Deafness and Mental Health

Guidelines for Working with People who are Deaf or Hard of Hearing

October 2008
Queensland Health 2008

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This document is designed to provide information to assist policy and program development in government and non-government organisations.

This work is a publication produced by the Princess Alexandra Hospital Brisbane South Health District, Division of Mental Health, Centre of Excellence, Deafness and Mental Health Statewide Consultation Service.

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Foreword

The National Mental Health Strategy 1992 provided a framework to ensure all Queenslanders have equitable access to mental health promotion, treatment and recovery services regardless of their cultural and linguistic backgrounds or individual challenges.

Deafness has been defined as the second biggest health issue facing Australia today, with an estimated 1 in 6 Australians affected by hearing loss.

The term “deafness” covers the spectrum of those who identify as culturally Deaf and belong to the Deaf community, and those individuals who have a hearing loss and identify primarily with the mainstream hearing culture.

Needless to say, it is paramount that interventions that promote mental health and reduce the impact of mental health problems must be underpinned by culturally inclusive policies and practices which are responsive to the diverse needs within the spectrum of deafness.

In recent years there has been an increased awareness of the importance of social inclusion and cultural competence, yet there has been limited practical application of how these concepts translate to the area of best practice in mental health service delivery for Deaf and hard of hearing consumers.

Using the Queensland Plan for Mental Health 2007–2017 template as a starting point, these guidelines will contribute towards the maintenance of a culturally competent workforce utilising inclusive practices that contribute to an accessible mental health system for those experiencing deafness.

I feel confident that these guidelines will support professionals in their service provision to deaf consumers. While acknowledging the path to accessibility is challenging, I am confident that this tool will assist professionals to achieve better outcomes. To this end it is my hope that the implementation of the various recommendations will do much to improve the lives of deaf people in Queensland.

Dr Aaron Groves,
Senior Director, Mental Health Branch

September 2008
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Introduction

The National Mental Health Strategy 1992 was developed to provide a framework for national reform of the mental health system. In July 2006, the Council of Australian Governments (COAG) agreed to the National Action Plan on Mental Health 2006–2011, recognising the need for a change in the way governments respond to mental illness. The plan provides a strategic framework that emphasises coordination and collaboration between government, private and non-government providers, aimed at building a more connected system of health care and community supports for people affected by mental illness. The strategy continues to be reaffirmed with the endorsement of the Queensland Plan for Mental Health 2007–2017, focusing on strengthening quality across all mental health and related services.

Complimentary to this was the development of the Framework for the Implementation of the National Mental Health Plan 2003–2008 in Multicultural Australia to address the issues of equity and access for all Australians. This Framework provides strategies for all health and community sectors to meet nationally accepted standards of service delivery in the provision of culturally competent and inclusive services.

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.

The Queensland Health report ‘Mental Health Needs of Deaf and People with Hearing Impairment in Queensland’ (Briffa, 2001) illustrates that Deaf and hearing impaired (sometimes referred to as hard of hearing) perceive the service they receive as being inequitable.

These guidelines aim to provide practical applications for theoretical frameworks based on policies of social inclusion. The guidelines will cover deafness from a socio-cultural and medical-disability perspective as well as provide an introduction to various groups within the deafness sector and the implications for the mental health sector.

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.
Princess Alexandra Hospital Brisbane South Health District

Division of Mental Health

Centre of Excellence

Deafness and Mental Health Statewide Consultation Service

The Princess Alexandra Hospital Brisbane South Health District (PAHBSHD), Division of Mental Health, working in partnership with specialist agencies, developed a Centre of Excellence for Deaf and hard of hearing people which was launched in November 2004. As a Centre of Excellence, the PAHBSHD Division of Mental Health offers a State-wide psychiatric consultation service that strives to ensure that appropriate and accessible mental health care is provided to Deaf and hard of hearing people in Queensland.

The service is the first of its kind in Australia and also offers training and an extensive set of resources to assist mental health professionals to provide appropriate, accessible and equitable care to this group.

Our Vision

Improving Mental Health Access and Outcomes for People Who are Deaf or hard of hearing

Our Mission

The Deaf Mental Health Team will assist people who are Deaf or hard of hearing to access culturally affirmative and inclusive mental health care and treatment through:

- Education
- Support of Clinical Staff
- Support of Clients
- Prevention Strategies
- Consultation

These initiatives are aligned with the priority areas identified within the Queensland Mental Health Plan 2007–2017.

For referrals, please contact the service by phone, fax, TTY, email or mobile SMS – consult website for current contact details <http://www.health.qld.gov.au/pahospital/mentalhealth/damh.asp>.
PART

1.

Deafness and Mental Health
Overview of Deafness and Mental Health

It has been well established that the mental health needs of Deaf and hard of hearing people are not being adequately met. Identified barriers to service provision in Queensland include inappropriate assessments and service providers’ lack of awareness of deafness related issues (Briffa, 1999). Worldwide there is a growing appreciation for the specialised skills required to work in mental health settings with Deaf and hard of hearing people.

Most of the literature regarding mental health and deafness is based on studies conducted overseas. Conflicting data exists in relation to the prevalence of mental illness in the deaf population. At a minimum, deaf people experience a prevalence of mental illness equal to that of the hearing population. Other studies suggest that disproportionately high numbers of deaf people within mental health services is a result of lack of knowledge about preventative measures and poor communication at the point of assessment, resulting in poor diagnostic and treatment services (Queensland Health, 2004).

However, some studies suggest that deaf people have a greater likelihood of experiencing mental illness at some point in their lives. This may be due to a range of issues including:

- they experience increased social isolation and emotional vulnerability, leading to higher risk of abuse
- there are often major communication issues surrounding the family of deaf people if the family is experiencing deafness for the first time
- poor education opportunities and limited social expectations can reduce the cultural capital of deaf people
- they face linguistic and cultural barriers to access and participate in existing mental health promotion, treatment and recovery services
- there is a lack of knowledge within the mental health sector of deaf specific considerations
- there appears to be limited knowledge and acceptance of mental health issues within the deafness sector.

In Australia, most graduate psychologists, therapists, and psychiatrists are ill-equipped to meet the mental health needs of deaf people. In part this is due to the lack of research available on mental health interventions and outcomes for Deaf and hard of hearing people. Internationally, the research into outcomes for deaf clients in therapy is almost nonexistent (Munro, Knox, & Lowe, 2008). Guidelines for working with deaf people in the mental health setting will provide a basic introduction for mental health practitioners; however, measuring the success of therapeutic interventions should be explored further by each service provider.
Responsibilities of mental health service providers is to:

- improve the quality of life for Deaf and hard of hearing individuals with mental health problems, promoting protective factors and a focus on early support systems
- increase awareness of mental health issues of Deaf and hard of hearing Australians within the broader community and within the mental health and deafness sectors
- build accessible and responsive service systems, which draw on the strengths of the specialist deafness sector and the wider mental health sector.

In attempting to provide guidelines to accommodate working with people across the deafness continuum, it must be noted that Deaf people who use sign language, culturally Deaf people, will face similar barriers to those from a Culturally And Linguistically Diverse (CALD) background. In contrast, hard of hearing people almost always maintain a cultural identity as hearing people, thus facing barriers similar to those people who experience disability. Despite these divergent views of deafness, clinicians familiar with deafness from a cultural perspective are more likely to be capable of working with people with every type of hearing loss.

Background facts

One in six Australians have a hearing loss
[Access Economics, February 2006]

The prevalence of hearing loss (better ear – hearing disability) is expected to increase to 1 in 4 of every Australian by 2050
[Access Economics, February 2006]

1 in 5 Australians will experience a mental illness at some point in their life, a quarter of whom will receive treatment.
[Commonwealth Department of Health, and Aged Care and Australian Institute of Health and Welfare (AIHW) 1999]

“Over three million Australians are affected by some degree of hearing loss”
[Access Economics, February 2006]
Deafness Continuum

In order to deliver a service that recognises the needs of individuals, the term deafness should be viewed as a continuum. There is no singular hearing loss condition that defines deafness just as there is no singular human being that encompasses the entire human condition. The level of hearing loss in itself provides very little information about the social limitation experienced by the affected individual.

The continuum of deafness can be viewed not only through the objective lens of audiology but also through the subjective lens of personal meaning. The historical association of hearing loss with ‘disability’ and ‘handicap’ fails to pay respect to a person’s intrinsic identity and the level of difficulty that may or may not be associated with their particular hearing level. What was traditionally referred to as a hearing ‘impairment’ is now defined in terms of social participation.

Throughout this publication, the term ‘culturally Deaf’ will be used to define those deaf people who use sign language and belong to the Australian Deaf community. The term ‘hard of hearing’ will be used to define those individuals who have a hearing loss and do not use sign language as their preferred language. Other terms to define the latter are ‘hearing impaired’ and ‘people who have a hearing loss’, however, for the sake of ease, only the term ‘hard of hearing’ will be used but it must be noted that individuals with a hearing loss have various ways of defining themselves and clinicians must respect each individual’s choice.

Figure 1.1 – Deafness Continuum
Understanding Deafness

Although individuals within the deafness continuum have their own unique personal identity which must be respected, the diversity of deafness and its meaning is often managed by situating deafness within distinct models. Over the past few years, two opposing perspectives of conceptualising deafness in contemporary society have been reported and discussed. These models of deafness which are rooted in either the social or biological sciences are the medical-disability model and the socio-cultural model. The model used affects how deaf persons are treated and their identity.

Medical-Disability Model

The medical-disability model defines deafness as a pathological condition, focusing on the failure of the hearing mechanism. Deafness is defined as a medical condition that requires some kind of remediation, either through correction or compensation. It emphasises the need to encourage speech, hearing and lip reading based on the assumption that competency in a spoken language is the desired means for cognitive development and communication. (Munoz-Baell & Ruiz, 2000)

The vast majority of people with hearing loss acquire a mild to moderate hearing loss in adult life, with a small number of people acquiring deafness during childhood. People with acquired hearing loss commonly understand hearing loss as a sensory deficit within the body and often use hearing augmentation devices. A defining factor of the medical disability model is the use of speech and hearing as the preferred means of communication. The most commonly reported consequence of hearing loss for this group is a loss of social participation such as being unable to follow conversations in noisy social settings. Hearing parents whose children are born deaf often identify with hearing culture and also view hearing loss within the medical-disability model. (Access Economics, February 2006)

Socio-Cultural Model

In contrast to the medical-disability model, an ever increasing number of deaf people do not consider themselves to be handicapped or disabled but claim to be seen and respected as a distinct cultural group with its own beliefs, needs, opinions, customs and language. Members of the Deaf community define deafness as a cultural rather than an audiological term. The socio-cultural model recognises significant socio-linguistic differences between people who label themselves deaf and people who label themselves hard of hearing. (Munoz-Baell & Ruiz, 2000)

People who are born severely-to-profoundly deaf may grow up in or later join the Deaf community. When deafness is understood as a cultural-linguistic experience, it becomes a source of pride and cultural identity, rather than being a source of stigma. Members of the Australian Deaf community communicate using Australian Sign Language, known as Auslan. A common communication problem facing members of the Deaf community is the inability of most Australians to converse with them in Auslan and the lack of availability of sign language interpreters. This group would define the social consequences of hearing loss in terms of reduced social participation in the broader community and encounters the impact of this in terms of socio-economic loss and reduced social interactions rather than perceiving it as a burdensome disease. (Access Economics, February 2006)
Using the models defined above, it is apparent that culturally Deaf people and hard of hearing people, in general, belong to separate cultural and linguistic realities. It is for this reason that these guidelines have been separated into distinct chapters addressing the needs of both.

**IMPORTANT**

The common issue to individuals situated in either model of deafness is communication.

**Culturally Deaf**

“Culturally Deaf” is a term used to identify a group of people, with some degree of hearing loss, who identify as belonging to the Deaf community. Other terms used to represent this group include using the word “Deaf” with an upper-case “D” and “the signing deaf community”.

The Deaf community in Australia is a diverse cultural and linguistic minority group that encompasses a vast network of social, political, religious, artistic and sporting groups that use Australian Sign Language (Auslan) as their primary mode of communication. Accepting one's Deafness as part of a person’s identity is the core element in identification into the Deaf community.

Identification with the Deaf community is a personal choice and it does not depend on the degree of deafness, rather on identifying with the cultural model of deafness. Culturally Deaf people, whether they have hearing aids, cochlear implants or use sign language see themselves as normal, not as abnormal hearing people. Although the Deaf community is heterogeneous in ethnicity, race, religion and other cultural characteristics, the community shares attitudes and beliefs that bond as common experiences and is united in identity by sharing Auslan. ([http://www.deafservicesqld.org.au](http://www.deafservicesqld.org.au))

Included in the Australian Deaf community are some hearing people who use Auslan; for example some hearing children of Deaf adults, referred to as CODA’s (Children of Deaf Adults), and some Auslan interpreters. It is the use of Auslan that is the core of the Deaf community and is it’s most unifying and identifying characteristic (Johnston, 1989).

**Hard of hearing/hearing impaired/hearing loss**

“Hard of hearing”, “hearing impaired” and “people with a hearing loss” are terms used to refer to those people with some degree of hearing loss who identify primarily with the dominant ‘hearing’ culture. Hard of hearing people generally identify with the medical-disability model of deafness which focuses on hearing loss as a deficit with an aim to use technological and behavioural means to assist communication. The distinguishing characteristic of a person who is hard of hearing is their preference to communicate using spoken language, in contrast to a culturally Deaf person whose preference is to communicate using sign language. People who identify as hard of hearing may have sufficient residual hearing to enable them to use speaking and listening (oral/aural communication). They may or may not use assistive listening devices, hearing aids or cochlear implants.
PART

2.

Deaf with a Capital ‘D’ – Culturally Deaf
Planning Mental Health Services for Deaf People

DID YOU KNOW

- Sign language is the Deaf person’s preferred language
- Deaf people have a rich culture referred to as ‘Deaf culture’
- Culturally Deaf people consider themselves a culturally and linguistically diverse group not necessarily a disabled group
- Deaf people face similar challenges as CALD consumers in the mental health setting

People who use Australian Sign Language as their preferred mode of communication are commonly referred to as belonging to the Australian Deaf community in much the same way as those people from a Culturally And Linguistically Diverse (CALD) background belong to their own ethnic communities and identify as a member of that community; for example Cambodian, Italian, Filipino, Serbian. It is for this reason that, in the written form, a capital ‘D’ is used when writing the word ‘Deaf’ to identify this cultural and linguistically diverse group of the deafness continuum. This socio-cultural model of deafness, as discussed earlier, does not view deafness as a deficit or loss but rather as a cultural identifier.

Therefore, in the planning and delivery of mental health services for the Deaf community we must consider some of the challenges faced by CALD consumers in accessing equitable services then superimpose these onto the considerations required when providing an equitable service for the Deaf consumer. In summary, the Deaf community could be considered a CALD community and it is from this premise that these guidelines will operate.

The Framework for the Implementation of the National Mental Health Plan 2003–2008 in Multicultural Australia provides strategies for all government, private and non-government organisations across the health and community sectors to meet nationally accepted standards of service delivery and workforce practice in the provision of culturally competent and appropriate services.

Summarised below is an interpretation of the principles underpinning the Framework that are applicable to, and set in the context of, the Deaf community.

- An acknowledgment of the importance of (Deaf) culture in determining the risk and protective factors that influence mental health.
- (Deaf) consumers, carers and their families have the right to access mental health care provided in a manner which responds to their social, cultural and linguistic diversity.
The provision of culturally competent, responsive and efficient mental health services requires partnerships across the health and welfare systems and with consumers and carers from the (Deaf) community.

- A culturally competent workforce is fundamental to the provision of culturally appropriate mental health services.
- A recovery focus which respects (Deaf) consumers personal and cultural belief system should drive service delivery.
- Initiatives to ensure quality in mental health services must be culturally appropriate for (Deaf) consumers.
- Initiatives to develop innovative ways to provide services and research must be culturally competent and inclusive.
- Culturally appropriate service models, which are shown to be effective, must be sustainable in the long term and become part of mainstream health care.
- Achievement of better health outcomes for (Deaf) consumers, their families and carers will require funding models and allocation of resources which consider the needs of the (Deaf) community.

Australian Federation of Deaf Societies (AFDS), in their submission to the Senate Select Committee on Mental Health 2005, stated that the key issues for people who are Deaf and have a mental illness are:

- the lack of Deaf-specific mental health services which are aware of and able to provide culturally and linguistically appropriate services to the Australian Deaf community
- the low awareness of mental health issues by the Deaf community, including the right to an Auslan interpreter when using such services
- the small pool of appropriately skilled and qualified Auslan interpreters available for mental health appointments.

In order to address these issues AFDS recommended:

- the development of a national strategy for the provision of culturally and linguistically appropriate mental health services to the Australian Deaf community
- funding for mental health awareness raising in the Deaf community
- funding for professional development for Auslan interpreters and Deaf Relay interpreters in order to increase the pool of appropriately skilled practitioners available to work in mental health settings.

Ref <http://www.afds.org.au>
Deaf Culture

What has commonly come to be referred to as ‘Deaf culture’, is the variety of ways Deaf people have “accumulated a set of knowledge about themselves in the face of the larger society’s understanding, or misunderstanding, of them. They have found ways to define and express themselves through their rituals, tales, performances, and everyday social encounters” (Padden & Humphries, 1988).

Cultures are highly specific systems that both explain things and constrain how things are known. Each culture prescribes “a set of control mechanisms – plans, recipes, rules, instructions … for the governing of behaviour” (Geertz, 1973).

Everyday elements of Deaf culture

Values

- “Deaf” is the preferred term not hearing impaired.
- Strong Deaf history and pride associated with being Deaf, thus extensive use of the word “Deaf”. (See Figure 2.1).

Figure 2.1 – Examples where the word ‘Deaf’ is used

- Sign language is a preferred and valued language.
- Preference for face-to-face communication and visual means of receiving information, for example sign language, pictures, diagrams, demonstrations.
- Deaf humour is more visually based because humour and culture are closely linked. Hearing humour is often aurally/orally based, for example a play on words, puns or idioms. Therefore, humorous quips may not have the intended effect on a Deaf person and can be challenging to interpret.
- English is used as a ‘second language’ to the majority of Deaf people.
- Many Deaf people use a narrative form of relaying information. Story telling is how the Deaf culture is passed on.
- Value placed on what school they attended. The communication philosophies/strategies used during formative education affects the communication modalities a Deaf person uses and provides a background for shared history. For example, Oral deaf school, Deaf (sign language) school, ‘mainstream hearing school’, use of interpreters, type of sign language.
Importance placed on Deaf events such as Deaf sports, Deaf festivals, Deaf parties, provide opportunities to communicate in their native language which requires face to face contact.

Value placed on ‘Deaf art’- work by some Deaf artists communicate messages about the two models of deafness – medical-disability model and socio-cultural model, and often refers to the suppression of Deaf people and the associated struggle for recognition. (See Figure 2.2).

The hands symbolise Deaf culture because sign language is at the centre of the culture. (See Figure 2.3).

Figure 2.2 – Example of Deaf art expressing an opinion about the models of deafness

"Untitled" by Betty G. Miller 1994. Informally known as “The Big Ear”, it represents the medical view of deaf people – where they are seen as an ear to be fixed, not a person. Untitled portrays with mixed media the battle between medical and cultural understandings of Deaf people.

Behaviours

People who are not deaf are referred to as “hearing”.

Gain a Deaf person’s attention by visual or tactile means. For example, flicking the light switch, stamping on the floor or table, tapping on the upper arm.

The ‘Deaf nod’ is where Deaf people use nodding as a means of acknowledging that you are talking to them (similar to ‘aha’, ‘hmm’, ‘uh-huh’) but doesn’t necessarily mean agreement or affirmation of what was said. A nod, gratuitous concurrence, may be used to appease a person of the dominant culture without actually concurring with that person.
‘Visual noise’ is distracting in the same way aural noise is distracting or annoying to hearing people. For example, blinking lights, people passing, flashing jewelry.

- Use of visual alerts e.g. flashing lights, vibrating alarms, baby cry alarms.
- Captioned TV and DVD provide access to popular media and training materials.
- Pointing at someone is not regarded as rude in Deaf culture.

Deaf people often use ‘name signs’ when they are talking about people who are not present. If the person is present they tend to point to the person they are talking about, although sometimes name signs are used instead of pointing. ‘Namesigns’ are specific signs to indicate a particular person. It may be a descriptive sign like “hooked nose” / “curly hair” or a sign related to the person’s habit, like “hand on hip” / “twiddle moustache” or an initialised sign like “K.L” / “P.B” or a combination of the above.

The ‘Long Goodbye’ is a Deaf cultural phenomenon. Using a visual language means that face-to-face communication is optimal. Deaf people tend to seize the opportunity of face-to-face contact thus a tendency towards extending the communication. They also show a greater preference than hearing people for approaching each person individually to say goodbye rather than a general “goodbye everyone” which everyone may not see. (See Figure 2.4)

**Figure 2.4 – The Long Goodbye**
Auslan (Australian Sign Language)

DID YOU KNOW

- Auslan is a distinctly different language to English
- Other countries have their own native sign languages, for example ASL American Sign Language; JSL Japanese Sign Language; LSF French Sign Language
- The name is written as Auslan, not AUSLAN

What is Auslan?

- Auslan is the name given to the natural sign language (or native sign language) of the Australian Deaf community.
- Auslan, like other sign languages, use a variety of ways to convey meaning, including hand shapes, orientation, location, movement, facial expression, natural gestures, body language and fingerspelling.
- Auslan has a grammatical system independent of English.
- Auslan has different dialects within Australia but rarely do they inhibit communication amongst users.

(Adapted from Johnston, 1989)

History of Auslan

- Auslan is a term coined by Trevor Johnston in the early 1980’s to name the natural visual-spatial language that is used by the Australian Deaf community. It is derived from the first letters of the words Australian Sign Language
- Auslan developed from the varieties of signed languages brought to Australia by deaf immigrants and hearing educators of deaf children from the early nineteenth century onwards (Johnston, 1989).
- Auslan was incorporated into the government’s Australian Language and Literacy Policy (Dawkins, 1991). This policy opened to door to the recognition of first language use by Deaf people and subsequently to the provision of interpreters in many settings.
Fingerspelling

- Fingerspelling is the manual representation of letters of the alphabet on the hands.
- Fingerspelling is used in different sign languages and registers for different purposes. It may be used to represent words from a spoken language which have no sign equivalent, for emphasis, for clarification, or when teaching or learning a sign language or to represent names of people or places.
- Auslan uses a two-handed alphabet whereas some sign languages use a one-handed alphabet.

**Figure 2.8 – Two handed manual alphabet** (Johnston, 1989)

Auslan and English

- Unlike English, there is no written form of Auslan.
- Deaf people will often write English words but use the sentence structure of Auslan.
- English is used as a ‘second language’ in the Deaf community.
- Deaf people in Australia rely on English for reading and writing but competency levels vary greatly. Likewise, fluency levels in Auslan vary from individual to individual.
- It is difficult to sign Auslan and speak English simultaneously due to the vast differences in the two languages. However, mouthing an English word may clarify a word when there may be a number of English words with the same meaning. For example excellent, outstanding, superb, brilliant.
Learning Auslan

- Auslan is a rich and complex language requiring commitment to achieve fluency that parallels the effort required to attain fluency in any other foreign language.

- Of those who use Auslan as their preferred language, only 10% learn from their parents with the rest learning from their peers at Deaf schools or social networks later in life. Ninety percent of Deaf children are born to hearing parents (Lane, 1995).

- Like any other language, basic conversational Auslan can be achieved by partaking in conversational classes. However, Auslan requires face-to-face tuition due to its visual nature.

- To achieve fluency in Auslan, socialising with the Australian Deaf community in addition to tertiary study is optimal.

- Children may achieve fluency naturally without formal classes if they have Deaf parents. Socialising and/or working extensively with Deaf people may also lead to fluency.

- To learn Auslan, see ‘Professional Development’ (page 71).

**IMPORTANT**

There are elements that are important to good Auslan use, just as there are elements that are important to good English use. The availability of materials using a poor standard of Auslan is of concern to Deaf Australia (the peak advocacy body for Deaf people) because it means that people who are learning Auslan are often learning it incorrectly or inappropriately.

For this reason Deaf Australia has established the Auslan Endorsement System. This system uses highly fluent and experienced Auslan users to test materials according to a list of established criteria <http://www.deafau.org.au>.

Cross cultural communication – a comparison between Deaf culture and Australian Anglo ‘hearing’ culture

Employing a sign language interpreter is a valuable start to bridging the communication and cultural divide that exists between the hearing professional and the Deaf client. However, in order to provide a more equitable access to the service being offered, the hearing professional must aim to understand the values that underpin the perceptions and behaviours of their Deaf clientele.

“Culture and communication are inseparable because culture not only dictates who talks to whom, about what, and how the communication proceeds, but it also helps determine how people encode messages, the meanings they have for messages, and the conditions and circumstances under which various messages may or may not be sent, noticed or interpreted.”

[Samovar & Porter, 1982, p.32]

Collectivism vs Individualism

Collectivist and individualist cultures encompass such issues as identity, loyalty, obligation and independence. What is considered to be normal desirable behavior in one culture can be deemed maladaptive in a different culture. (Mindness A 1999)

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<tr>
<th>Collectivist</th>
<th>Individualist</th>
<th>Possible implications for the Mental Health setting</th>
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<tbody>
<tr>
<td>Deaf culture</td>
<td>Australian Ango ‘hearing’ culture</td>
<td>Examples</td>
</tr>
<tr>
<td>Deaf community members help each other, pool resources, duty to share information, distinct insider/outsider boundaries, loyalty and obligation to the group</td>
<td>Individuals encouraged to be independent, self reliant, take responsibility for ones own actions. Emphasis on personal opinions and choices,</td>
<td>• Hearing clinician viewed by the Deaf person as ‘outsider’ whereas Auslan interpreter viewed as ‘insider’ – has implications for therapeutic alliance.</td>
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<td><strong>Tip:</strong> Discuss this with the interpreter before the sessions, review literature related to this area, learn the fingerspelt alphabet to introduce yourself, learn some ‘Meet and Greet’ signs as a minimum and use them with the client every session.</td>
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<td></td>
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<td>• If Deaf person deems the service ‘deaf-friendly’ he/she is likely to inform the Deaf community through the unofficial ‘Deaf grapevine’. This works conversely if the Deaf person is dissatisfied with the service received. Word spreads faster in a minority community where information sharing is valued.</td>
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<td>• Deaf community members are much more likely to know which if its members have a mental health issue.</td>
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<td>• Confidentiality may be viewed with skepticism. Trust is difficult to regain if broken.</td>
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<td>• In sexual abuse, an abused Deaf person is less likely to disclose the identity of the abuser if the abuser is also Deaf.</td>
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**Collectivist**  
(GROUP FIRST)  

**Individualist**  
(INDIVIDUAL FIRST)  

**Possible implications for the Mental Health setting**

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<tr>
<th>Deaf culture</th>
<th>Australian Anglo ‘hearing’ culture</th>
<th>Examples</th>
</tr>
</thead>
</table>
| Worst punishment is ostracism from group | If ostracised from one group can find another group | - Limited ‘accessible’ groups to which to belong.  
- Great concern over being criticised by other Deaf people but much less concern about being criticised by hearing people. |
| Preference to engage in many activities together | Pursue individual activities | - Deaf people have their own sporting and social clubs, festivals, events, political and religious groups. Inclusion in these clubs may contribute to wellbeing.  
(see Deaf Sport & Recreation Qld; Deaf Services Qld; Deaf Australia) |
| Identifies self as belonging to Deaf community first and foremost. | Identifies self as belonging to a number of different groups simultaneously with no one group completely defining individuals identity | - Deaf people’s pride in their language and culture is evident in their prime identity as a Deaf person. They don’t view their deafness as a disability and thus want their identity recognised and valued by the clinician. A Deaf artist, social worker or carpenter will often identify as ‘Deaf person’ first, profession second.  
**Tip:** Use the term “Deaf man/Deaf women” in your conversations. Don’t use “hearing impaired”. |
| Achievements of the group are paramount. | Status depends on personal achievement | - Deaf people have conferences called ‘Deaf Way’, festivals titled ‘Deaf Festival’ and advocacy titled ‘Deaf Pride’.  
- Clinicians must be mindful that Deaf role models have more kudos amongst Deaf people than hearing ones.  
- A Deaf person achieving something is celebrated and talked about by the whole community and adds to Deaf pride.  
**Tip:** Keep abreast of Deaf issues and role models. Not all Deaf people will know of Deaf role models but they would be happy to hear of them. |
| Deaf hero defined as someone who has helped Deaf people, and/or created solidarity.  
For example FJ Rose, a Deaf man who set up a school for Deaf children in Victoria in 1860  
Danni Wright, Deaf women, using Auslan, presented the Pope with the ‘gift of knowledge’, Sydney, July 2008  
Deaf Lawyer, Deaf doctor | Heroes are those who achieve personal best, for example sports heroes, actors, successful entrepreneurs. | - Deaf people working in an industry or achieving something which can help other Deaf is highly valued. When a Deaf person recognises another Deaf person’s achievement, it is likely to increase their feelings of self esteem, for example “They are Deaf, like me, and look what they have achieved”.  
**Tip:** Before asking the Deaf person to make a decision, suggest that they might like to discuss their options with a friend first. |
| Tend to consult, collaborate before making decisions – ultimately deciding what is best for the Deaf community at large. | Tend to have individual yet equal opinions. Collaboration and consultation has to be a conscious strategy for decision making | - The Deaf person not wanting to make a decision independently or on-the-spot may be viewed as weak, unassertive or collusive.  
**Tip:** Before asking the Deaf person to make a decision, suggest that they might like to discuss their options with a friend first. |
Collectivist

(Group first)

<table>
<thead>
<tr>
<th>Collectivist (Group first)</th>
<th>Individualist (Individual first)</th>
<th>Possible implications for the Mental Health setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deaf culture</td>
<td>Australian Anglo ‘hearing’ culture</td>
<td>Examples</td>
</tr>
<tr>
<td>Unspoken system of reciprocity. Skills and time shared collectively with no obvious ‘tally’ of who did what but an unspoken expectation that everyone helps other members of the Deaf community.</td>
<td>Traditional reciprocity. You do this for me and I will do that for you.</td>
<td>▪ If the Deaf person has promised to do something for another Deaf person they tend to honour that promise. Being known as a breaker of a promise does not sit well with the Deaf community. Deaf people may feel more anxiety about disappointing other Deaf. ▪ Deaf people will often engage other Deaf for work, for example trade work. This is seen as loyalty to the Deaf community.</td>
</tr>
</tbody>
</table>

High Context vs Low Context

These terms deal with the question of how much information must be made explicit in a given culture compared with how much is already understood implicitly because of shared experience (Mindness, 1999). “The level of context determines everything about the nature of the communication and is the foundation on which all subsequent behavior rests …” (Hall, 1976, p92)

<table>
<thead>
<tr>
<th>High Context</th>
<th>Low Context</th>
<th>Possible implications for the Mental Health setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deaf culture</td>
<td>Australian Anglo ‘hearing’ culture</td>
<td>Examples</td>
</tr>
<tr>
<td>Individuals within Deaf Culture share the same cultural experiences. A common context regarding beliefs, values, friends, history, way of talking, shared experiences allow implicit knowledge to guide the conversation. New conversations begin with the assumption that much is known about person already.</td>
<td>Individuals within mainstream hearing culture do not necessarily assume a commonality of shared background and experience. Information often needs to be carefully detailed to transmit the message effectively. New conversations begin from the stance that very little is known about the person until they divulge information.</td>
<td>▪ The order of formal and informal conversational markers can be in reverse for Deaf and hearing people. The hearing professional spends time with small details in the ‘rapport building’ phase of the consultation because very little is known about the person. In contrast, because information sharing is valued in the Deaf community the Deaf client usually wants to share the important information first. Rapport automatically exists amongst Deaf people so they may feel the professional is ignoring the reason for their visit if too much ‘rapport building conversation’ is taking place.</td>
</tr>
<tr>
<td>Interpersonal contact amongst Deaf people takes precedence over the details of the communication. Information flows and is shared easily due to a common cultural base.</td>
<td>The goal of the communication amongst hearing people takes precedence over the interpersonal dialogue.</td>
<td>▪ If there is more than one Deaf person in the group/meeting they are more likely to be keen to engage in interpersonal communication with other Deaf members before the purpose of the group meeting is addressed. The very fact that communication can take place easily may override the goal of the meeting. After all there may be a lot of catching up to do.</td>
</tr>
<tr>
<td>High Context</td>
<td>Low Context</td>
<td>Possible implications for the Mental Health setting</td>
</tr>
<tr>
<td>------------------------------</td>
<td>------------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Deaf culture</strong></td>
<td><strong>Australian Anglo ‘hearing’ culture</strong></td>
<td><strong>Examples</strong></td>
</tr>
<tr>
<td>Make correct assumptions about what they think the other person wants to know.</td>
<td>Assumptions are avoided with the knowledge that the individual may not share the same values, beliefs etc; thus assumptions may be incorrect.</td>
<td>▪ A hearing professional may learn to be mindful of their assumptions about deafness. However, a Deaf person’s assumptions about the hearing person may remain unchallenged. A service may be aiming to be culturally affirmative, but the Deaf person may assume that it won’t be, given the history of oppression and inequality. <strong>Tip:</strong> Point out the ‘Deaf-friendly’ aspects of your service in the first meeting.</td>
</tr>
<tr>
<td><strong>In Auslan, tenses, pronouns and proper nouns are implicit in the conversation after the initial ‘setting the scene’</strong>.</td>
<td>In English, proper nouns, tenses and pronouns can be repeated continually throughout the conversation.</td>
<td>▪ When a hearing clinician is in conversation with a Deaf person the Auslan interpreter may interject to ask for clarification of who said what to whom. This is especially important if a number of people are mentioned in the conversation. <strong>Tip:</strong> Using whiteboards to draw or write the names of the stakeholders is useful to aid clarification in these instances.</td>
</tr>
<tr>
<td>When being introduced to another Deaf person the questions exchanged relate to background and group membership because it is important to ascertain where the person is placed in the known social context of the Deaf community.</td>
<td>When hearing people are introduced to each other the questions exchanged generally relate to personal background, for example work, hobbies, where they live.</td>
<td>▪ Deaf people usually engage in a lengthy conversation after being introduced despite the fact that they have just met for the first time. ▪ A Deaf and hearing person meeting for the first time may share disparate introductory information.</td>
</tr>
<tr>
<td>Information sharing is highly valued, flows freely and rapidly.</td>
<td>Information sharing is compartmentalised and restricted.</td>
<td>▪ “Gossip” in the Deaf community is the communication grapevine for sharing information. It is almost a ‘given’ that “gossip” will occur. ▪ It is often the reason Deaf want to use a service not regularly used by other Deaf people. But, conversely, it can also be the reason that they prefer a service used by other Deaf people so they can ask them “what are you here for?” <strong>Tip:</strong> The issue of confidentiality may need to be reiterated repeatedly.</td>
</tr>
<tr>
<td>Intuitive approach to a task. For example sensory input from the situation and synchronicity of linked events</td>
<td>Analytical approach to a task. For example data collection, planning, causality</td>
<td>▪ May impact on the Deaf person’s uptake of suggestions of planning ahead to change outcomes or collecting data to order to change behaviours. For example keeping a diary or records of behavior or activities may be unfamiliar. ▪ Consequences of actions – causality may be an unfamiliar concept. ‘Coincidence’ is more familiar a concept for a Deaf person. <strong>Tip:</strong> Linking events in the person’s life may be useful, especially if done in a visual way, for example pictorial diaries.</td>
</tr>
</tbody>
</table>
**Cultural Interpretations of Time**

Time organises our life in different ways according to cultural interpretations. Varying perspectives of time can cause confusion and frustration when the parties lack knowledge of each others cultural mores. Cultures can be identified as past-oriented, present-oriented or future-oriented. (Mindness 1999)

<table>
<thead>
<tr>
<th>Deaf culture</th>
<th>Australian Anglo ‘hearing’ culture</th>
<th>Possible implications for the mental health setting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Timeframes</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Minimal value placed on being ‘on-time’. Half hour late for meetings, appointments, is acceptable. | Being ‘on-time’ is viewed as desirable but being ten minutes late is acceptable. | - The Deaf client is late for an appointment and doesn’t apologise.  
- Deaf person is patient and more accepting of waiting. |
| Schedules, agendas, timeframes are not as important as the interpersonal interactions. A ‘go with the flow’ is more acceptable. | Schedules, agendas, timeframes are generally adhered to. | - Goal setting around a timeframe may not be adhered to or seen as important to Deaf client.  
- Deaf client doesn’t show up to an appointment. No explanation is offered. Rescheduling is not seen to be bothersome. |
| **Introductory time** | | |
| Greeting time is brief but informal. Hugging is common. Introductory small talk is brief, because so much is implicitly known about the person already. It is more imperative to share information. Information sharing may go for a protracted length of time even in the introductory phase. | Greeting time is a series of predictable utterances. For example “How are you? How are the kids/wife? How is work? Lousy weather today”. First names used often. Rapport building small talk is desirable. | - Deaf people may wonder why you are talking about the weather when they are there to see you to discuss their health.  
- If another Deaf person is present and they are involved in deep conversation and appear to be ignoring the hearing professional, who is anxious to get started.  
**Tip:** If another Deaf person is present schedule protracted introductory time.  
- If there is only one Deaf person with no other Deaf to converse with, get to the point of the meeting quickly. |
| **Closure of conversations** | | |
| Due to limited access to professionals in the past Deaf people are not used to having to adhere to a timeslot for a conversation. Conversations about their wellbeing have been usually with other Deaf people where long untimed conversations are the norm. Leave taking is long and protracted. Each individual at a Deaf gathering is approached and hugged and arrangements are made for when they will see each other again. At a mixed gathering Deaf people are the last to leave. This is the Deaf cultural phenomenon known as ‘The Long Goodbye’. | Leave taking is preceded by body language and cultural nuances that indicate the completion of a meeting. For example. closing of the file, standing up, calling the receptionist to make another appointment. The language is brief. Closure of consultations are often rapid and dependent on the allocated consultation time. | - To the Deaf person the health professional may appear to leave abruptly, because the Deaf person didn’t pick up on the hearing cultural nuances of leave taking.  
**Tip:** The hearing professional should use explicit unambiguous language to indicate the closure of the session. For example “Now we are finished for the day I will see you next week”  
- The Deaf person may continue to engage in conversation long after they have been shown to the door.  
**Tip:** If more than one Deaf person is present, consider a time and place for the Long Goodbye. For example is the meeting room booked long enough? |
Communicating with Deaf People

The following tips are a guide for best practice when communicating with culturally Deaf people.

Interpreters

☑ Engage the services of a sign language interpreter.
☑ Respect a Deaf person’s wish to use an interpreter, even if they can reasonably communicate with you by speech because a Deaf person may use speech for expressive communication but require sign language for receptive communication.
☑ Allow the deaf person to decide where to sit for access to the interpreter.
☑ Review “Strategies for Working Alongside Accredited Auslan Interpreters”. (See page 33)

Attention

☑ Gain the Deaf person’s attention by a gentle touch on the upper arm.
☑ Stamping on floor or tapping on the table or other vibration means are acceptable in social context.
☑ Flicking lights on and off is a way of gaining the attention of a large group of Deaf people.

Adequate Lighting

☑ Ensure adequate lighting is on your face, not behind you.
☑ Avoid glare, shadows and dim nightlights.
☑ In the dark, shine the torch to illuminate your own face not the Deaf person’s.
☑ Flicking or flashing lights can be distracting to a Deaf person.

Visual communication

☑ Maintain eye contact, it is considered rude to break eye contact during a conversation with a Deaf person.
☑ Use lots of facial expression and body language.
☑ Try some Auslan yourself, or learn the fingerspelt alphabet or mime. Deaf people appreciate a hearing person’s efforts to communicate.
☑ Make sure your face is clearly visible to give the Deaf person access to your lip patterns and facial expressions as they glance between you and the interpreter.
☑ Speak at normal pace, not too fast, not too slow.
☑ Use visual aids such as pictures, diagrams, models, where possible.
Avoid misunderstandings

- Let the Deaf person know the subject of the conversation before beginning to communicate, for example “we need to discuss your medication”.
- Cue the Deaf person to any change of topic.
- Use open-ended questions rather than “yes” or “no” questions.
- Don’t assume a nod means agreement or affirmation.
- Clarify to ensure the Deaf person understands. Even with an interpreter some Deaf people, due to an inequitable education system, may not fully understand the information given.
- Rephrase – when the person doesn’t understand something the first time, try to say it in another way, for example “are you thirsty?” can be rephrased to “do you want a drink?”
- Allow for breaks from time to time, especially in intense and long conversations.
- Write down important information such as times, dates, medication names and dosages, doctors’ names.

Plain English

- Use plain English for writing notes. Respect that English is regarded as a ‘second language’ for Auslan users.

“I really appreciate when hearing people try to use sign language. It shows they respect my language. Most of the staff learn the Auslan alphabet quickly. I usually only have to show them twice, then they remember it. I prefer staff who can fingerspell, it doesn’t matter to me if they are slow.”

[Deaf man, 40, at Pathology Clinic]

“The nurses just arrive for their shift (at the hospital) and don’t know I am Deaf. They start talking to me with their face looking down at the chart or something or the lights are really dim and I can’t see their face properly.”

[Deaf women, 32, Day Surgery Unit.]
Plain English Please

“The worse thing is they assume all Deaf people can lipread well. I am not a good lip reader. Also it frustrates me when they don’t bother getting an interpreter for me ... they write lots of information on paper and expect that I can read it.”

[Deaf women, 21, GP appointment]

- Writing in English to replace an interpreter is NOT an acceptable practice – it is unethical and unfair.
- When written information and instructions are provided to a Deaf client, as an addition to an interpreted version, plain English should be used.
- Many Deaf people have problems understanding English as it is very challenging to learn English (an aural/oral language) when you cannot hear the language spoken every day. Historically, Deaf people have not had access to education whereby English is taught in the context of ESL (English as a Second Language).
- It is imperative, particularly in the medical, legal and educational settings, that people understand that English is used as a ‘second language’ to Deaf people in the same that English is a second language to people from a CALD community.
- A Deaf person’s level of English should not be assessed as relating to the person’s intelligence.
- Deaf people will often write English words but use the sentence structure of Auslan.
- Do not expect that writing something in English will be fully understood by the Deaf person.
- Although some Deaf people may have excellent English skills, writing complex procedures and conversations down on paper is not advisable.
- Be mindful of documents presented in written English with an expectation that everyone can read and understand them. For example signs around the workplace, the Rights and Responsibilities Code, Patient Information Sheets, Medication Fact Sheets, forms.
- Documents, forms, brochures, instructions should be accompanied by an Auslan interpretation of them or, at the very least, a plain English or pictorial version to ensure information is not misunderstood.

EXAMPLE

**SOPHISTICATED English:**
“Recreational drug use and alcohol consumption will inhibit the effectiveness of the prescribed medication; this could lead to a relapse in your symptoms. It is advisable that you exercise and eat healthy food whilst on this medication and you will notice marked improvement in your wellbeing.

**PLAIN English:**
“Drugs like marijuana, cocaine, ecstasy, etc and drinking alcohol will make the tablets not work properly so it means you could get sick again. You should exercise and eat healthy food and you will feel better.”
Keep it Visual

Deaf people rely on their vision and sense of touch to make meaning of the world. Therefore, it is respectful to use visual and tactile means to communicate. Lipreading is NOT an easy visual task. Writing in English, as mentioned above, although a visual means, is not always an accessible means of communication. Auslan is a natural visual communication system thus the preferred mode of communication for Deaf people.

In addition to using interpreters and written English the hearing professional should aim to use visual aids to compliment the interpreted utterances. Wherever possible aim to produce information visually by using:

- Pictures, posters, photographs, diagrams, symbols, signs, models, books with graphics, flip charts, flow charts and comics.
- OHT’s, computers, data projectors, whiteboards, captioned DVD’s (to be viewed at least twice if using interpreters), handouts, preparation notes outlining main points prior to discussions, timetables and calendars.
- Use dots points, short sentences, clear space between paragraphs, use multiple examples, facial expressions, mime, gestures, demonstrations, objects and real life situations.

Figures 2.5 - Examples of visual communication

| × | Printing + Drugs + Alcohol + Your Medicines = You get sick again |
|   | ![Drugs](image1.png) ![Alcohol](image2.png) ![Medicines](image3.png) ![Sick](image4.png) |
| √ | Exercise + Health Food = You stay well |
| ![Exercise](image5.png) ![Health Food](image6.png) ![Well](image7.png) |

Figures 2.6 – Example of visual communication – ‘Feelings’ [Glickman & Gulati]
Sign Language Interpreting

What is a sign language interpreter?

A sign language interpreter acts as a cultural and linguistic bridge to enable communication to take place between people who do not share the same language. The interpreter does not merely convey the actual words spoken/signed but is responsible for conveying the meaning, intent and emotion of the message.

In order to convey the meaning of a message, an interpreter must not only possess a solid understanding of both languages and cultures, but they must also be familiar with the subject at hand. Interpreters do not add their own opinion nor do they delete any part of the message. An accredited sign language interpreter, bound by a Code of Ethics, will interpret everything spoken in the room plus any sounds that take place within hearing distance, for example a helicopter close by, a baby crying in waiting room, mobile phones ringing, a siren outside, people talking in a nearby room.

Why use a professional interpreter?

In Australia professional and paraprofessional interpreters are accredited through NAATI – the National Accreditation Authority for Translators and Interpreters – and are bound by the NAATI Code of Ethics. These include impartiality, confidentiality, accuracy, professional conduct and professional development. NAATI currently have two levels of accreditation for Auslan/English interpreters, Para Professional (formerly Level 2) and Professional (formerly Level 3).

Always use an accredited interpreter to safeguard the integrity and legal rights of both parties. By using unaccredited interpreters the organisation may be at risk of breaching the Anti-Discrimination legislation. Family members and friends are not usually accredited interpreters and should not be used as interpreters in professional settings due to lack of competence, bias or personal interest which may compromise the interpretation process.

In the Mental Health setting it is preferable to obtain the services of interpreters in the following order of preference:

- Professional (formerly Level 3) Interpreter who has training and experience in mental health and with whom the client is familiar; or
- Para Professional (formerly Level 2) who has had training and vast experience in mental health interpreting and with whom the client is familiar; or
- Professional level or Para Professional level interpreter with some mental health experience working with a Deaf Relay Interpreter who has training and experience in mental health.
Deaf Relay Interpreter

What? The Deaf Relay interpreter (Deaf person) acts as a communication relay between the accredited hearing interpreter and the Deaf client, ensuring that the message is transmitted in an accessible format for both parties.

Why? Some Deaf people use a type of sign language that may not be easily understood by a hearing Auslan interpreter, for example, the language of a Deaf person with a mental illness; a Deafblind person, a Deaf person from another country or a Deaf person with an intellectual disability. In some instances a Deaf Relay interpreter may be used because it is more culturally appropriate, for example, an indigenous Deaf person.

The specific meaning of a word or term (denotation) and the associated meaning (connotation) are influenced by culture (Westermeyer, 1993). A Deaf Relay interpreter and the Deaf client share a common culture and language which aids mutual understanding. The Deaf Relay interpreter may also draw on additional skills and experience to enable the message to be relayed effectively, for example, skills in Deafblind tactile signing, foreign sign languages, or experience with Deaf indigenous clients.

How? In Queensland, only booking agencies that are sign language specialists are currently able to source a DRI. These agencies have the expertise to match the DRI with the client and the subject. It is important for the clinician to book the DRI and the accredited hearing interpreter at least 15 minutes before the appointment time so they can collaborate on technical, communication, and cultural aspects of the impending teamwork. The clinician must also be available to consult with both interpreters pre and post session.

Figure 2.8 – Deaf Relay interpreting
What type of interpreter do I book?

Interpreter booking forms may have a choice of five types of interpreters:

- **Auslan**
- **Deafblind**
- **Signed English**
- **Oral**
- **Deaf Relay***

1. **Auslan** is the native language of the Australian Deaf community thus is the preferred language of those individuals who identify as culturally Deaf.

2. **Deafblind** interpreting has three main types: hand-over-hand tactile signing; tactile fingerspelling; or visual frame. These all require different skills; thus the client’s preferred mode must be stated when booking the interpreter.

3. **Signed English** is an artificial language system devised in the 1970’s by well-meaning, but ill-informed, hearing professionals. It uses a combination of signs (native and contrived) presented using English grammar. It is not a language but rather a code of communication.

4. **Oral** interpreters silently mouth the spoken language for the non-signing deaf consumer. Oral interpreters also use facial expressions and gestures to enhance the transfer of the message.

5. **Deaf Relay*** interpreters act as a conduit between the hearing interpreter and the Deaf client. In this process the DRI will ensure the message is rendered in a mode that is accessible to the client.

* N.B. If you are booking a Deaf Relay Interpreter you will also need a NAATI accredited hearing interpreter as well.

Preferred interpreter

Some policies encourage the Deaf client to choose their preferred interpreter. This empowers the individual and provides assurance that the interpreter’s skills will satisfactorily meet the client’s needs. However, if the nature of an assignment is complex, requiring the interpreter to possess a high level of understanding of the subject matter, in some cases it may be deemed more appropriate for the professional to choose a specialist interpreter in consultation with the client. Collaborative consultation with the Deaf consumer over choice of interpreter establishes a climate of trust and professionalism.

How do I find my clients preferred interpreter?

- Ask the client for the name/s of their preferred interpreter/s. If booking through an agency, you can ask the agency if that particular interpreter is registered with their agency.
- Alternatively, you can contact either NAATI, ASLIA, AUSIT, or Deaf Australia, and find the interpreter details through their freelance interpreters directories.
Deaf Australia’s website has a visual directory where photographs of interpreters are posted. This is due to the fact that many Deaf people know their interpreter by face and namesign* but not necessarily by English language name. When trying to establish the clients preferred interpreter, if possible, show the client the visual registry on your computer or print it out and ask them to point to their preferred interpreter. See contacts under Freelance Interpreters in these guidelines. (See page 36)

* Namesigns are specific signs to indicate a particular person. (See Deaf culture page 14)

Interpreter Feedback

It is advisable to establish a feedback mechanism at the closure of the appointment to ascertain if the client and the professional were satisfied with the interpreter. This can be in the form of a feedback card and most interpreting agencies will provide these if requested. Feedback cards for Deaf mental health consumers should be visual and should not be filled in whilst the current interpreter is present.

Figure 2.9 – Examples of graphics for interpreter feedback cards
Strategies for Working Alongside Accredited Auslan Interpreters

ASLIA recommends that the following strategies be used to maximise the effectiveness of the communication exchange when working alongside a professional interpreter.

Meet with the interpreter beforehand

- Clarify unique vocabulary, technical terms, acronyms, jargon, seating arrangements, lighting and other needs.
- Provide interpreter with any written materials ahead of time.

Reserve seats for the Interpreter and deaf participants

- Provide a clear view of the speaker and interpreter.
- Deaf participants may still choose to sit elsewhere.

Interpreter should be in the consumer's sight line

- This allows deaf participants to pick up visual cues and the expressions of the speaker.
- In small group discussions, consider using a circle or semi-circle seating arrangement instead of a theater style arrangement.

Be aware of lighting

- Provide good lighting so the interpreter can be seen.
- If lights will be turned off or dimmed, be sure the interpreter can still be seen clearly (use spotlight or small lamp to direct light toward the interpreter).

Talk directly to the deaf person

- Maintain eye contact with the Deaf person.
- Avoid directing comments to the interpreter (for example "Tell him ..." or "Ask her ..."), respond directly to the deaf person.

Speak naturally

- Speak at your normal pace. Interpreters will ask you to slow down or repeat if necessary.
- Interpreters listen for concepts and ideas, not just words, to render an accurate interpretation.
Avoid private conversations – everything will be interpreted

- Whatever the interpreter hears will be interpreted. Do not ask the interpreter to censor any portion of the conversation.
- Ask the Deaf person directly if they are following the conversation.

One person should speak at a time

- An interpreter can only accommodate one speaker at a time. Encourage the group to follow this rule.
- If you are facilitating a group discussion, be aware that the interpreter will be several seconds behind. Pause before recognising the next speaker to allow the interpreter to finish with the current speaker.
- Avoid asking the interpreter for opinions or comments regarding the content of the meeting.
- Interpreters follow a code of ethics which requires impartiality and confidentiality with all assignment related information.
- Do not assume the interpreter has prior knowledge of the Deaf person or will be interpreting future appointments.

Provide a short break every hour

- Interpreting is mentally and physically taxing.
- Do not expect the interpreter to interpret during these breaks.

Ref <http://www.aslia.com.au>

Australian Sign Language Interpreters Association (ASLIA) has developed ‘Guidelines for Interpreting in Mental Health Settings’ <http://www.aslia.com.au>. Although these guidelines are produced for interpreters, it is a useful document for clinicians to read because it illustrates the complexities of interpreting in the mental health setting.

Interpreters and clinicians require a close working relationship to enhance therapeutic outcomes.
Sign Language Booking Agencies

Some of the booking agencies below are for spoken languages as well as sign languages, whereas others are sign language specialists. Agencies have different methods of receiving and confirming bookings with varying fee structures, cancellation fees and policies. Specialist booking agencies tend to have a greater knowledge of the individual client’s language needs and are thus more likely to find an interpreter to complement the client and the professional setting in which the interpreting is to take place.

<table>
<thead>
<tr>
<th>Interpreter Agency</th>
<th>Services</th>
<th>Contact Details</th>
<th>Region covered</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>NABS National Auslan Interpreting Specialists Payment Service&lt;br&gt;&lt;br&gt;<img src="image.png" alt="nabs" /></td>
<td>Sign Language Interpreting Specialists&lt;br&gt;*Provides all medical interpreting for Indigenous Deaf people, including public and private health services.</td>
<td>Web Address: <a href="http://www.nabs.org.au">www.nabs.org.au</a>&lt;br&gt;Telephone: 1800 24 69 45&lt;br&gt;Fax: 1800 24 69 14&lt;br&gt;TTY: 1800 24 69 48&lt;br&gt;Mobile/SMS: 0427 671 261&lt;br&gt;Email: <a href="mailto:bookings@nabs.org.au">bookings@nabs.org.au</a>&lt;br&gt;Feedback: <a href="mailto:feedback@nabs.org.au">feedback@nabs.org.au</a>&lt;br&gt;Postal Address: 930 Gympie Road Chermside Qld 4032</td>
<td>National</td>
<td>Free for private medical</td>
</tr>
<tr>
<td>SLSA Sign Language Services Australia&lt;br&gt;&lt;br&gt;<img src="image.png" alt="slsa" /></td>
<td>Sign language Interpreting specialists&lt;br&gt;Deafness Awareness Training&lt;br&gt;Hearing Awareness Training&lt;br&gt;Information Service</td>
<td>Web Address: <a href="http://www.slsa.net.au">www.slsa.net.au</a>&lt;br&gt;Telephone: 1300 66 42 77&lt;br&gt;Fax: 1300 79 55 84&lt;br&gt;Mobile/SMS: 0422 458 306&lt;br&gt;Email: <a href="mailto:bookings@slsa.net.au">bookings@slsa.net.au</a>&lt;br&gt;Postal Address: PO Box 2099 Keperra 4054 Qld</td>
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### Interpreter Agency Services Contact Details Region covered Cost

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<td>DeafSQ Deaf Services Queensland</td>
<td>Sign language Interpreting specialists 24 hour emergency interpreting service Deafness Awareness Training Auslan Classes Community, Employment, and Lifestyle support services</td>
<td>Web Address: <a href="http://www.deafservicesqld.org.au">www.deafservicesqld.org.au</a> Telephone: 07 3892 8500 Mobile SMS: 0417 603 438 Fax: 07 3392 8511 TTY: 07 3892 8501 Helpline: 1800 645 916 Email: <a href="mailto:dsq@deafsq.org.au">dsq@deafsq.org.au</a> Postal Address: PO Box 173 Annerley Qld 4103</td>
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### Freelance Sign language interpreters Check these following websites for registers of freelance interpreters: | Region covered | Cost |
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<td>AUSIT: <a href="http://www.ausit.org">www.ausit.org</a></td>
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### On Call Spoken languages and sign language | Region covered | Cost |
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### QITS Queensland Interpreting and translating service Spoken languages and sign language | Region covered | Cost |
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<td>Fee for service</td>
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### Queensland Health Interpreter Service Spoken languages and sign language * Contact NABS for all sign language interpreting for Indigenous Deaf people using Queensland Health services | Region covered | Cost |
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<td>Statewide</td>
<td>Free for consumers of QLD Health services</td>
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</table>
Contacting Deaf People

DID YOU KNOW

- It is always preferable for professionals to attempt to contact their deaf client directly. Do not rely on family members or friends to ‘pass on a message’
- At a minimum, all organisations providing services to Deaf people should have a mobile phone number to contact Deaf consumers via text message

One of the most common conundrums for hearing professionals is how to contact their deaf client by the use of telecommunications. Hearing people predominantly use the telephone which, traditionally, required the use of intact hearing. Deaf people’s awareness of consumer rights combined with persistent lobbying by deaf consumer groups has seen the rise of new technologies. Historically, deaf people have often had to rely on hearing family or friends to make or receive calls for them. However with these new technologies available, deaf people can now manage their own affairs which has contributed towards the independence of Deaf and hard of hearing people worldwide.

Mobile Text Messaging – SMS

Text messaging on a mobile phone has become the communication of choice for short messages to and from deaf people. Organisations that offer a service to deaf people should also have a mobile phone number for contact with their deaf clients. This is particularly useful for confirming appointments, changing appointment times, and transmitting short pieces of information. Some interpreting agencies allow Deaf people to book their own interpreters via SMS.

Teletypewriters – TTY

A teletypewriter is an electro-mechanical device which can be used to communicate typed messages from point-to-point through a simple electrical communications channel. It looks similar to a typewriter and has a small LED display screen for reading the message.

TTYs can communicate with other TTYs directly through the phone system or can communicate with voice users via the National Relay Service.
National Relay Service – NRS

Visit <http://www.relayservice.com.au> for a view of how the National Relay Service works with your internet or telephone. A 3 minute video will show you just how easy it is to use the NRS.

The NRS is an Australia-wide telephone relay service provided for people who are deaf or have a hearing or speech impairment.

The NRS is available to everyone. It is a service that allows the hearing person to speak to a deaf consumer via a Relay Officer (RO). The deaf person must have a fixed phone service with a Teletypewriter (TTY) installed OR a computer with internet connection.

The NRS provides free training on how to use their service. There are various options to use depending on the consumer’s hearing and speech ability.

Figure 2.7 – Example of one NRS option - text to voice

MSN and Email

Many Deaf and hearing impaired people have computers which make it an obvious choice for communicating with hearing people. Asking a deaf client for their email address is an acceptable protocol. It is useful for emailing details of their next appointment or for a brief consultation.

It is important to remain mindful that email and instant messaging are both text based technologies requiring English as the communication mode. Given that English proficiency varies markedly in the Deaf community, it may only be useful for short concrete communication.

Fax Machines

With the advent of computers, fax machines, like TTYs, are rapidly becoming obsolete technology. However, given that communication can occur in a non-verbal form, written English and fax machines are still in use by older deaf people. The same guidelines for other text based technology applies – keep English plain and to the point.
Videotelephony

“It can be difficult to find an Auslan interpreter at short notice, particularly in settings such as health services, doctors' offices, hospitals, mental health services, community health centres, workplaces, police stations, and in various settings within the education sector. VRI can provide an excellent and viable alternative.” (VicDeaf, 2008)

Videotelephony or video-based telephony is regarded as the "Deaf equivalent to the voice phone." (Deaf Australia, 2007)

**Video Relay Service – VRS**, allows a deaf person to telephone a hearing person using a sign language interpreter and vice versa. The interpreter and the deaf person communicate in sign language using a broadband video connection, while the interpreter speaks with the hearing person via speakerphone or headset. VRS services are usually 24 hours/day 7 days/week and is usually a government funded free service.

**Video Relay Interpreting – VRI**, allows a hearing person and a Deaf person who are in the same room to have a conversation via an interpreter who is in a different location, via a video link. VRI services are usually open ‘business hours’ similar to face to face interpreting services and are usually operate on a fee-for-service basis.

Key issues regarding Video Relay Interpreting service for Deaf people in the Healthcare setting include:

- It is imperative that health care practitioners use interpreters to diagnose and treat Deaf patients.
- There is a severe shortage of accredited interpreters.
- Auslan interpreters are often not available to be ‘on call’ for emergencies.
- Deaf people are provided with greater flexibility in attending appointments without having to rely on the availability of interpreters to attend in person at the consultation.

(Findings from Harper, April, 2008)

**Mental health telemedicine programmes in Australia**

The results of a study of mental health telemedicine programmes suggest that telehealth can increase access to mental health services for people in rural and remote areas, particularly those who have been poorly served by mental health services in Australia. (Lessing & Blignault, 2001)

(Findings from Lessing & Blignault, 2001)
Considerations for the Mental Health Setting

Cultural Misunderstandings

Given that culture and behaviour are inextricably linked, the following points illustrate some behaviours unique to Deaf culture that may lead to misunderstandings.

- Physical displays by Deaf people may reflect frustration about communication rather than aggression. Alternatively, it may simply be the natural use of sign language where tone and voice pitch is reflected in the face and body language of the Deaf person. Often signs are made larger and use more space if a person is distressed. Large and repetitive signs are simply a grammatical feature of the communication process.

- Some Deaf people use their voice when signing. Often the voice of a Deaf person is unusual, lacks clarity and may appear loud due to the fact they can’t hear their own voice. A Deaf person may prefer to use their voice for expressive language but prefer the use of sign language for receptive language. Therefore, just because a Deaf person can talk it is important not to assume they do not need an interpreter. Always enquire about their communication preference.

- When a Deaf person nods it may not necessarily indicate agreement but rather ‘yes I know you are talking to me’ or “ah- ha, hmmm” or ‘I am nodding at understanding each word I see but may not understand the complexity of the sentence’ or ‘I am agreeing with you due to the power differential between us’. Use open ended questions and be mindful of ambiguity.

- Do not assume the Deaf person lacks social graces – direct talk is the norm in Deaf culture. For example “Gee you look fat” as opposed to the hearing way which may be “Gee your looking slightly more filled out these days”. In a world where communication is challenging there is little room for ambiguity and Deaf people live in a visual world so they say what they see.

- Lip reading is a difficult and tiring task. Only 30% - 40% of words are unambiguously visible on the lips. (Barnett, 2002; Steinberg, 1991) People have varying degrees of proficiency, therefore do not assume all Deaf people are good lip readers.

- It may be difficult to communicate while the Deaf person is highly distressed. Mime, gestures, pictures and basic signs (‘drink’, ‘wait’, ‘interpreter’, ‘soon’) could be used to settle the person until a sign language interpreter or experienced deafness worker can attend. Maintain awareness that communication difficulties may have been the trigger for the outburst and restraining may exacerbate the situation.

IMPORTANT

Restraining the hands of a person who uses sign language is like gagging a person who communicates verbally and may lead to increased anger and frustration. If necessary to restrain, try to do it in such a way that they can still use their hands to communicate.
Examples of cultural misunderstandings

Situation 1

**Behaviours:** A Deaf man arrives at the Mental Health Unit reception area. He appears to be using large repetitive gestures, arms waving about, a deep frown, angry facial expression with unusual vocalising, and occasionally bangs his hand on the counter.

**Assumptions:** The hearing receptionist thinks he is being aggressive and calls for help to restrain.

**Fact:** The Deaf man is explaining in vivid and fluent sign language that someone had recently stolen his wallet. He saw who it was and is very upset and wants to make a formal complaint to the police. He went to his local Mental Health Unit where he has been before and is asking to see his case worker. Deaf people will often go to a place they know and trust. When the receptionist turns his back on the Deaf man he bangs on the counter to gain his attention – a Deaf cultural behavior.

Situation 2

**Behaviours:** A Deaf woman is pulled over by the police road patrol at night. The officer shines a torch in the women’s face whilst talking to her then, after a moment, forcibly assists her out of the car. The woman signs and vocalises, trying to communicate. The officer turns the women around and handcuffs her. She is transported to the police station to be charged with resisting arrest, drink driving and aggressive behavior towards a police officer. The officer asks her if she “consents to partake in an electronic interview?” The woman nods.

**Assumptions:** The hearing police officer assumes the women can hear, assumes the women is noncompliant by not getting out of the car when asked, assumes she is intoxicated, assumes she can hear in the dark, assumes she is aggressive, assumes she understands complex English, and assumes a nod indicates agreement.

**Fact:** The police officer was in fact asking the women to get out of the car but with the torch shining in her face, she was unable to see the officer’s face for clues to what he was saying. The officer assumed the women was being noncompliant thus forcibly removing her from the car. To the officer’s ear, the Deaf women’s unusual and loud voice sounded as if she was intoxicated. Deaf people cannot hear their own voice or pitch. Once out of the car, when the officer was talking in the dark, the Deaf woman was unaware that she was being given a directive. Deaf people require light to ‘see’ the communication. Again, the officer assumed noncompliance as well as mistaking the person’s natural gestural language to be aggressive and handcuffed her. With the Deaf women still handcuffed, she was unable to use her hands to indicate that she is Deaf. When asked (in sophisticated English too difficult to lip read) if she consents to have her interview recorded, the women does not understand what is being said but nods to indicate that she was spoken to and to appease the officer. The ‘Deaf nod’ is a common cultural behavior which does not necessarily indicate affirmation or agreement.
Intake and Assessment of Deaf People

Assessment of culturally Deaf clients is both an art and a science. The science is the gathering of information and administering tests. The “art” entails synthesising the knowledge of deafness and sign language with knowledge of assessment and treatment.

(Glickman & Gulati, 2003)

Assessors or programs unfamiliar with the needs of Deaf people often use assessment tools that have not been designed for Deaf people. They may ask inappropriate questions, fail to collect pertinent data, or use inappropriate means of communication. This leads to misdiagnosis and, historically, was responsible for the disproportionately high number of deaf people in the mental health system.

Checklist

☑ Ascertain if the client has a hearing loss – ask or look for clues such as unusual speech, problems following the conversation, inappropriate responses to questions, requests repeats of what is said, intense watching of the speakers mouth, speaking with an unusually loud voice, or the client may reach for or request pen and paper.

☑ Arrange an appointment to take place in conjunction with an interpreter and/or in a room with assistive listening devices.

☑ If necessary make a referral or seek advice and resources from a similar service which uses culturally sensitive practices.

☑ Review “Strategies for Working Alongside Accredited Auslan Interpreters”. (See page 33)

☑ Ensure the physical environment is conducive to effective communication.

☑ Complete a hearing and communication checklist with client if some confusion still exists about hearing loss and optimum communication modes. (Contact PAHBSHD page 3)

☑ Review ‘Communicating with Deaf People’ (See page 25)

☑ Use culturally appropriate assessment tools (contact PAHBSHD)

☑ Clarify with the client the preferred means of communicating regarding confirmation of follow up appointments, for example mobile text messages, TTY, email, NRS, letter. (See ‘Contacting Deaf People’ page 37)
Counselling with the Deaf Client

“The skill of a counsellor lies in how far they are successful in minimising the inappropriate effects of their personal unconscious.”

[Corker, 1995]

Journeying towards growth and change can be equally challenging for the therapist and the client. How each individual creates their own structure of meaning is vital in understanding the attitudes and beliefs which may impede the growth of others. The therapist’s assumptions about Deaf people and attitudes about deafness will affect the journey and outcomes for their Deaf client.

Corker (1995) asserts that the task of the ‘talking therapies’ is generally to work within the whole infrastructure of a client’s communicated messages, whether implicit or explicit. This provides unique challenges for the hearing therapist and the Deaf client.

Guidelines/self-reflecting questions for the hearing therapist:

Before the sessions

- ‘Know thyself’.
- Do you have an understanding of the models of deafness? Cultural-linguistic and medical-disability model. An understanding of these models will inform many processes.
- Have you identified the communication preferences of client, for example sign language user or oral/aural or combination of both.
- Do you know how to book and work with a sign language interpreter? (See page 31)
- Read the ASLIA Guidelines for Interpreters Working in the Mental Health Setting (reference below) to gain an appreciation of the complexity of the interpreting process thus contributing towards a successful therapist/interpreter relationship.
- Have you considered the clients preferred interpreter and the experience of the interpreter?
- Be mindful of ‘therapeutic alliance’ issues when working with an interpreter.
- Have you considered time pre and post session to establish working relationship with the interpreter? A conversation with the interpreter before the session will be valuable.
- Have you discussed your model of therapy and session goals with the interpreter?
- Are you familiar with cross cultural communication issues with culturally Deaf people? (See page 20)
- Is your counselling model culturally affirmative? (See box page 44)
- Have you asked the client and interpreter how they prefer the room set up?
- Have you determined how you will manage the booking/confirmation of follow up sessions? (See ‘Contacting Deaf People” page 37)
During the sessions

- Be mindful of the use of metaphors and idioms. Deaf people may not be familiar with many ‘hearing’ metaphors. Metaphors/idioms that are visual rather than aural are usually more useful. For example blossoming flower – visual. “Once bitten, twice shy” – aural.
- Consider using visual aids such as white board, pictures, models, drawings.
- When using visual methods of instruction be mindful of the deaf person not being able to listen to you (watch the interpreter) and look at white board/pictures simultaneously.
- Given that most Deaf people use a narrative form of expression, be mindful of breaks for the interpreter to refresh his/her mind, body and voice to contribute to a better quality of service.
- Learn culturally sensitive ways of interrupting, especially due to Deaf client’s narrative style. For example the sign for “hold” is useful – ask the interpreter in your pre-session time.
- Open ended questions are useful.
- Keep language clear, simple and concrete but avoid patronising.
- Try to explore one piece of information at a time rather than gathering as much data as possible in one question. For example, avoid ‘When was the last time you saw your GP’ and ‘Did your GP say to continue your meds as usual or decrease them gradually?’ – three questions in one.
- Avoid terms which have both abstract and concrete meanings, have a double or multiple meaning, or has oppressive connotations.
- Check out incongruencies in the client which may indicate they have misunderstood and ascertain that the client’s meaning has been correctly understood. (Corker 1994).

After the sessions

- Determine process for follow up bookings/confirmation with client, for example SMS? NRS? Fax? (See ‘Contacting Deaf People’ page 37)
- Provide interpreter with debriefing or post session discussion.
- Ascertain the client’s satisfaction with the interpreter. (See ‘Interpreter Feedback’ page 32)
- If client feedback on interpreter is positive, book the same interpreter for subsequent sessions because interpreter consistency is optimal.

What does it mean to be culturally affirmative?

A culturally affirmative program provides opportunities for cultural involvement and growth for the patient who desires it. Cultural affirmation should not be mistaken for cultural promotion. It does not push a particular cultural orientation on those who do not want it.

...in a mental health setting cultural promotion carries risks. It can be disrespectful of client’s actual degree of cultural identification; a client might feel more or less culturally Deaf.

… Cultural sensitivity implies some knowledge of deaf people’s special needs and abilities, such as knowing to provide an interpreter for a client who uses sign language….cultural affirmation goes beyond cultural sensitivity, because it includes having cultural competence, relevant self awareness, and a special knowledge and skills. (Quoted from Glickman & Gulati, 2003 pp x-xi)
Deaf clients in hearing groups – group therapy, meetings, workshops, training programs

Tips for facilitators

Interpreter considerations

- Spend a few minutes with interpreter before and after each session to ascertain any communication issues.
- Introduce the interpreter to the Deaf participants before the session starts.
- Be mindful you may need more than one interpreter, one for each group with Deaf participants.
- Interpreting for group work requires intensive concentration. If the sessions go for more than two hours, or are less than two hours but very intensive, you will require two interpreters. Check with the booking agency.
- Negotiate break times with interpreters and try to structure the sessions so the break times ‘fit in’ and are not seen to be disruptive to the flow of the sessions.
- Often familiarity between group participants occurs in the lunch and tea breaks. Ensure an interpreter is available for these breaks but don’t overwork your interpreter. Similarly if the group has a social gathering at the end of the group work process, ensure an interpreter is booked for this event.
- During group activities that require an altered seating arrangement, be aware that the Deaf person will still need visual access to the interpreter.
- An interpreter can only interpret one person’s voice at a time, therefore the facilitator must manage group discussion so people don’t speak over the top of each other.

Cultural considerations

- Ensure your ‘ice breaker’ activity is culturally sensitive. For example one that does not require extensive reading of instructions in English; that does not rely on ‘hearing humour’; one that is sensitive to the fact that the Deaf person must look at the interpreter for oral content; one that doesn’t require a physical activity AND talking simultaneously. For example mime, picture cards.
- Represent participant’s names visually not just orally, for example name stickers on clothing, name placards on table, name/photo register at sign-in table.
- Due to the time lag in the interpreting process the Deaf person often misses out on contributing to group discussion. This can be managed by time delay tactics such as pausing naturally when posing questions, glancing down at notes before expecting a response or writing the question on a whiteboard as you voice the question. This give the interpreter time to catch up and the deaf person time to consider the question.
Turn taking is paramount. Use ideas such as raising hands before speaking, which allows the Deaf person to see who has spoken or a ‘talking stick’. Again, the facilitator must be aware of the interpreting time lag.

Keep in mind Deaf people use visual communication. Resources and tools that are visual are appreciated and considered to be ‘deaf-friendly’. When explaining a new activity, demonstrate what is required rather than a lengthy verbal explanation.

Remember that English is generally used as a second language to Deaf sign language users. When introducing new vocabulary/concepts use multiple examples and check for understanding in a sensitive way.

Allow the group to read any notes before starting the verbal instructions because the Deaf person cannot read notes and listen (watch the interpreter) at the same time, whereas hearing people can read and listen to a voice simultaneously. Reading the notes beforehand assists with understanding context.

Check with the Deaf participants at the end of the first session for feedback on communication processes.

**Group considerations**

- Explain communication protocols to the whole group at beginning of the first group session and reiterate throughout subsequent sessions if necessary.
- When breaking into smaller groups or pairs, if you have two or more Deaf participants don’t assume they must automatically be in same group.
- Be mindful of the power balance in the groups given that Deaf people are of a minority culture and have been marginalised.
- To foster a feeling of inclusion, encourage the hearing participants to attempt to communicate with the Deaf participants independently. For example learning some Auslan signs and/or alphabet (include the fingerspelt alphabet in the handouts? Put a poster on the wall?), writing notes using plain English (provide each participant a small note pad and pencil?), mime and gesture, or ask the interpreter to assist with a ‘getting to know you’ conversation.
- Remember that the hearing participants are listening to a variety of voices and tones in the group whereas the Deaf person is receiving all the discussion through one ‘voice’ – the interpreter. This can be tiring and boring. Try to break up the monotony by having visual activities that do not require lengthy speech.
- If the interpreter is late (traffic delays do happen), rather than hold up the whole group before commencing, remain flexible and perhaps alter the session to start a visual activity that can be commenced without the interpreter. For example a familiar activity from a previous session.
Part

3.

Hard of Hearing
Hard of Hearing Consumers of Mental Health Services

Difficulties with communication can cause frustration, social isolation and loneliness. This may lead to low self esteem, withdrawal and depression.

[Australian Hearing, 2008]

Hard of hearing is one term used to describe those who have a hearing loss and communicate predominantly orally. Another term used is hearing impaired. These two terms are only used by those individuals who have a hearing loss but do not identify themselves as ‘culturally Deaf’ that is they do not use sign language as a preferred language. Hard of hearing people generally identify as hearing people who may require hearing augmentation and behavioural adjustments in order to achieve social inclusion.

When providing interventions in the mental health setting, it is paramount that the practitioner understands the difference between hard of hearing and culturally Deaf consumers. Culturally Deaf consumers, those who use sign language, don’t view deafness as a deficit, whereas hard of hearing consumers are most likely to view their deafness as a loss of hearing and thus a loss of access. As mentioned in the initial chapters of these guidelines, these two views of deafness are frequently referred to as two distinct models – the medical-disability model (hard of hearing) and the socio-cultural model (culturally Deaf). Therefore much of the focus of this chapter is on the medical perspective of hearing loss and hearing augmentation.

The hearing system

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

**Figure 3.1 – How the ear works**

![Diagram of the ear](Sound Waves)

1. The sound makes the eardrum vibrate
2. The eardrum makes the bones vibrate
3. The bones make the fluid move and the hair cells bend
4. Then the auditory nerve takes the message to the brain

Picture Source: www.hearing.com.au
## Causes of deafness

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<th>Sensorineural</th>
<th>Mixed</th>
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<td><strong>Definition</strong></td>
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<tr>
<td>May be acquired or congenital</td>
<td>May be acquired or congenital</td>
<td>Occurs when there is problem in both the conductive pathway (outer or middle ear) and in the nerve pathway (inner ear)</td>
</tr>
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<td>Caused by damage to, or malfunction of, the cochlear or the hearing nerve in the inner ear</td>
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<td>Leads to a loss of loudness</td>
<td>Leads to loss of loudness and clarity.</td>
<td></td>
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<tr>
<td>Can often be remediated by medical or surgical treatment</td>
<td>Assistive listening devices provide varied benefits</td>
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<td>Blockages of ear canal due to wax, objects etc</td>
<td>The aging process</td>
<td>Inherited</td>
</tr>
<tr>
<td>Outer ear infection</td>
<td>Excessive noise exposure</td>
<td>Premature birth</td>
</tr>
<tr>
<td>‘glue ear’ – middle ear infection</td>
<td>Diseases such as Meningitis and Meniere’s</td>
<td>Damage to unborn baby from viruses such as rubella</td>
</tr>
<tr>
<td>Perforated ear drum</td>
<td>Viruses, such as mumps, measles</td>
<td>jaundice</td>
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<tr>
<td>Ostosclerosis- bony growth around the stapes</td>
<td>Drugs which can damage hearing, for example gentamycin</td>
<td></td>
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<tr>
<td>Partial or complete closure of ear canal</td>
<td>Head injuries</td>
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## Degrees of deafness

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

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

- Before speech is usually present (pre-lingual hearing loss).
- After the usual time of development of normal speech (post-lingual hearing loss).
Deafness commonly affects both ears (bilateral hearing loss) but sometimes it only affects one ear (unilateral hearing loss). People with deafness may be able to hear some sounds clearly, and other sounds not as clearly.

Those with a mild or moderate hearing loss may not have any trouble with hearing in quiet surroundings but experience difficulty following conversations in noisy environments.

**Figure 3.2 - Impact of Hearing Loss**

Content from Queensland Transcultural Mental Health, 2007
Hearing Augmentation

Hearing Aids

A hearing aid is basically a miniature public-address system. Hearing aids can be categorised in many ways. The simplest way to categorise them is by the place in which they are worn e.g. behind the ear (BTE), in the ear (ITE), in the canal (ITC), completely in the canal (CIC).

Figure 3.3 – Common types of hearing aids

Assistive Listening Devices

Assistive listening devices can be used with or instead of hearing devices. They can assist when watching television alone or with members of the family, communicating over the phone or going to public venues such as churches, theatres, interview rooms or workplaces.

Telephone

- **Telephone devices** amplify the ring of the telephone and have a volume control to increase the loudness of the incoming voice.

- **Induction loops** minimise background noise and improve the clarity of the incoming voice. Induction loops are used with telecoils or the T switch on hearing aids. Many public telephones have an in-built induction loop.

- **TTY (teletypewriters)** are text-based devices enabling people with a severe or profound hearing loss to communicate via the telephone line.

Television, music and other entertainment

- **Television amplifiers** can be used with or without hearing aids and do not require an earphone socket. They do not affect the volume of the TV when others are watching. A small microphone is attached to the TV speaker using velcro and is connected by a wire to a set of earphones or to a neckloop that transmits the signal to your hearing aid.
- **Induction loops** for hearing aid wearers eliminate background noise and improve the clarity of sound. Neckloop devices are used in conjunction with the telecoil on hearing aids and transmit sound from the TV to the induction coil in the hearing aid. Induction Loops can also be used to listen to personal stereos, iPods® or MP3 players, computer sound systems and gaming consoles such as the XBox® or Sony Playstation®.

- **Infrared systems**, with no cords to trip on, transmit invisible light to a receiver worn around the neck. The system can be connected to headphones or to an induction loop for use both with or without a hearing aid. An infrared system can be coupled to a TV, radio and stereo simultaneously. The listener can move from one to the other without having to reconnect. An infrared system can have an alerting facility to let the listener know if the phone or the door bell rings.

- **Captioning** is available on TVs and DVDs. Most new televisions now have subtitles available automatically on the remote control. DVD’s have an option to select on the main menu for captioning ‘For the Hearing Impaired’. This will not only display the spoken language but also additional noises from the film, for example ‘mysterious music’, ‘bomb explodes in background’, ‘footsteps approaching’.

**FM systems**

- FM (frequency modulated) systems are commonly used to transmit sound from one person to another over distance, overcoming the effects of noise, reverberation and distance.

**Alert systems**

- **For the door** – a remote control flashing signaller indicates that there is someone at the door.
- **For the phone** – a teleflash with a high intensity warning light and an extra loud sounder for the phone warns you about incoming calls.
- **Vibrating alarms** – devices commonly used to wake people in the morning.
- **Visual smoke detectors** – indicates that there is smoke in the house.
- **Remote pagers** – indicate baby cry alarm, phone ringing, door bell.

Information courtesy of Australian Hearing <http://www.hearing.com.au>

**DID YOU KNOW**

Qld Fire and Rescue Service now have subsidised Visual Smoke Detectors for deaf people who are unable to hear the audible smoke detectors. See <http://www.fire.qld.gov.au>
Cochlear Implant

A cochlear implant (Bionic Ear) is an artificial hearing device, designed to produce useful hearing sensations by electrically stimulating nerves inside the inner ear. The Bionic Ear was pioneered in 1978 by Professor Graeme Clark and his team in Australia.

Figure 3.4 – Internal component of the cochlear implant

The present day multi-channel cochlear implants consist of 2 main components:

1. the cochlear implant package and electrode array (or receiver-stimulator)
2. the speech processor and headset.

Cochlear Implants help people who have severe to profound sensorineural hearing loss and are not receiving enough help from their hearing aid. Hearing aids amplify sound, making the sound louder. The ear with a sensorineural hearing loss may not be able to process the information due to damaged hair cells. Despite hearing certain sounds, some people affected by severe hearing loss cannot understand speech (<http://www.earscience.org.au>). Cochlear implants are one alternative offered to these people. The stages of implantation include assessment, surgical intervention, ‘mapping’ and speech therapy. An individual may experience a variety of intense emotions during these stages. Support can be obtained from the self help group Cochlear Awareness Network (CAN) <www.cochlear.com>.

Sophisticated though it is, the cochlear implant does not fully reproduce the sounds experienced by someone with full hearing. The effectiveness of the cochlear implant varies considerably. Factors that determine the benefit recipients will gain include:

- whether they developed spoken language before going deaf (people who have learned to speak usually benefit most)
- the time since deafness first occurred
- their level of motivation
- the environment in which they live, an encouraging home, school or work environment will help implant patients achieve their full potential
- the number of surviving auditory nerve fibres in the implanted ear.

“*I have a cochlear implant now, so I can make sense of some speech sounds, but I still like people to face me before they start talking. I need people to be aware of how the cochlear implant works, its strengths and its limitations, so I can feel more included in conversations.*”

[University Student, 24]
Communication Modes for Hard of Hearing People

DID YOU KNOW
- Only 30-40% of words are unambiguously visible on the lips
- Just because a person can speak doesn’t mean they can hear
- Not all deaf people are adept at lip reading
- There are a variety of ways a hard of hearing person may wish to communicate
- Q: How do you know an individuals’ preference?  A: Ask them!

Expressive communication

People who identify as hard of hearing generally use speech to communicate. Residual hearing with or without the assistance of hearing aids, assistive listening devices and/or cochlear implants enable the hard of hearing person to develop and/or maintain speech. The ability for a hard of hearing person to speak clearly can depend on when they acquired the hearing loss, the degree of hearing loss and the ability to hear and regulate their own voices. For young hard of hearing children, it can take many years of speech and language therapeutic intervention to learn speech sounds and use oral communication effectively. For late-deafened adults, speech is acquired before the onset of deafness.

Receptive communication

1. **Lip reading** involves watching the person’s mouth and face as they speak to extract meaning. It is a partially innate skill that can be developed and proficiency varies markedly. It requires a lot of energy and concentration and is therefore difficult to sustain for long periods of time. As people age, their vision may decrease thus affecting their lip reading ability. Facial expressions, body language and contextual cues are used to enhance understanding. Lip reading requires optimal environmental conditions such as good lighting.

2. **Speech to text** transcription via voice recognition software (also known as automatic speech recognition or computer speech recognition) converts spoken words to machine-readable input. For example ‘Dragon Naturally Speaking’.

3. **Communication Access Realtime Translation (CART)** services is the instant translation of the spoken word into English text using a stenotype machine, notebook computer and real-time software with the text appearing on a computer monitor or other display, such as a projector screen. CART is also often referred to as real-time captioning. CART offers word for word translation and is provided by a professional who is skilled and trained in using the stenographic equipment. Many captioning services offer remote CART and internet captioning where the stenographer is not physically present at the event but can listen-in through a telephone line.
CART services are useful for many hard of hearing individuals who often miss out on details when only hand written notes are used for communication. Individuals tire of writing and therefore often tend to shorten their conversation and eliminate details. CART services for hard of hearing people is an inclusive practice which, in some ways, may be likened to the access sign language interpreters provide to Deaf people. With CART services hard of hearing people are able to have access to the full message with all the subtle nuances and micro aspects of the communication which contributes towards inclusivity. CART technology is primarily used by people who are late-deafened, oral deaf, hard of hearing, or have cochlear implants. Culturally Deaf individuals also make use of CART in certain situations.

4. **Oral interpreter** – A limited number of hard of hearing or deaf people may require the use of an ‘Oral interpreter’. Oral Interpreters mouth a speaker’s words silently for people who are deaf or hard of hearing. Speech reading is usually done by those who were raised orally and do not know sign language. Sign language is typically not done in addition to oral interpreting. Oral interpreters are skilled at pronouncing words clearly by the lips. They are also skilled in quickly substituting words which are hard to lip read, while keeping the content and emotion of the speaker’s statement intact.

5. **Sign Language** – Some hard of hearing people have skills in sign language and may prefer sign language as adjunct to their aural receptive language skills. Although they may not identify as a culturally Deaf person, they find sign language useful in aiding understanding.

“My hearing aid helps amplify sound, it works in conjunction with my residual hearing but it doesn’t help me understand speech in every situation. I use a combination of speech, lip reading and sign language depending on the situation.”

[Social Worker, 50]

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**Additional Resources**

Lip reading classes are provided by Better Hearing Australia Brisbane, Ph/TTY: (07) 3844 5065 <mailto:bhabris@qil.com.au>.

Self Help for Hard of Hearing People. SHHH also provides a Training and Resource Kit for improving Communication with Older Hearing Impaired people <http://www.shhhaust.org>.

The Shorthand Reporters Association of Australia (SRAA) lists those of its members who offer CART services <http://www.sraa.org>.

The Australian Caption Centre <http://www.auscap.com.au> and Nican <http://www.nican.com.au> are currently funded to provide these services.

Agencies specialising in Sign Language interpreters can source Oral interpreters. (See page 35)
Communicating with Hard of Hearing People

The following tips are a guide for best practice when communicating with hard of hearing people.

- **Gain Attention** – Gain the person’s attention before beginning the conversation. Call the person by name and/or gently touch their upper arm.

- **Face Each Other** – Hard of hearing people need to see your face clearly to gain help from facial expressions and to lip read. Maintain the same eye level, for example sit if the person is sitting and keep eye contact. Avoid shadows on your face and habits such as pencil chewing and putting your hands in front of your face.

- **Avoid Background Noise** – If possible move to a quiet area or reduce noise. Televisions, radios, people taking in the background and air conditioning may interfere with the person’s ability to understand.

- **Reduce the Distance** – The level of voice decreases over distance. Standing within one metre of the person is recommended.

- **Optimise Lighting** – Good lighting helps with lip reading ability. Avoid backlighting or silhouette effects.

- **Speak Clearly** – Speak at a normal rate maintaining the normal inflections and rhythms of your speech. Do not shout, use your normal volume. Shouting may distort the message. Do not exaggerate lip movements. Be aware that a non-Australian accent, beards and moustaches may impede lip reading.

- **State the Subject** – Let the person know the subject of the conversation and cue in to any change of topic.

- **Check for Understanding** – Ask for feedback to check for understanding of what has been said. Use open-ended questions rather than yes or no questions. Remember that smiling and nodding does not confirm understanding.

- **Repeat, Rephrase or Write Down** key messages to help with communication, for example names, dates, times & medication dosages. Make use of diagrams and handouts.

- **Use Facial and Body Expression** – Do not use exaggerated mime.

- **Provide visual information** in addition to speech

- **Check Hearing Aids are working** – If you are not sure contact an audiologist for help.

- **Don’t give up** – If your are attempting communication with a deaf or hard of hearing person, whether it be by speaking, sign language, fingerspelling,mime, written English, please don’t give up if you are not understood the first time … try a different way, persist and be creative!!!
Common Misconceptions about Hearing Loss and Aging

- **“Why don’t you speak up?” “You young people all mumble these days.”** Hearing loss in older people may begin gradually and progress slowly. In the early stages it is often unrecognised.

- **“She hears when she wants to.”** There is often inconsistent listening behavior. This is because parts of hearing which are important to speech (the high frequencies) usually deteriorate sooner than those which relate more to environmental sounds (low frequencies).

- **“I heard but I didn’t understand”, “All right! There’s no need to shout.”** There may be problems of distortion. This can be like trying to listen on a bad phone line. Making it louder does not always make it clearer.

- **“Why on earth don’t they get a hearing aid? – … (and stop being a bother to me)”** A well fitted hearing aid can be a great help, however, some hearing aids may only make the sound louder, they do not always 'correct' hearing. Newer models of hearing aids are tuned signal processors and do not only just amplify. The person’s own non-intact hearing still has to decode the imperfect message they have received and make sense of it. Therefore, clinicians must be mindful of the limitations of the hearing aids and also ensure the physical environment (acoustics, lighting, seating position) is not having a detrimental impact on the hard of hearing person’s ability to communicate optimally.

Information courtesy of Better Hearing Australia (2008)

“Sometimes people assume I can hear speech because I wear a hearing aid so they shout at me. Shouting distorts their face and mouth so it makes it harder for me to work out what they are saying. I prefer they just use a normal voice and not too slow.”

[Hard of hearing consumer, 35, Government workplace]

“I am alright with male voices, they are deeper but some females have a higher pitch that I just can’t hear well. I am always asking my daughter to repeat herself. I prefer it when she gives me context before she starts talking, like, for example she will say ‘I will tell you what happened on the bus today …’ this helps a lot.”

[Hard of hearing man, 59, Restaurant Manager]
Intake and Assessment of Hard of Hearing People

Mental health service providers should incorporate into the intake procedures a means to identify consumers who may have a hearing loss. This identification will assist in ensuring appropriate diagnosis and inclusive service delivery.

It is important to take into account the influences that a hearing loss may have in a person’s behavior or attitude. Some psycho-social aspects of hearing loss as identified by Better Hearing Australia, include grief, disconnected feelings, fear, social isolation, lack of stimulus, physical strain, self-consciousness, loss of opportunities, relationship problems, anxiety, loss of pleasure, loss of meaningful conversation and loss of privacy. (Better Hearing Australia, 2008)

A hearing checklist to assist the assessment process can be obtained from Queensland Health, Deafness and Mental Health Statewide Consultation Service. If a hearing loss is suspected, consult with the consumer regarding referral for formal audiological assessment.

Symptoms that may indicate the presence of a hearing loss:

- Problems following conversation, particularly in groups and when background noise is present
- Problems discriminating speech sounds (‘I can hear your voice, I just can’t understand what you’re saying’)
- Inappropriate responses to questions/blank looks/smiling/nodding
- Requests for people to repeat what they said
- Accusations of mumbling
- Intense watching of the speaker’s mouth
- Social withdrawal or endless talk to avoid having to listen to others
- Volume of television or radio turned up loudly
- Speaking with a loud or soft voice
- Unusual sensitivity to loud sounds
- Behavior such as anger and frustration
- Complaints of tinnitus or vertigo

The environment of the mental health service:

- If possible, minimise background noise originating from outside or inside the room (telephones ringing, air conditioning, laughter, footsteps, radio, rain on tin roof, traffic).
- Hard reflective surfaces such as walls, windows and desks cause reverberation and reduce speech intelligibility. In contrast good insulation including carpeted floors, heavy curtains and padded furniture will reduce reverberation.
- Good lighting is important for assisting lip reading.
- A range of assistive listening devices should be provided according to consumer’s need. (See page 51)
PART

4.

Groups within the Deafness Sector
Indigenous Australians

Hearing loss, like ear disease, is significantly worse in Indigenous communities than in the wider population, and when it occurs in early childhood it has major implications for speech and language development and learning. (Couzos, Metcalf, & Murray, 2003; Kelly & Weeks, 1991)

Developmental, educational and vocational consequences are compounded by continued poor access to therapy, hearing aids, special teachers, classroom sound-field systems, and other rehabilitative programs. (Coates, Morris, Leach, & Couzos, 2002; Couzos et al., 2003)

Middle ear disease is an important health issue but there is also a need for a greater focus on the communicative and social consequences of Aboriginal hearing loss. Widespread Aboriginal hearing loss acts as a direct barrier to communication. It also contributes indirectly to the linguistic and cultural barriers that constrain intercultural communication. These barriers can have a negative impact on social and emotional wellbeing, educational opportunities and access to almost all services where access depends on effective communication. (Howard, 2007b)

Figure 3.3 – Aboriginal Art – Norma Benger Chidanpee

When babies are born in the dry season this is also the time of the birth of the dragonfly, which hums and buzzes around the air excited about the birth of the new season.

The grandmothers catch the dragonflies to test babies' hearing, making them buzz near the babies' ears. When a baby responds we know that they have good hearing.

Dr Damian Howard states that research indicates that hearing loss among Aboriginal school children is associated with linguistic educational disadvantage and incompetence, social isolation and interpersonal difficulties. (Howard, Quinn, Blokland, & Flynn, 2003)

Those Indigenous people with hearing loss experience greater frustration and stress during communication in noisy contexts which can contribute to family violence and reduced social and emotional wellbeing. (Howard, 2007a)
There is strong anecdotal evidence that supports the contention that hearing loss may be a factor that is relevant to the occurrence of criminal behavior. 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. (Howard et al., 2003)

Indigenous prisoners in Australia represented 24% of the total prisoner population (ABS 2006). In the National Aboriginal and Torres Strait Islander Social Survey, 45.3 % of Indigenous peoples aged 15 years or over that were incarcerated and 35.8% that were not incarcerated had a disability or long term health condition. (ABS 2006)

**Communication planning with Indigenous people living in remote communities**

- Limit background noise or move to somewhere quieter to make it as easy as possible for people to understand you.
- Be aware that indigenous people who appear very shy and those who have lower literacy levels probably have a hearing loss and may be easily ‘shamed’ by problems that arise as a result of their communication difficulties.
- Develop and use visual flip charts, pamphlets and DVDs as an aid to communication, instead of just talking. This is particularly important when presenting unfamiliar ideas and new information, or proposing new ways of doing things.
- Where possible, create opportunities for those with a hearing loss to observe others and what others do before they themselves participate in an activity.
- Use multi-stage communication processes so information can be ‘passed around’ among the people within a community or meeting. This means, for example, allowing time for discussion breaks during meetings so that information can be relayed to those who may not have fully understood what was said. Do not expect an immediate response. Time for discussion will give people time to understand the issues, what has been proposed and form an opinion.
- Adhere to 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
- Use amplification equipment. Different equipment will be needed for group situations and as an aid for communication with individuals.

Taken from Fact Sheet from website <www.eartroubles.com> by Dr Damian Howard
Tips for working with Indigenous people who use sign language

☑ Book an accredited Auslan interpreter before you meet with the client.
☑ Book a Deaf Indigenous Relay Interpreter.
☑ Spend time with the interpreters beforehand to brief them about the purpose of the interaction and to allow the interpreters to explain the role and the process of working with two interpreters.
☑ If the interpreters have not met the Deaf indigenous person before, allow the interpreter/s time to engage with the client before the formal communication takes place.
☑ Maintain awareness that indigenous Deaf people have limited proficiency in English and may not have a strong linguistic base of any kind thus impacting on their ability to acquire knowledge and comprehend consequences.
☑ Do not rely on written English to communicate – this is unethical and unfair.
☑ Use plain, concrete language even when using the services of an interpreter, but avoid condescending behaviours and comments.
☑ Use pictures, diagrams, photographs and other visual means to enhance communication.
☑ Although direct questioning is often the preferred manner when working with Indigenous Deaf people, this is not always the case. In some situations it may be less intimidating, and more culturally sensitive to use a guided narrative style to elicit information.
☑ Avoid negative questions, for example “you couldn’t see him could you?” or “you didn’t understand did you?”
☑ Follow cultural rules regarding eye contact with indigenous people.
☑ Be aware of ‘gratuitous concurrence’ where a Deaf person will nod or seem to agree to statements but in fact they may be merely indicating that they understand what is being said to them not necessarily agreeing with what is being said to them. Can be interpreted sometimes as ‘oh I see’, ‘aha’, ‘hmm’, ‘uh-huh’, ‘yes’.
☑ Welcome family members into the discussion.

O’Reilly, 2005

Sign language is nothing new to many indigenous groups in Australia.
"A long time ago, before white settlers came ... there were different tribes," says Patty.
"They had different languages ... hence they couldn't communicate. They would need some kind of language they could trade with, and they would start using these hand signals and signs ... and that's how this aboriginal sign language developed."

“There’s one thing I've noticed about indigenous sign language,” says Deaf Services Queensland interpreter, Mike Levett.
"The slightest thing can have meaning. It can be twitch of the nose ... it can be a raise of an eyebrow or a little thing on the lips ... a little twitch. It all has meaning."

[Taken from ABC Radio Interview 20/4/08 <http://www.abc.net.au>]

[57x757]Part 4 – Groups
[57x18]Page 62 Deafness and Mental Health 2008
Additional Resources

Deafness and Mental Health – Indigenous Social and Emotional Wellbeing Project Qld Health


This Indigenous EarInfoNet web resource and yarning place (electronic network) is a ‘one-stop info-shop’ for people working, studying or interested in addressing ear health and hearing loss among Indigenous peoples <http://www.earinfonet.org.au>

Deadly Ears is an ear health program of Royal Childrens Hospital, Brisbane <http://www.health.qld.gov.au>

National Auslan Booking and Payment Service (NABS) provides NAATI interpreters and Deaf Relay Interpreters free of charge for all public and private health related appointments involving a deaf Indigenous client <http://www.nabs.org.au>

Fact sheets and information relevant to hearing loss in Australian indigenous people <http://www.eartroubles.com>
Deafblind

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. Also referred to as ‘dual sensory loss’. A person with deafblindness uses residual vision and/or hearing, touch, smell and taste, to make sense of the world. The communication modality used by an individual depends on the degree of sensory loss, their communication ability and personal preference.

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<th>Deaf</th>
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About 90% of the information we receive about the world comes through vision and hearing.

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

The impact of dual sensory loss varies and can include difficulties with:

- 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:

- Grief and loss
- Isolation
- Frustration
- Fatigue
- Low confidence and self-esteem

Information taken from Able Australia (formerly the Deafblind Association)  
<http://www.ableaustralia.org.au>

Fact sheet on ‘Communication Etiquette for Deafblind People’ found at the above website.
CODAs

CODAs - Children of Deaf Adults

Hearing children born to deaf parents are often called CODAs (Children Of Deaf Adults). Many of these hearing children grow up in a deaf-culture environment. Many of them learn to sign before they learn to speak. In the past they were often pressed into service as interpreters for their parents, even while they were still very young children. Now, with the greater recognition and availability of professional interpreters, CODA’s have this role is reduced. Deaf parents usually involve their hearing children in deaf activities and events, embracing a Deaf way of life. At the same time, these children must function as part of the hearing world, because they are in fact hearing. They go to hearing schools, usually grow up with hearing friends and participate in hearing activities and events. Therefore, most CODA’s are regarded as bilingual and bicultural. With additional training, some become professional interpreters as adults. A few CODA’s 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 sign language is not affirmed and valued within the family. Conversely, some hearing parents of Deaf children cannot communicate in sign language with their child.

When working with hearing children of Deaf parents, clinicians should equip themselves with an understanding of this group and consider such questions as:

- What is the child’s preferred language? – Spoken or signed?
- Does the child have effective communication with their parent/s or caregivers?
- Does the child have an understanding of concepts relating to the mental health area? They may know the sign but not the English or vise versa
- Are the child’s parents aware that the child has a mental health issue? If not, why not?
- Do the Deaf parents have access to programs and services that could assist them in supporting the child? For example, do these programs and services provide interpreters?
- Do the child’s parents have effective parenting and basic child psychology skills?
- Have the Deaf parents ‘missed out’ on the incidental learning required to emotionally nurture the child?
- Has the child ‘grown up too soon’? For example acted as the parent’s interpreter in ‘adult’ situations or acted as the mediator between the hearing world and the Deaf world for the parents?
Employment, Deafness and Mental Health

Did you know?

- Depression and anxiety are the most common mental illnesses in the workplace.
- Australian workplaces, as a whole, lose over six million working days a year as sick leave due to mental illness (JobAcesss – Understanding Mental Illness 2008 [http://www.jobaccess.gov.au]).
- Anecdotal evidence indicates that the majority of depression and anxiety for deaf people in the workplace stems from ill-informed communication practices leading to reduced opportunity for the deaf employee.

Barriers that exclude people from community life include specific barriers found in the employment sector for those who have a hearing loss. Participation and equal opportunities in employment is a foundation of social inclusion as it creates opportunities for financial independence and personal fulfillment. The working life of an individual can be a satisfying experience which can contribute greatly to their overall feeling of wellbeing. Conversely, a negative work life experience may leave an individual unfulfilled and have far-reaching impact on the individual’s emotional life and economic future. (Gillard, 2008)

Some barriers deaf people face include communication issues, lack of accessible training opportunities, poorly defined career path, limited participation in the social milieu of the workplace and limited opportunity to engage with the public. Deaf people are often found to be overlooked for promotion and career enhancement opportunities which can contribute to feelings of worthlessness leading to an array of mental health disorders.

“I have been working for this company for seven years but never been promoted. I have asked many times if I can become a team leader but they keep saying it would be too difficult because I am Deaf. I am bored with my job and need a challenge. It really gets me down, coming here day in and day out doing the same job. I don’t have any motivation anymore.”

[Deaf man, 40 yrs]

“When my department was restructured they put me onto filing duties. Other people got more interesting jobs where they got to deal with the public. I said I could deal with the public through interpreters and other communication means like writing and gesture but they still overlooked me. I don’t feel like going to work anymore but I need an income. I feel depressed, I hate filing.”

[Deaf women, 45 yrs]
Organisations and businesses that have Deaf or hard of hearing employees or consumers should acquire an understanding of social inclusion and cross cultural work practices.

Culturally diverse workers who are at odds, or who simply do not understand each other, inhibit productivity. Culturally competent workgroups, on the other hand, create cooperative workplace environments where productivity expectations can be met or surpassed. (National Centre for Cultural Competance, Georgetown University, Washington DC <http://www11.georgetown.edu>)

“Reducing social exclusion means supporting people who are marginalised in their daily struggle against prejudice and misunderstanding in the employment and training sector.” To this end, the Australian government is currently establishing the National Mental Health and Disability Employment Strategy. The Strategy aims to address the barriers faced by people with a disability and/or mental illness that make it harder for them to gain and keep work.
<http://www.workplace.gov.au>

Additional Resources

Auslan For Employment (AFE) and Workplace Modifications Scheme (WMS) provide financial support to employers to improve access in the workplace. Both are available through the National JobAccess Disability Employment Information and Advice Service <http://www.jobaccess.gov.au>

‘WORK TALK’ By Damien Howard © - This article covers some of the common experiences of people with auditory processing problems in the workplace. While people with listening difficulties often excel when able to use their skills effectively, ‘talk-focused’ work processes can present challenges <http://www.eartroubles.com>
Culturally and Linguistically Diverse (CALD) Consumers

Did you know?

- When workers from other agencies do not develop an understanding of the cultural practices, beliefs and values of the person they are working with, they are at risk of making assumptions about people’s behaviour and responses, based on their own cultural values and attitudes (AMPARO, 2007)

Deaf people from a CALD background have additional needs that must be considered in the mental health setting. These include specialised communication needs, migrant settlement/refugee issues, cultural differences in values, norms and beliefs, attitudes to Western medicine, family configurations, and gender issues.

Although culturally Deaf people (sometimes written as Deaf with a capital ‘D’ to identify this group as a cultural and linguistic minority) already identify as CALD community, there may be an additional cultural group to which the person identifies.

For example:

- Deaf Hispanic
- Deaf Indigenous Australians whose first language is an Indigenous dialect
- Deaf Filipino
- Deaf Somalian
- These people are regarded as having two CALD identities – culturally Deaf (Deaf) plus their country of origin identity.

Literary evidence indicates a correlation between cultural perceptions of hearing loss and the early childhood learning and development process. (Tong, Cornes, & Wiltshire, 1999) These writers argue that where hearing loss is perceived to be a ‘shame on the family’ or a ‘family tragedy’, early identification and intervention to assist in language and cognitive development may not occur. It may also be reflected in poor emotional and social attachments with consequent behavior and mental disorder. Furthermore, families may be unwilling to access services because of the feeling of shame, or these services may be perceived as culturally inappropriate.
Cultural sensitivity

In addressing the problems faced by people from a CALD background, health service providers are encouraged to have a culturally sensitive approach to the assessment, diagnosis and management of clients. Using cultural assessment tools in combination with knowledge of the deafness continuum, will contribute towards the clinician’s ability to address the mental health needs of the CALD client in an effective manner.

Interpreting

Having a severe hearing loss places a significant barrier between the person and the hearing world. This is compounded where the person does not have English or Auslan proficiency. The greater number of interpreting links, the greater margin for error of misunderstanding, particularly in the complexities of health care language.

In Australia, Deaf people from a CALD background may use a combination of their native sign language, Australian Sign language (Auslan), English, country of origin spoken language, international accepted gestures, mime and home signs. This can be challenging for interpreters and clinicians. In these situations it is paramount that the interpreter and clinician have an excellent working relationship.

Interpreting for Deaf people from a CALD background almost certainly requires either a NAATI accredited interpreter who is familiar with the client’s linguistic nuances OR a Deaf Relay Interpreter working with a NAATI accredited interpreter.

Additional Resources

National Auslan Booking and Payment Service (NABS) provides Deaf Relay Interpreters free of charge for most appointments involving an Indigenous client and free of charge for private medical appointments for Deaf non-indigenous people <http://www.nabs.org.au>


Cultural Awareness Tools produced by Multicultural Mental Health Australia <http://www.mmha.org.au>
Part 4 – Groups

Deaf and Hard of Hearing Patients in Hospitals

Access for Deaf or hard of hearing people in the public health system is all about education and communication.

“Of all the achievements, I put education first. Education is the most important thing and it is probably one of the most challenging things. All the technology in the world is only of value if you actually have people who know how to use it and also consumers who are aware that the facilities exist. Education in communication strategies is also critical”

(Towers, 2007)

Hospitals can provide accessible services for their deaf or hearing-impaired patients. Princess Alexandra Hospital in Brisbane has introduced facilities such as visual fire-safety alarms, televisions with caption capabilities, telephones with volume controls, sign language interpreter booking services, captioned education videos, telephone typewriters, personal listening devices and staff training on communication. Deafness Forum is working with health systems in other States and Territories to encourage similar initiatives. (Lawder, April 2007)

Considerations for when a Deaf or hard of hearing person presents as a patient in the hospital setting:

- Ascertain if the person is a sign language user or hard of hearing.
- Does your hospital have clear signs distinguishing services for Deaf and services for hard of hearing?
- Has your facility liaised with other hospitals who implement inclusive policies?
- Does your facility have a patient resource kit available for Deaf and hard of hearing patients?
- Have Auslan interpreters been booked for communication with medical professionals?
- Does the ward Social Workers know of the Deaf patient? Social Workers are often able to coordinate access issues for the Deaf patient.
- Are the TV’s captioned? Does the facility have DVD’s which are captioned?
- Have staff received training in basic sign language for hospital use, for example ‘Blood pressure’; ‘pain’; ‘temperature’?
- Have staff received training in Deafness Awareness Training and Hearing Awareness Training?
- Are there sign language and/or visual resources available on the ward for nursing staff?
- Are there visual alerts available for smoke alarms?
- Have all staff been made aware that patients is Deaf, thus being prepared to communicate accordingly?
- Have emergency evacuation procedures considered the Deaf patient?
- Does the patient have access to TTYs?
- Does the ward have a mobile phone to allow text messaging to and from Deaf family or for patient follow up?
- Are resources, pamphlets, videos offered to patients accessible and sensitive to the communication needs of the patients? For example plain English, pictorial, captions
**Professional Development**

In order for organisations to provide a culturally competent and inclusive service, it is imperative that employees are encouraged to participate in ongoing professional development opportunities which will contribute towards the provision of a “deaf friendly” service. The table below lists types of training available. Contact details of providers and funding for training are found in ‘Additional Resources’. (See page 72)

<table>
<thead>
<tr>
<th>Training</th>
<th>Provider</th>
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<tbody>
<tr>
<td><strong>Deafness and Mental Health Workshops</strong></td>
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<tr>
<td>Working with clients who are Deaf or hard of hearing in mental health settings.</td>
<td>The Princess Alexandra Hospital Brisbane South District (PAHBSD), Division of Mental Health,</td>
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<tr>
<td><strong>Deafness Awareness Training</strong></td>
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<tr>
<td>Deafness Awareness Training provides the opportunity for participants to learn about deafness primarily from the socio-cultural perspective. The type topics covered include, but not limited to:</td>
<td>Deaf Australia</td>
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<tr>
<td>▪ Introduction to the Deaf community and Deaf culture</td>
<td>Deaf Services Queensland</td>
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<tr>
<td>▪ Introduction to Auslan – Australian Sign Language</td>
<td>Sign Language Services Australia</td>
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<tr>
<td>▪ How to work with a sign language interpreter</td>
<td>Hands at Work</td>
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<tr>
<td>▪ Communication with Deaf people</td>
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<tr>
<td><strong>Hearing Awareness Training</strong></td>
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<tr>
<td>Hearing Awareness Training provides the opportunity to learn about deafness primarily from the medical-disability perspective. The topics covered include, but not limited to:</td>
<td>Sign Language Services Australia</td>
</tr>
<tr>
<td>▪ The types of deafness</td>
<td>Better Hearing Australia</td>
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<tr>
<td>▪ Causes of deafness</td>
<td></td>
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<tr>
<td>▪ Social impacts of hearing loss</td>
<td></td>
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<tr>
<td>▪ Communication with hard of hearing / non signing deaf people</td>
<td></td>
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<tr>
<td>▪ Assistive listening devices</td>
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<tr>
<td><strong>Deaf Deaf World</strong></td>
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<tr>
<td>Deaf Deaf WORLD is an interactive training program that allows hearing participants to experience a “Deaf world”</td>
<td>Deaf Australia</td>
</tr>
<tr>
<td><strong>Auslan Tuition</strong></td>
<td></td>
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<tr>
<td>Community classes focus on basic conversational Auslan</td>
<td>Deaf Australia</td>
</tr>
<tr>
<td>Auslan in the Workplace</td>
<td>Deaf Services Queensland</td>
</tr>
<tr>
<td>Employment sector tuition involves teaching signs relevant to the particular workplace.</td>
<td>Sign Language Services Australia</td>
</tr>
<tr>
<td></td>
<td>Hands at Work</td>
</tr>
<tr>
<td>TAFE courses</td>
<td>Southbank TAFE</td>
</tr>
<tr>
<td>▪ Cert II Auslan</td>
<td>North Coast Institute of TAFE</td>
</tr>
</tbody>
</table>


**Additional Resources**

**Tools**

Outcomes Rating Scale (ORS) & Session Ratings Scale (SRS), Auslan version - DVD
<mailto:louise@envisionsr.com.au>


Cultural Awareness Tool – ‘Understanding Cultural Diversity in Mental Health 2002’ by Multicultural Mental Health Australia. For orders t - 02 9840 3333  f – 02 9840 3388 <http://www.mmha.org.au>

Mental Health Care of Deaf People – CD of extensive range of pictorial tools to facilitate communication with Deaf people. Glickman and Gulati, 2003

Hearing Help Hospital Package - especially designed for staff at hospitals and nursing homes contact Better Hearing Australia Brisbane. Ph/TTY: (07) 3844 5065 <mailto:bhabris@qil.com.au>

Self Help for Hard of Hearing (SHHH). A training and resource package to improve communication with older hearing impaired people <http://www.shhhaust.org>

SignBank - interactive, internet-based Auslan database. Users can retrieve video clips and line drawings of individual signs, as well as information about the origins, meaning, usage and grammar of signs. Registered users can add new signs and meanings <http://www.auslan.org.au>

Funding for Auslan tuition and Deafness Awareness Training - may be possible through Auslan For Employment (AFE) <http://www.jobaccess.gov.au>

Health and mental health programs – for online resources and tools to increase the capacity of health and mental health programs to design, implement, and evaluate culturally and linguistically competent service delivery systems, visit the National Centre for Cultural Competence (NCCC) <http://www11.georgetown.edu/>

Deaf Children Australia’s free call Helpline - can answer questions from professionals and provide information on deafness and hearing impairment. Ph: 1800 645 916, TTY: 1800 508 523 or <mailto:helpline@deafchildren.org.au>
Reports, Newsletters, Booklets

Deafness and Mental Health Newsletter


Journal of Deaf studies and Deaf Education <http://jdsde.oxfordjournals.org/>


Deaf blind resources and information <http://www.ableaustralia.org.au/>


Mental Health Booklet - written by, and for, people with a disability who have mental health support needs. The booklet is designed to help and support disabled people who need to use mental health services <http://www.mind.org.uk/Information/Booklets>

Websites

ACE Australian Communication Exchange <http://www.aceinfo.net.au>

AFDS – Australian Federation of Deaf Societies <http://www.afds.org.au>

Aussie Deaf Kids <http://www.aussiedeafkids.com>

Australian Hearing <http://www.hearing.com.au>

Australian Sign Language Interpreters Association <http://www.aslia.com.au>

Better Hearing Australia <http://www.betterhearing.org.au>

Deaf Australia (formerly Australian Association of the Deaf Inc.) <http://www.deafau.org.au>

Deaf Children Australia <http://www.deafchildrenaustralia.org.au>
References

Deaf Services Queensland <http://www.deafservicesqld.org.au>

Deaf Sport and Recreation Queensland <http://www.dsrq.org.au>

Deaf Sports Australia <http://www.deafsports.org.au>

Deaf Student Support Program - Griffith University – Australia <http://www.griffith.edu.au>

Deafness Forum <http://www.deafnessforum.org.au>

Disability Services Queensland <http://www.disability.qld.gov.au>

Eartroubles <http://www.eartroubles.com>

Indigenous Ear Health and Hearing <http://www.earinfonet.org.au>

Media Access Australia <http://www.mediaaccess.org.au>

Parents of Deaf Children- Queensland support group <http://www.podqld.org>

Royal Institute for Deaf and Blind Children <http://www.ridbc.org.au>

Sign Language Services Australia <http://www.slsa.net.au>


References


The person in the centre is a person who has many troubles and is in darkness. This person knows nothing and has no support. Drink bottles to the front show one way that this person has tried to cope. The person is incomplete (no legs), like fading away, dying.

On the left in a brighter place, is a counsellor who can assist a person in learning and opening up the world for that person. Someone has noticed. The two birds are now taking the troubled person by the hands and are now lifting that person out of the troubled area and are taking that person to the counsellor.