations, check you have completed the following:

Item	Check
I have debriefed with the interpreter. Interpreters, although often itinerant in nature, are considered part of the multi-disciplinary team in terms of language and linguistic considerations, and will be useful in the formulation of assessment and report.	
I have enlisted the expertise from a range of clinicians or professional staff with experience in working with deafness.	
I have highlighted any limitations in the assessment report including suitability of measurement tools, as well as resource issues (i.e. availability or appropriateness of interpreters).	
I have contextualised the report and recommendations. Consider English is a second language for many Auslan users, and some people may not have been exposed to sign language (or any language) consistently all their lives.	
I have contextualised the report and recommendations. Consider the impact of language deprivation and the history of deaf education and language philosophies, how this can provide valuable insights into a persons social, emotional and academic development.	

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