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Shaping the future of deaf mental health

NHS Deaf Mental Health Working Group

Facilitated by SignHealth

Contents

THE DEAF HEALTH CHARITY SIGNHEALTH

Key findings

1. There are unfair and avoidable differences between the mental health services available to deaf and hearing people. Deaf people do not receive equitable healthcare.
2. Mental health related self-help resources are not readily available in British Sign Language.
3. There is a lack of consistent, accessible early intervention services for deaf people, across all ages.
4. There is a lack of consistent and universally available community specialist provision for deaf adults across England and not enough deaf specialists.
5. Deaf people are unable to access community mental health teams, resulting in:
    a. many deaf people remaining in secure provision or inpatient care without ability for discharge,
    b. high attrition rates with deaf people not attending appointments, or dropping out of the support system due to barrier fatigue,
    c. referrals to higher tier support at a later stage after symptoms have escalated due to not receiving support needed earlier.
6. There are inconsistent and disjointed referral pathways with gaps in planning across deaf services for people who use BSL and those who have language deprivation / delays.
7. Poor deaf awareness and cultural competency is evident across the NHS resulting in incorrect referrals and misdiagnoses among deaf patients.
8. The communication needs of people who are deaf are being neglected.

Recommendations

Overarching recommendations

Some of the recommendations found through this project are sector specific, but the eight highlighted below must be implemented at a more systemic level in order for deaf mental health provision to achieve the attention and influence necessary to address the inequalities in services and patient experience.

Immediate

1. A strategic/policy lead in NHS England with responsibility for deaf mental health.
2. Given the clear case around the need for change, for the Clinical Reference Group to be redesignated as a Lead and Inform CRG.
3. For colleagues within Public Health to be commissioned to do a needs assessment looking at the demographic and epidemiological evidence of need and demand for an all age full pathway specialist mental health service for deaf people on a regional footprint
4. Integrated Care Boards to action the recommendations made to them by NHS England on the commissioning of BSL Interpreting and the involvement of deaf people in the development of services (see appendix).

Medium Term

1. Mandatory deaf experience/cultural awareness and Accessible Information Standard (AIS) training for under- and post grad training for all medical, nursing and Allied Health Professionals and to be included as part of trust inductions.
2. To ensure NHS providers comply with the AIS, including, for example, ensuring an alert pops up when booking appointments that a BSL Interpreter is needed to make the appointment accessible and that this is booked prior to the appointment.
3. For the NHS Workforce Plan to include a focus on deaf staff to enable accessible and supported training and development opportunities.
4. To identify national research priorities within deaf mental health and support teams to develop research capability across the university and health sector.

National Deaf CAMHS

1. For a website to be developed bringing all the service information together with a wide range of resources to build understanding and resilience around mental health, information about self-help and positive strategies for both deaf children, young people and parents (hearing and deaf).
2. National Deaf CAMHS has had no uplift in funding since it was set up. This should be rectified given the increase in demand and activity over the years.
3. For the agreed proposal around provision for young people aged 18 – 25 to be funded and set up.
4. Working alongside social care there is a need to map out specialist community residential placement options for deaf young people and scope the need for more provision.

Specialised mental health services for deaf adults

1. Commitment to the development of a regionally based specialist mental health hub for deaf people which provides equitable care across the country. For this service to include neuro-developmental and neuro-psychological assessments for deaf people alongside mental health.
2. Ensure access to mental health crisis teams through text, email, and video relay, and provide training to staff to ensure they recognise the specific needs of deaf people.
3. Ensure that more deaf-led community services are commissioned so that deaf people who are ready to leave secure services can be discharged and supported to live independent lives.

Deaf forensic mental health services

1. Provision of specialist deaf forensic mental health services and accommodation
2. Deaf prison in-reach available to all deaf prisoners
3. A coordinated, collaborative pathway for deaf patients (including women) in forensic services with specialist commissioners who have knowledge of deaf forensic mental health and specialist assessments by experts in deaf forensic mental health.

Introduction

There is good evidence that deaf people across age ranges have rates of mental health problems which are higher than the hearing population. There are a range of reasons for this including biological, psychological, social, linguistic and cultural challenges of living in an overwhelmingly hearing world.[1]

Whilst there are areas of excellence in specialist mental health service provision for deaf people with mental health problems, these are patchy and there is a significant postcode lottery.

There are significant difficulties for deaf people accessing existing mainstream services. They encounter clinicians who do not understand the deaf experience and deaf culture. For those whose first language is British Sign Language, often interpreters are not booked and clinicians do not know how to work with them.[2] For those deaf people with language deprivation, self-help and psycho-education information is not accessible.

The majority of the NHS England budget for specialised commissioning for deaf mental health is steered towards inpatient and secure provision with a significant lack of consistent community provision.

This report outlines the stark inequalities and gaps in mental health service provision for deaf people in England. It was created with input from deaf service users, the wider Deaf community, families and carers and staff who work within the services.

Within it we have outlined the issues based on this collective experience, but more importantly made some clear recommendations about what needs to happen for there to be true equality.

- **Dr Sophie Roberts,**
  Clinical Lead for Deaf Mental Health

Contextualising mental health experiences

Trauma-informed care shifts the focus from "What's wrong with you?" to "What happened to you?" A trauma-informed approach to care acknowledges that healthcare organisations and care teams need to have a complete picture of a patient's life situation — past and present — in order to provide effective healthcare services with a healing orientation. Adopting trauma-informed practices can potentially improve patient engagement, treatment adherence, and health outcomes, as well as provider and staff wellness. It can also help reduce avoidable care and excess costs for both the health care and social service sectors.[3]

One in four people will experience mental health problems in any given year to varying degrees. Research shows that mental health problems within the Deaf community are disproportionately higher than those of our hearing peers, with prevalence in the Deaf community of 30-60%.[4] Mental health problems are not an inherent health risk for all people who are deaf, but are instead a result of repeated exposure to cumulative adverse and traumatic experiences throughout our lifetime.

To ensure that a child has appropriate emotional and cognitive development, it is essential that they have consistent access to a functional language before the age of five, which is the optimal age for language acquisition.[5] If this does not happen, their emotional and cognitive development will lag behind that of their peers.[6] This will have an impact on their ability to emotionally regulate their feelings, leading to delays in developing healthy connections with others.[7] If a child is unable to access the incidental learning required in their first language, it increases the likelihood that their emotional development will be impacted into adulthood and will have an effect on how they respond or react to stressful situations.[8]

Of the children who are deaf at birth, 90% have hearing parents.[9] The Newborn Hearing Screening picks up 1 in 1,000 from birth, and another 1 in 1,000 children are identified as deaf by the age of five. This programme has supported many new parents to identify their child's deafness at an early age. However this approach often sees deafness through a medical model of disability, rather than seeing the potential for a deaf person to live a positive life and be an asset to their family and community.

Sign language, and its potential to support communication and the development of language from birth, is often omitted from early conversations in health settings. In addition, most families do not have contact with positive deaf role models to support their understanding of Deaf culture and experiences.

Deaf people face barriers in accessing mental health services, due to communication barriers, lack of specialised service providers and practitioners, lack of cultural knowledge and competence, and inadequate understanding of deaf culture within hearing mental health systems. However, if self-care interventions or primary care provider support were readily accessible, not all deaf people would require specialist interventions by tertiary mental health services.

Without mental health resources in British Sign Language, it is difficult for deaf people to learn about mental health or identify when we may be struggling and require medical support.

To effectively address the high incidence of mental health problems experienced by deaf people, it is essential that all relevant stakeholders read this report through a trauma-informed lens.

Deaf people are experts by lived experience. It is imperative when working towards culturally competent health care to understand that deaf people's everyday exposure to adverse life experiences make us uniquely positioned to articulate how current provisions are inefficient. Our views offer important insights on how improvements could be made to better meet deaf people's needs.

Background and context

The Griffiths report in 1988 ‘Community Care: Agenda for action’ demonstrated that people with mental health conditions should be cared for within their community if safe to do so[10] and the large institutions were slowly closed down. In 1992 the health of the nation report was followed by the national service framework in 1999 which outlined the need for care pathways across age groups with further development of community based provision and crisis services.

Our needs as deaf people are never considered in these service transformations.

The same is true for the most recent NHS Long Term Plan.

Specialist mental health services for deaf people have developed in a more piecemeal and ad hoc way, often driven by serious incidents and enquiries (such as the Daniel Joseph report in 2000[11]). This has resulted in some areas of excellent practice.

Current specialised service provision

The National Deaf Child and Adolescent Mental Health Services (CAMHS) established in 2008 across England offers an equitable accessible service for deaf children and families through four regional community teams and a small inpatient unit in London. However the funding has remained static since inception, despite a significant increase in demand.

NHS Therapies for Deaf People with anxiety and depression was nationally commissioned for the first time in 2021 from SignHealth, providing a countrywide Talking Therapies (formerly IAPT) service delievered in British Sign Language.

For adult community provision there are very small teams in London, Manchester, Bristol, Birmingham, Newcastle/Middlesborough, 1 nurse part-time in South Yorkshire and a part-time psychologist in Nottingham.

Some of these services are Specially Commissioned, others have developed through agreement with local Clinical Commissioning Groups. The model of service provision is that service users must be accepted by the local community mental health team and cannot be referred directly.

There are 3 (non-secure) inpatient centres for deaf people in London, Birmingham and Manchester, providing a total of 44 beds.

Within the secure estate there are providers across the independent sector providing a total of 34 low secure, 14 medium and 10 high secure beds across Northampton, Manchester, Bury and Rampton. There is limited prison in reach and no consistent forensic community service.

Financial context

Current NHS England specialised commissioning funding:

Deaf services	Budget
Low secure budget	£9,006,554
Medium secure budget	£5,022,306
High secure budget	£unknown
General adult deaf budget – community/inpatient	£11,190,364
National Deaf CAMHS – community	£3,437,370
National Deaf CAMHS – community/inpatient	£4,053,411
Total	£32,943,953

Clinical Reference Group

During the 2022 clinical leadership review and transformation of NHS England the structure of commissioning and Clinical Reference Groups (CRG) was re-organised. Deaf mental health, having previously been represented at the Specialised Mental Health CRG via the Deaf Mental Health Working Group (DMHWG), and prior to this, having a Deaf CRG in its own right, was changed to 'Respond and Advise'. A decision was made that no plans were needed for any active programme to be implemented for regular meetings or a policy lead, possibly because deaf mental health wasn't specifically mentioned in the Long Term Plan.

Members of the DMHWG however, with collective extensive experience of working within deaf mental health across National Deaf CAMHS, specialised mental health services for deaf adults in community and forensics including outreach and inpatients, disagreed with this decision, believing that transformation is urgently required. With no mention of deaf people in the NHS Long Term Plan and no people with deaf mental health policy in their remit, a serious concern was raised as to the future of mental health services meeting the growing and significant needs of deaf people in England.

SignHealth wrote to the Director of Mental Health for NHS England, Claire Murdoch outlining the case for urgent consideration and this letter was co-signed by the majority of clinicians working in deaf mental health. In response, we were tasked to carry out a scoping project that outlined the issues and inequalities faced by deaf people during their mental health journeys and present to NHS England what needs to happen for a better future.

View letters in the appendix.

What did we do?

Presented below is a concise overview of the five main themes identified during this scoping project.

We asked stakeholders, including deaf people using services and clinicians providing services, three questions designed to gain an accurate understanding of the current state of mental health provision for deaf people:

1. What problems are there currently with the pathway to get mental health support?
2. What needs to happen for the service to be equitable with hearing services?
3. What three things would immediately make a difference?

Five main themes were identified:

1. Early intervention
2. Number of specialised services and specialists
3. Cultural competency and trauma-informed practices
4. Referral and transition pathways
5. Aftercare and community services

This report explores these themes in depth across all NHS deaf mental health services. We gathered valuable insights and ideas to address the challenges and opportunities present in the deaf mental health sector. We have divided the sector into three - National Deaf CAMHS, specialised mental health services for deaf adults and deaf forensic mental health services.

Theme 1

Early intervention

For all three deaf mental health pathways we identified opportunities for early intervention which are being missed. If deaf people can have their mental health needs identified and supported early in their presentation, this will prevent many of the more serious problems developing and reduce the use of higher level services including forensic inpatient services.

Early intervention

National Deaf CAMHS

Early intervention plays a crucial role in supporting the mental health of deaf people, as deaf people are at higher risk of conditions such as depression, behavioural issues, social disorders, and youth offending[12]. Additionally, the lack of opportunity to effectively communicate with others leads to feelings of isolation, low self-esteem, and challenges in building relationships.

The current system and approach to mental health services, as outlined in the NHS Long Term Plan, are not effectively meeting the needs of deaf young people. The NHS Long Term Plan acknowledges that young people are more susceptible to mental illness during critical life transitions, but the current structure of mental health services creates gaps for those who are deaf as they move from child to adult services. Deaf young people face inadequate access to specialised interventions due to their needs stemming from language deprivation, complex health issues and adverse childhood experiences.

There is a wealth of information and self-help resources which hearing children and young people can access online through apps, TikTok, YouTube etc. This information is often not accessible to deaf children and young people, with an almost total lack of signing, rarely accurate subtitling when available and often inaccessible language.

In addition, school-based resilience programmes and early support outlined in the green paper in 2017[13] led to the setting up of educational mental health practitioners and mental health support teams in schools. These staff are unable to communicate using sign language and have very limited understanding of the developmental challenges facing deaf children. Furthermore, local child and adolescent mental health support teams do not understand Deaf culture and its effects.

The establishment of National Deaf CAMHS in 2008 has enabled accessible regional provision of a specialist mental health service for deaf young people up to the age of 18.

Bailey's Story

When Bailey was referred to Deaf CAMHS at 17, she was experiencing low mood following a relationship breakdown. Adapted trauma-informed Cognitive Behavioural Therapy was begun. However, it quickly became apparent that Bailey faced significant challenges with social communication. Consequently, an autism assessment was conducted, revealing that she was on the autism spectrum. Despite facing educational challenges, Bailey did not have a global learning disability.

By the time the assessment was completed, Bailey had turned 18. Unfortunately, her chronic self-harm and emotional dysregulation persisted. Efforts were made to refer her to the local adult Community Mental Health Team (CMHT), but she did not meet their referral criteria. Additionally, the Learning Disability team did not accept her as she did not have a learning disability. Her issues were too complex for British Sign Language Talking Therapies.

Unfortunately, no accessible and appropriate service was available for Bailey to continue her therapy. Deaf CAMHS attempted to refer her to mainstream post-abuse services for adults, but she disengaged from these services due to lack of accessibility. As a result, Bailey was lost to follow-up, highlighting the significant gaps in support for people facing multiple challenges like hers.

This case highlights:

- The need for comprehensive and personalised mental health services for deaf people confronting complex obstacles
- The vital importance of continuity of care
- The crucial need to address gaps in appropriate, consistent and necessary support.

Specialised mental health services for deaf adults

Deprivation of language and isolation during a deaf person's formative years often results in a lack of emotional literacy and an inability to comprehend their emotional responses.[14] Consequently, this creates difficulties in self-recognition when mental health problems arise. As a result, they are unable to communicate their thoughts and feelings in a manner which feels appropriate to hearing people, which further hinders their ability to regulate their emotions. Moreover, emotional dysregulation is frequently a trauma response caused by repeated exposure to highly distressing situations and cumulative adverse experiences, such as a lack of accessible communication. Due to the paucity of mental health information available in British Sign Language, deaf people may encounter additional challenges in acquiring emotional literacy skills and achieving positive mental health.

Deaf adults with mental health problems face numerous barriers to accessing appropriate care, such as difficulties navigating primary and secondary care systems, a lack of awareness among service providers, and a scarcity of specialised services. Consequently, timely interventions to prevent serious mental health problems are frequently overlooked.

Early intervention necessitates empowering deaf people to actively participate in the management of their mental health. When communication requirements are not met, people are frequently excluded from vital discussions and decisions regarding their health. By providing accessible communication channels and written materials, including the use of qualified and registered British Sign Language (BSL) interpreters, deaf people can participate fully in the process, express their concerns, and collaborate with health professionals to develop effective treatments.

Abbey's Story

Abbey, a 28-year-old deaf woman raising two young children, had tried to share her mental health concerns with her GP but it had been difficult because they did not consistently provide an interpreter during appointments. She reached out to the Deaf Adult Community Team (DACT) in the South West London and St George's Mental Health NHS Trust for advice and support when she started experiencing depression and suicidal thoughts due to various life challenges.

Upon contacting DACT, Abbey received guidance and assistance, including a letter sent to her GP requesting a referral to the local mental health service. Unfortunately, the local Community Mental Health Team (CMHT) displayed reluctance in providing an assessment, citing that they do not work with deaf people. DACT emphasised the obligation to provide accessibility and offered to support Abbey throughout the process…

Abbey's story continued…

Abbey faced multiple setbacks during her attempts to receive an assessment from the CMHT. Her initial appointments were cancelled twice, once due to staff sickness and another time due to the unavailability of an interpreter. These cancellations occurred without informing Abbey, causing her and DACT to make wasted journeys. Finally, when the assessment did take place, the CMHT concluded that Abbey did not meet their threshold for support, resulting in her discharge without any offer of assistance.

DACT recognised the CMHT's limited resources but highlighted the fact that Abbey, as a deaf person, faced significant barriers in accessing the support available to hearing people in primary care and other settings. They suggested a collaborative approach, proposing a short-term period of joint work between DACT and the CMHT to establish achievable goals and identify additional resources for long-term support. However, the CMHT maintained their stance of not offering any input, leaving Abbey with a negative experience of mental health services and without the help she desperately needed.

This case highlights:

- Many of the challenges faced by deaf people seeking mental health support highlighting urgent need to improve accessibility and communication support provisions
- Barriers delaying timely mental health interventions

Early intervention

Deaf forensic mental health

Deaf people face heightened risks when attempting to access mental health support, particularly when their initial point of contact lacks awareness of the social and cultural factors that contribute to how a deaf person may manifest mental health problems. Adverse life experiences that are unique to deaf people, such as language deprivation, barrier fatigue, internalised ableism and ongoing communication inaccessibility can not only contribute to mental health problems, but also cloud the assessment process; without a background understanding of these influences, accurate diagnosis and effective treatment become challenging for professionals.

Our findings from the feedback we received revealed significant gaps and barriers in the early intervention process for deaf forensic patients that hinder effective assessment and timely support. Misunderstandings and a lack of awareness regarding the specific needs of deaf people can contribute to the escalation of mental health problems, potentially leading to a crisis.

Front line services (such as emergency services or police) often do not accurately recognise that agitation or animated behaviour in a deaf person, resulting from their language modality, does not necessarily indicate a crisis or a risk to themselves or others. Additionally, there is a notable disconnect or lack of pathways for deaf people to receive comprehensive assessments in the community, leading to an escalation of their condition and eventual admission to inpatient forensic services.

This highlights the urgent need for increased deaf awareness and specialised guidance for health services and the police to make informed decisions and develop proactive strategies to support deaf people before crises occur.

John's Story

John is a very isolated deaf man living in a rural area with his elderly parents. His parents are unable to sign or meaningfully communicate with him. Following an accident, John is reluctant to travel to nearby towns to meet other deaf people. John spends his days walking around the local town trying to speak with people and doing his grocery shopping. John's sign language has been understood to be aggressive behaviour by both local businesses and the police in his local area and he is subsequently barred from nearly every business in town. The police are regularly called to remove him from where he is due to concerns that he is acting aggressive. Local social services were also concerned that John may be a child sex offender with severe mental health problems.

John was subsequently assessed by a specialist in deaf forensic psychiatry who concluded that John had no mental disorder and was merely trying to communicate with local people who had no understanding of his communication needs. He had no history of any form of sexual offending. Following this, social services were able to put in support to help John be less isolated, addressing the underlying problem.

This case highlights:

- The prejudice and isolation deaf people can experience
- How services without deaf awareness can contribute to the problem and may lack the knowledge necessary to respond appropriately or identify support needed
- The important role of specialists in understanding the context the deaf person is in and in finding the correct diagnosis and treatment.

Theme 2

Number of specialised services and specialists

There are a small number of specialised services for deaf mental health, within which work a small number of specialist psychiatrists, psychologists, nurses, social workers, occupational therapists and other disciplines. These services are not equitably distributed across the country and recruitment to vacant posts is very challenging with very few deaf people qualified or able to train to gain clinical roles.

Number of specialised services

National Deaf CAMHS

Nearly 80% of deaf children are educated in mainstream schools, where the majority of education professionals do not understand the challenges deaf children face. Deaf children are supported by peripatetic teachers of the deaf but most only get weekly, monthly or termly visits. Other school staff have a limited understanding of the deaf experience and are unaware of the developmental challenges that are unique to being deaf in a predominantly hearing environment, as well as the profound effects of language deprivation. This knowledge gap leads to the poor identification and management of early mental health problems, which, when combined with the difficulty deaf children and adolescents frequently face in gaining access to appropriate resources, advice, and early assistance as outlined in the previous section, results in significant delays in receiving critical mental health support.

The result is that deaf children and young people are more likely to be referred to the highly specialised National Deaf CAMHS when more universal support would be more appropriate.

There are issues with staff recruitment within National Deaf CAMHS, particularly due to the barriers deaf people have accessing higher education and clinical training.

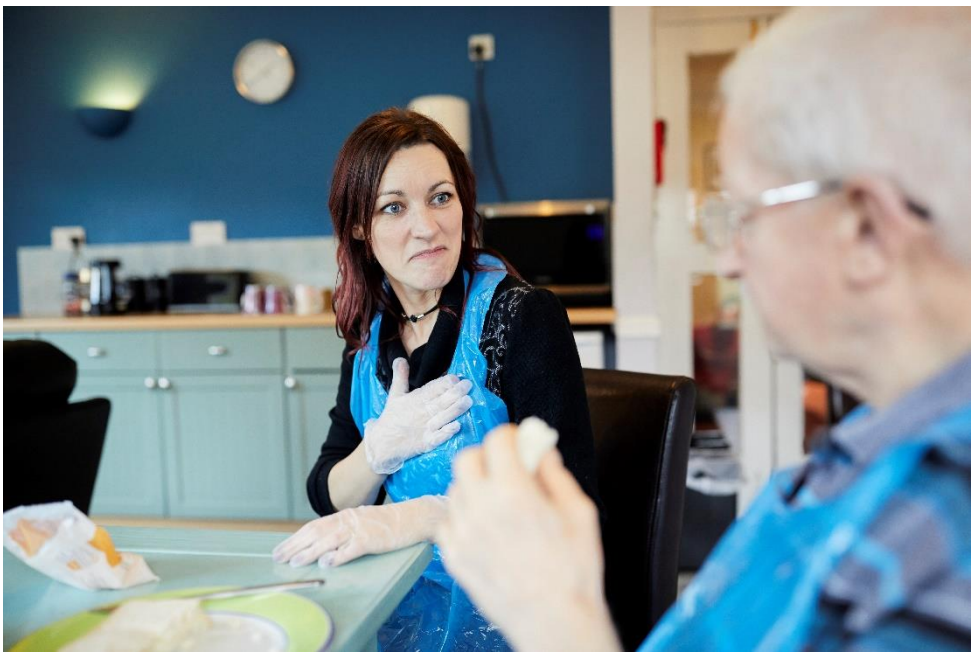
Another issue is where deaf children/young people require a more specific intervention, for example specialist post abuse/trauma therapy or inappropriate sexualised behaviour interventions, there is not enough expertise around how this needs to be adapted to meet the needs of deaf children and young people.

Specialised mental health services for deaf adults

Frequently, the required pathway for deaf people to gain access to support is through hearing services initially where deaf people can then be referred to deaf services. Led by SignHealth, a coalition of charities conducted a review of the Accessible Information Standard (AIS) in late 2021, surveying 1,000 people including NHS and social care professionals in England as well as disabled people with information and communication needs.[15] The survey indicated that 67% of Deaf people lack accessible means to contact their GP service. In addition, a substantial 81% of people with communication needs have attended appointments where their communication requirements were not met.

Due to systemic barriers, Deaf adults frequently encounter significant obstacles when attempting to gain access to Community Mental Health Teams (CMHT). These obstacles include difficulties navigating the primary and secondary healthcare systems, impeding their access to the appropriate services. The effectiveness of referrals also depends on the knowledge and awareness of hearing services about available deaf services, which may not always be comprehensive.

Due to insufficient specialised services and specialists, deaf people are frequently referred to general services. When they are referred to local support services, the lack of funding for communication support, such as BSL interpreters, becomes a barrier. Without appropriate communications support, many deaf people are unable to receive the necessary assistance. In addition, some community deaf services lack specialists like occupational therapists, social workers, and psychologists. This lack of specialised services and specialists restricts deaf people's access to tailored resources and interventions.



Faisal's Story

Faisal, a 34-year-old deaf man diagnosed with schizophrenia, resides in a non-specialist residential care facility on the south coast. Despite his specific needs, Faisal lacks access to deaf support or interpreters, leading to feelings of isolation and loneliness. Despite the need for a deaf care home to accommodate his specific requirements, social services have rejected this option on the grounds of cost, disregarding Faisal's need for appropriate care and support.

Faisal requires regular depot injections for his schizophrenia treatment. However, the lack of consistent staff and interpreters at the depot clinic complicates the administration process, causing Faisal to experience confusion and anxiety during his visits. Furthermore, Faisal's care coordinator and psychiatrist from his local CMHT both left the team earlier this year. He is waiting for new staff to be allocated, and in the meantime has had no named person looking after him for several months.

The Deaf Adult Community Team (DACT), based in London, has played a vital role in supporting Faisal's mental health needs. They previously attended Faisal's CMHT appointments, offering specialised input and ensuring his access to appropriate treatment. Additionally, they facilitated connections with deaf-specific resources and collaborated with social services. However, due to the absence of support from Faisal's local team, the DACT is unable to fully address the gaps in his care, as they operate from a considerable distance.

This case highlights:

- The consequences of inadequate support and limited understanding of deaf people's needs within the current mental health care system
- Costs being cited as a barrier and grounds for refusal for placement in a deaf care home that would be able to tailor to the patient's specific requirements
- The impact of constant staff turnover and lack of interpreters, hindering essential treatment, resulting in missed doses and setbacks in recovery
- Urgent concern for those deaf people with similar stories who cannot access DACT.

Deaf forensic mental health

The disparity between deaf and hearing services is substantial, with limited or non-existent provision of low level mental specialised health services for deaf people. This includes the absence of community forensic teams, prison mental health in-reach programs, and secure mental health services specifically tailored for deaf people. This absence hampers access to appropriate mental health support for deaf people who are in prison.

Community-based supported housing accessible for deaf people is scarce, and delays in developing bespoke placements worsen the issue. Deaf patients' needs are often not recognised in health care. Access to BSL interpreters continues to be an issue, highlighting the need for more community-based deaf services and sign language fluent professionals. Through this scoping exercise we found that deaf people who use sign language are being placed in hearing wards without interpreters or good communication options. Without communication support, patients and staff cannot interact freely and efficiently. This situation denies deaf patients access to the therapeutic milieu of the ward and means that staff cannot meaningfully assess the deaf person’s mental state. While a deaf person may be on the same ward as a hearing person, they receive grossly different levels of treatment and support.

The forensic pathway lacks sufficient services for women who are deaf. The underdevelopment of the deaf women's forensic pathway is a pressing concern and requires substantial investment and attention, as one low-security ward exists nationally. Due to capacity limits or the requirement for higher security placements, finding an acceptable location for patients is difficult. Given the low proportion of deaf women who need specialised support, it requires at least two blended safe care programmes.

Sammy's Story

Sammy experienced significant challenges with her mental health due to communication barriers and a lack of specialised services. She attended a deaf school and college, but when it closed, her mental health began to suffer. Her journey through psychiatric care facilities further exacerbated her struggles as the staff faced difficulties communicating with her effectively, leading to frustration and feelings of isolation.

In mainstream services, Sammy found it incredibly frustrating to communicate with the staff. As British Sign Language (BSL) was her primary mode of communication, the staff's reliance on written communication left her feeling misunderstood and angry. Her mental state deteriorated and she engaged in both life threatening self-harm and violence to others.

Sammy was referred to the only deaf secure women's service in the UK but was turned down repeatedly on the basis that they could not manage her presentation. This meant that there was no suitable service for her.

Sammy was eventually admitted to a hearing ward with specialist deaf in-reach at St Andrew's in Northampton, where she was able to receive medical treatment in a language that she could access, and benefitted hugely from. She recognises that the provision available to her as a deaf woman was not equitable to that which she would have received as a deaf man. She strongly advocates for sufficient specialist deaf secure mental health services for deaf women, like her, to be able to get the support they need and would get if they were male or hearing.

This case highlights:

- How a lack of deaf awareness can be a significant barrier to deaf people's access to treatment at an early stage and exacerbate mental health problems
- A lack of deaf secure mental health services for deaf women means that treatment and recovery may be delayed or unavailable
- A positive outcome was achieved because a specialist deaf in-reach service was available to facilitate treatment in her own language, British Sign Language
- For deaf women to receive equitable access to health care, more specialist deaf secure mental health services need to be made available.

Theme 3

Cultural competency and trauma-informed practices

Many deaf people lead very different lives to the hearing population of England, are part of the Deaf community and have their own cultural identity. There is also emerging research which shows that deaf people in mental health services have higher levels of trauma than hearing peers.[16] This means that mental health services for deaf people need to understand the lived experience of deaf people, the range of trauma experienced by deaf people, and what mental disorder looks like in deaf people. Trauma informed care for deaf people has to mean understanding the deaf person's individual life experiences. The cultural competency issues described below apply to services for deaf young people and adults.

Deaf people come from diverse backgrounds with different cultural intersections shaping their identity, perceptions, values and experiences. Our findings show that there is a lack of training in relation to the deaf experience, deaf awareness and deaf mental health for all key professionals working with parents, carers and deaf children such as school nurses, speech and language therapists and education staff. Incorporating effective cultural competency into the support provided will enable professionals to create a supportive and empowering environment that fosters deaf young peoples' overall wellbeing, success and potential.

In cases where a referral to a specialist service is necessary, the importance of cultural competency becomes even more evident. Cultural competency equips professionals with the knowledge and skills to understand and appreciate the cultural nuances of their clients. By recognising and incorporating these cultural factors into treatment approaches, professionals can establish a foundation of trust, effectively engage with the person and provide care that is culturally sensitive and relevant. This approach fosters a positive therapeutic relationship, empowering the person to actively participate and take ownership of their mental health journey. By valuing and respecting their cultural context, professionals create an environment that enhances the person's overall engagement and investment in their wellbeing.

Our findings show that deaf people working in NHS services face significant barriers to career and professional development. One notable challenge is the lack of funding available for the completion of training. For instance, when a NHS staff member who is deaf enrols in a counselling course, they may be provided with an interpreter during the course sessions. However, they are often prohibited from using their Access to Work [17] interpreter for a crucial essay or case study component at the end. This restrictive policy has resulted in many deaf NHS staff dropping out of their courses, resulting in wasted time, financial resources, and missed opportunities for increasing the number of qualified deaf counsellors and therapeutic workforce. The absence of adequate support for deaf professionals

in pursuing their training aspirations hinders their career progression and limits the diversity and inclusivity of mental health services.

Due to a lack of specialised services and specialists, it is imperative that hearing services collaborate with deaf specialists to meet the needs of deaf individuals. However, our findings demonstrated that local teams may not currently take deaf specialists' recommendations into account or adhere to them in full. A failure to fully evaluate or adhere to the advice of deaf specialists can have negative effects on the quality of mental health care provided to deaf individuals. By incorporating the knowledge of deaf specialists, local teams can enhance their understanding of deaf culture, communication preferences, and the nuances of providing effective mental health support. As a result, care and outcomes can be improved, allowing deaf people to receive the required individualised and extensive support.

Deaf forensic mental health

Forensic mental health services have very little understanding of the unique needs of the deaf forensic mental health population, resulting in inadequate coordination and assessment processes. It is not sufficient to have professionals who lack knowledge of cultural and linguistic aspects of deafness to assess and provide mental health support to deaf prisoners. This knowledge deficit is evident at multiple stages of the assessment procedure, including access assessments to secure services. Access evaluations conducted by non-specialists are of limited value, with frequent instances of both missed diagnoses, and incorrect diagnoses. In addition, errors in risk assessment often occur when it is assumed that deaf individuals pose no risk simply because they are deaf, or that their normal behaviour automatically indicates a risk.

It is essential to raise awareness of deaf prisoners and to ensure they receive the appropriate care. This includes providing guidance and support not only to the deaf prisoners themselves, but also to prison staff responsible for their welfare. By providing comprehensive training and education on deaf culture and sign language, professionals can address the unique requirements and difficulties of deaf prisoners. Nonetheless, prisoners and their families should not bear sole responsibility for disclosing their deafness. Instead, proactive efforts should be made to identify and assist deaf prisoners in all facilities.

By promoting awareness and advocating for the development of deaf-specific services, we can strive to improve the overall wellbeing and outcomes for deaf people involved in the criminal justice system.

Theme 4

Referral and transition pathways

Deaf people face numerous barriers when trying to access suitable mental health support. Processes like using a phone number for appointments can disadvantage us, and the requirement for a deaf person to be under a Care Programme Approach (CPA) to access nationally commissioned specialist deaf mental health services creates a significant obstacle. It is worth noting the irony that deaf people must first undergo assessments by hearing services, despite the existence of specialist services intended to fill the gap in assessing and supporting deaf people.

Referral and transition pathways

National Deaf CAMHS

Although National Deaf CAMHS is now well established in England, there is a concerning lack of awareness of the service among professionals and service providers, including deaf services and mental health professionals, which was highlighted within the scoping project.

Major access issues remain however for community-based mental health services designed for deaf young adults between the ages of 18 - 25. The NHS Long Term Plan identified this as a priority for all CAMHS given the high thresholds for adult CMHT's, but did not consider deaf young people's needs. Transition is a major issue as community based specialised mental health facilities for deaf people in England are not universally accessible across the country. Where there are services (such as in London), the process is that when transition is needed, National Deaf CAMHS have to refer back into local CAMHS, who then refer onto generic adult CMHT, who can then involve the specialist deaf adult community team. This is a very poor experience from a service user journey perspective.

A data gathering exercise and proposal was completed in 2021 and presented through the programme of care board and although NHS England acknowledges this service gap, there is a lack of clarity regarding funding allocation. As a result, deaf young people are at risk of experiencing heightened distress and isolation without timely and tailored support at a crucial time of transition. Addressing this gap through the development of clear funding mechanisms and pathways is crucial for maintaining therapeutic support for deaf young people with mental health problems.

Specialised mental health services for deaf adults

To provide deaf people with effective mental health care, it is essential to establish specific pathways and protocols throughout the entire process, from triage and referral to discharge and aftercare. This includes transitions between general and specialised mental health and deafness (MHD) services, as well as transitions between specialised MHD and general CMHT. In addition, it is necessary to develop intervention pathways that address crucial areas such as communication and language, recovery and safety, and risk management.

Currently, the mental health and deafness service pathways are frequently not adequately documented, and when they are, they may be out of date or lack validation. This situation can lead to confusion and inconsistency in the provision of care. This lack of clarity can be particularly problematic for practitioners and referrers who are unfamiliar with the service and the Deaf community.

> **"As someone totally new to the mental health and deafness service and the Deaf community, I would agree that the pathways are not clear and often do seem to be 'in the heads' of people rather than clearly documented. As a new practitioner with the service, I have no idea how everything fits together and there is no written guidance to refer to. I feel this lack of clarity probably impacts on some referrers to our services. If our pathways in aren't clear, then we may miss those initial opportunities to support people with their mental health needs."**
>
> **- A practitioner from the deaf adults team**

Implementing specific pathways and workflows in mental health services is crucial, especially for deaf people. These pathways address the unique communication and language needs of deaf people throughout their journey. By establishing clear pathways, deaf people can receive timely and appropriate assessments and referrals, leading to equal access to quality care and improve overall mental health outcomes.

Deaf forensic mental health

Emerging obstacles in referral and transition pathways in forensic deaf mental health services necessitate attention and development in multiple areas. First, the referral system has undergone significant changes with the move to provider collaboratives. Hearing forensic services working as part of provider collaboratives know little about the specific requirements of the deaf forensic population and are frequently unaware of the unique manifestations of mental disorders in deaf people and the availability of specialised services. Therefore, crucial aspects such as Mental Health Act assessments and access assessments for secure services are susceptible to missed diagnoses, overdiagnosis of non-existent problems, and significant inaccuracies in risk assessment.

As demonstrated in Sammy's story, the specific requirements of deaf women in the forensic pathway are not adequately addressed. Nationally, there is a shortage of secure facilities for deaf women, with only one low-security ward available. This lack of adequate placements makes it difficult for deaf women, particularly those who require higher levels of security, to find suitable care options.

Theme 5

Aftercare and community services

Mental health conditions frequently require long-term support and management. Aftercare ensures continuity and prevents relapse or mental health deterioration. Regular follow-up appointments permit the monitoring of progress, if necessary, the modification of treatment plans, and the identification of emergent issues or concerns. In addition, aftercare provides a safety net for deaf people, especially during transitions or vulnerable periods. It ensures that ongoing support is accessible even after the initial phase of treatment has concluded. This can be essential for preventing crises, delivering timely interventions, and promoting general wellbeing.

There is very limited availability of specialist residential and supported accommodation for deaf people with mental health problems and this leads to long delays in discharge from inpatient beds. Hearing community mental health services are not able to meet the unique needs of deaf people, and the nationally commissioned specialist deaf services cover large regional areas. There are areas of good practice with local specialist services, but these have developed in response to local commissioners identifying local need and this is far from the norm across the country.

Aftercare and community services

National Deaf CAMHS

With the setting up of National Deaf CAMHS there was for the first time access to a universal, regionally based specialist community service for deaf children and young people. Corner House at South West London and St. George's Mental Health Trust is an inpatient unit providing Tier 4 care to young people from England, aged 11-17 years. From there young people are stepped down to regional Deaf CAMHS community teams.

Our findings indicate challenges persist in finding suitable social care placements for deaf young people, especially those with complex trauma histories and language difficulties. This gap in provision highlights the importance of collaborating with social care to map out specialised community service and residential options for deaf young people and assess the need for additional provisions.

Appropriate residential options can provide environments that are conducive to deaf young people's growth, development, and wellbeing. This includes access to sign language interpreters, communication aids, deaf-friendly environments, and staff who are trained in deaf culture and communication, or preferably staff who are deaf themselves. Placements also offer more opportunity for collaborations with healthcare providers, social services, and other relevant stakeholders. This collaborative effort would promote coordination, information sharing, opportunities for interventions and the development of comprehensive care plans at an early stage in life of a deaf person.

Specialised mental health services for deaf adults

Transitioning from specialised mental health services for deaf adults back into the community can be difficult, and without the necessary follow-up support, deaf individuals may struggle to navigate hearing services that may not provide the same level of understanding or accessibility. Findings from the feedback received demonstrate that community-based recovery or activity groups frequently struggle to provide interpreters for deaf participants, which creates additional barriers to their participation. Lack of accessible aftercare or follow-up for deaf people departing adult mental health services can lead to an increased risk of relapse, feelings of isolation, limited access to specialised support, and reduced engagement with mental health care providers. Collectively, these obstacles impede the deaf people's access to essential and supportive services, highlighting the imperative need for enhanced deaf mental health care provisions.

It is essential to establish effective aftercare protocols to ensure continued care and support for deaf individuals transitioning out of specialised services.

Aftercare and community services

Deaf forensic mental health services

There is a significant gap in aftercare and community services for deaf people with significant forensic mental health needs. Once a deaf person enters the deaf forensic pathway, gaps often arise in pathway planning and goal setting for their eventual discharge. This can result in prolonged stays and difficulties in transitioning out of the service for deaf patients in secure deaf services who lack a clear discharge plan.

Deaf prisoners receive little support in prison and are very isolated while incarcerated. Upon their release from prison, many of these people are left without the necessary support, leading to a distressing cycle of reimprisonment. This revolving door phenomenon highlights the urgent need for comprehensive and tailored community-based services to address the specific needs of deaf prisoners transitioning back into society. Efforts must be made to bridge this gap and establish effective aftercare provisions to break the cycle and provide deaf people with the support they need to successfully reintegrate into the community.

Steve's Story

Steve was detained at a deaf low secure service and progressed well. When ready for discharge he was placed in a residential care placement for hearing people. No member of staff in the placement could sign or communicate with him. No other resident could sign or communicate with him. Steve became increasingly isolated and his psychosis returned.

While floridly psychotic he committed a further offence and was remanded in custody for over a year, where again he had no one who he could communicate with. Steve was eventually re-admitted to a deaf secure service and has now been discharged to a specialist deaf residential care placement with deaf forensic community aftercare. If he had been placed in appropriate accommodation after his first admission, the second admission would never have been necessary.

This case highlights:

- Deaf specialist aftercare services can reduce instances of relapse and re-offending
- The importance of access to deaf services or communication support in prisons and aftercare placements, to reduce isolation for deaf people with mental health problems.

Lesley's Story

Lesley is a deaf man with drug and alcohol problems. Since being a teenager he has been in trouble with the police and he has spent much of his adult life in prison. He is trapped in a cycle where he is released from prison, drinks to excess, and then re-offends. Lesley has never had support for his drug and alcohol use in prison because the interventions provided have not included any communication support, such as a BSL interpreter. Lesley has spent years watching other prisoners get help for their problems and change their lives, but he has never had this opportunity.

This case highlights:

- Poor use of resources as deaf people may become trapped in the system, unable to engage with the interventions that are provided.
- The importance of the Accessible Information Standard being followed for patients in all settings, including prisons. Information about drug and alcohol problems should have been made available in British Sign Language.

In response

This report has tried to convey deaf people's experiences of mental health support from the perspective of people who are deaf, as the service users, mental health professionals and project facilitators, as well as the concerned wider community of family, carers and friends.

We urge NHS England to respond to address the inequalities by taking action on the recommendations listed. With attention, awareness and leadership, we can together shape the future of deaf mental health in England.

The recommendations and key findings are available to download separately or to watch in BSL from www.signhealth.org.uk

Appendix

Appendix 1

Project Team

The research project was conducted by the NHS Deaf Mental Health Working Group in collaboration with SignHealth. The working group was comprised of a diverse range of mental health professionals, both deaf and hearing, across different NHS England services. Members represent services across National Deaf CAMHS, deaf adult community mental health and deaf adult forensics. A dedicated project team was formed, consisting of two representatives from each service, deaf and hearing to design and address the research questions.

This approach ensured that the input and perspectives of key stakeholders were incorporated while maintaining a manageable and productive group dynamic.

The NHS England representatives were as follows:

Sophie Roberts

Consultant Child and Adolescent Psychiatrist, National Deaf CAMHS (North) and National Deaf Clinical Lead

Alexander Hamilton

Clinical Director, Medium Secure Division, Consultant Forensic Psychiatrist for Deaf people, St Andrew's Northampton

Omar Nasiruddin

Consultant Psychiatrist, South West London and St George's Mental Health NHS Trust

Lenka Novakova

Deaf Advisor - Springfield University Hospital, South West London and St George's Mental Health NHS Trust

Kat Foden

Ward Manager, Deaf Adult Inpatient Service, Bluebell Ward, Springfield University Hospital, South West London and St George's Mental Health NHS Trust

Gillian Jeffrey

Forensic Social Worker, St Marys, Elysium Healthcare

Facilitators

THE DEAF HEALTH CHARITY
SIGNHEALTH

www.signhealth.org.uk

The project was facilitated by SignHealth, the deaf health charity dedicated to enhancing the health and wellbeing of Deaf people through a range of services delivered in British Sign Language. Registered with the CQC, SignHealth delivers social care via community outreach and residential services. SignHealth also delivers Therapies for Deaf People, a NHS talking therapies service (formerly IAPT) for deaf people with anxiety and depression in BSL. Other SignHealth services include advocacy, domestic abuse support, and health related campaigns, policy work and our growing work with children and young people.

Bryony Parkes

Head of Children and Young People Strategy

Bryony managed the Deaf mental health project. She has extensive expertise in working directly with deaf children and young people, as well as managing regulated youth services. Bryony holds an MA in youth work and community development and is Joint Negotiating Committee qualified, actively shaping SignHealth's strategic direction, informed by and for young people.

Abigail Gorman

Policy and Public Affairs Manager

Abigail led the Deaf Mental Health project team and maintained responsibility for collating the information and compiling this report. A member of the World Federation of Deaf People Human Rights Expert Group and a qualified human rights trainer, Abigail's professional research interests often centre around the subject of 'intersectionality'. She holds an MSc in Gender, Sexuality, and Law from Birkbeck University and has over a decade's worth of experience in delivering numerous workshops relating to human rights.

Appendix 2

Report to NHS England on the outcome of a Rapid Review of commissioning arrangements for British Sign Language interpreting services

Full review and recommendations available on the FutureNHS website – registration is required to view.

NHS England commissioned North East Commissioning Support (NECS) consultancy to undertake an independent national Rapid Review of British Sign Language services. Published 21 July 2021.

Specific recommendations

Developing a single ICS system level BSL service

The specific recommendations to be badged as Best Practice are that:

1. R1: A best practice guide is produced by NHS England setting out the issues faced by BSL users and recommending a co-ordinated ICS approach to providing face-to-face and video-relay BSL provision based on clinical need. The co-ordinated service should provide a single point of access and accountability for service users, clinicians and administrators irrespective of which local NHS services they are accessing
2. R2: As part of the best practice guidance, each ICS is encouraged to establish a lived experience panel to support a review of existing BSL services, advocacy arrangements and to undertake an initial Equality Impact Assessment (EIA) to consider the impact of COVID-19 on BSL users in their system. The lived experience panel should play a role in the on-going review and monitoring of improved local BSL provision and undertake future EIA reviews
3. R3: Each ICS is encouraged to agree a system plan to commission co-ordinated BSL services for the populations in their ICS, based on agreed national minimum standards that enables work with local VCS providers
4. R4: Each ICS is encouraged to set out a plan, including provision within their service specifications, to promote and increase awareness across clinicians, managers and administrators.
5. R5: Each ICS is encouraged to establish a BSL advocacy support service to address operational and quality issues on behalf of BSL users
6. R6: A set of best practice case studies are developed to share alongside the ICS guidance to demonstrate the positive impact of bringing services together and of involving service users and the local workforce in the process
7. R7: The best practice should also encourage local work to understand the availability of BSL interpreters within each ICS. Each ICS is encouraged to develop an adequate market for suitably qualified and experienced interpreters and/or to consider an employment model. This work should be based on an understanding of the potential to provide services with the local VCS including consideration of the necessary payment levels to ensure access to high quality interpreter support

Developing the national urgent and emergency 111 BSL interpreter support service
The specific recommendations are that:

8. R8: An enhanced national service is developed for urgent BSL support across England within NHS 111. This would include the BSL interpreter input to the Clinical Assessment Service and provide urgent and emergency BSL support
9. R9: A national group involving ICSs, national charities, 111 BSL leads and BSL users review the existing 111 BSL support service and co-produced revised specification to meet the needs of BSL users. Declarations of interest will need to be recorded
10. R10: The potential volumes of additional activity are modelled by the 111 analytical team. This work would identify the future demand on service provision with additional levels of urgent support
11. R11: A review is undertaken by national 111 commissioning leads as to the best commercial, contractual and procurement route to implement this service enhancement and how any recharge would work
12. R12: NHS England and Improvement and each ICS promotes the availability of the enhanced NHS 111 BSL service to healthcare professionals, managers, administrators, users and relevant stakeholder groups alongside improved local system service provision

Improving quality and education linked to BSL support
The specific recommendations are that:

13. R13: Minimum national standards are applied for the qualification and experience of interpreters across all ICSs and national services
14. R14: National work is undertaken with relevant charities to promote education for BSL users on how to make best use of empowering digital technology and support to successfully access health services including promotional and tutorial videos in BSL
15. R15: The AIS is reviewed and updated to reflect the changes in the system provision supported by a local implementation plan
16. R16: National work is undertaken with clinical professional bodies to promote awareness of the issues and solutions linked to BSL service use
17. R17: National work with the CQC is considered to increase their role in ensuring the needs of BSL service users are included within regulation

Appendix 3

Correspondence

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Claire Murdoch
Director of Mental Health
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12 July 2022

Dear Claire

RE: NHSE's regard for the mental health of Deaf people

SignHealth is very proud to be delivering the IAPT BSL contract which began in November 2021 and is already proving to be very successful. All of us in the Deaf community were overjoyed to see NHS England commission this service as it recognises both the importance of mental health services for Deaf people and that we often need leaders and commissioners to behave differently when considering our needs.

For many years we have been attending the Clinical Reference Group for Deaf mental health, which has most recently been part of the Specialised Mental Health CRG.

We have been advised that, as a result of the clinical leadership review, Deaf mental health is to be classed as a "Respond and Advise" CRG. The communication that was circulated to us as members confirms that CRGs in this category will not hold meetings and that this classification is because "there is no agreed active programme of work for the CRG".

There is a very urgent need for a transformation of Deaf mental health services in this country.

The specially commissioned NHS Deaf Child and Adolescent Mental Health service is currently the only service available to Deaf children and young people, with no lower level mental health service accessible to Deaf people anywhere in England.

The Year 2 report (2021) for the READY study (Recording Emerging Adulthood in Deaf Youth), a prospective longitudinal study of deaf young people in England, Scotland and Wales has found that deaf young people are experiencing significantly poorer mental well-being than their peers in the general population. The READY cohort registers only 3% of high well-being compared to 15% in the general population of the same age. 49% of the cohort have probable or possible depression which is a major cause of concern flagged by the study. Another worrying picture highlighted is that over 40% of participants registered in the two most lonely categories and over 15% had nobody to turn to if they felt depressed, unhappy or lonely.

For the past three years a coalition of charities, private sector organisations and NHS Deaf CAMHS have been trying to engage with NHS England about transforming this provision, most recently through the provider collaborative structure, but we have been unable to make progress. Recently, colleagues from Deaf CAMHS presented a proposal to extend the Deaf CAMHS service to 18-25 year old Deaf people and this received support from the Programme of Care Board yet there is no clarity on how this might actually be progressed or funded.

NHS England's own review of adult secure services in 2019 confirmed that more than 90% of Deaf adults in low and medium secure settings are ready for discharge yet there are no community services being commissioned and therefore nowhere for people to be discharged to.

We have been working with your colleagues on providing access to 24/7 mental health crisis lines. These services are not accessible to Deaf people who use British Sign Language and no consideration has so far been given to ensuring that they are. This is despite BSL access to 999 emergency services having just launched across the UK.

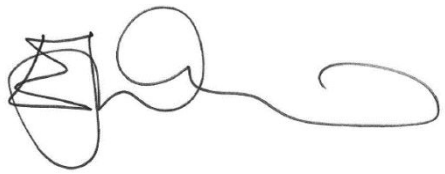
In 2020 NHS England commissioned a rapid review of BSL Interpreting across the NHS and you approved the 17 recommendations made by the review yet none of these has been actioned and there is no action plan in place or process of governance to ensure their implementation. One of these recommendations includes the broadening of BSL access to NHS 111 to ensure that Deaf people can access health provision in a similar way to the BSL Health Access service which SignHealth launched at the start of Covid. That service was forced to close in March 2021 due to a lack of funding, despite receiving 8,000 calls in its final month of operation, and no service has replaced it since.

In the meantime, as Deaf people, we are fighting for our rights and raising the profile of our beautiful community. This year we have won Oscars and BAFTAs and we have finally seen proper recognition of British Sign Language with the passing of the BSL Act.

It has never been more urgent or important that we work together to transform the provision of mental health services for Deaf people. We urge you to reconsider the classification of the Clinical Reference Group and thereby provide the framework for us to move this work forward.

We would welcome the opportunity to discuss this matter further with you.

Regards



James Watson-O'Neill
Chief Executive

Co-signed by:

Dr Sophie Roberts, Consultant Child and Adolescent Psychiatrist, National Deaf CAMHS and Clinical Lead for National Deaf CAMHS

Dr Alex Hamilton, Consultant Forensic Psychiatrist and Clinical Director – Medium Secure Division, St Andrew's Northampton and Clinical Lead for National Deaf Adult Mental Health Services

Issy Belither, Specialist Speech and Language Therapist for National High Secure Deaf Service Rampton Hospital

Dr Steve Carney, Consultant Psychiatrist, National Deaf Mental Health Service, Birmingham

Emmanuel Chan, Clinical Nurse Specialist, Mental Health and Deafness Service, Stockton on Tees

Lucy Gilbert, Team Manager, Deaf Service Nottinghamshire Healthcare NHS Trust

Dr Mary Griggs, Consultant Clinical Psychologist, Specialised Deaf Service, Bristol

Rachael Hayes, Deaf Service Consultant, National Deaf CAMHS

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Catherine Lock, Charge Nurse, Elysium Healthcare

Jason Lowe, Clinical Nurse Practitioner, Rampton Hospital and Deaf Prison in-reach service

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Dr Omar Nasiruddin, Consultant Psychiatrist, National Deaf Mental Health Service, Deaf Adult Community Team, South West London and St George's mental Health NHS Trust

Lenka Novak, Deaf Advisor, South West London and St George's mental Health NHS Trust

Shadreck Seke, Lead Nurse, All Saints Hospital Elysium Healthcare

Heather Thomson, Community Practitioner, Mental Health and Deafness Service, Newcastle

Dr Jo Turner, Deaf Adult Mental Health Service

Dr Rob Turner, Consultant Forensic Psychiatrist, John Denmark Unit

Copied to:

Steve Barclay MP, Secretary of State for Health and Social Care

Wes Streeting MP, Shadow Secretary of State for Health and Social Care

Gillian Keegan MP, Minister of State (Minister for Care and Mental Health)

Rosena Allin-Khan MP, Shadow Minister for Mental Health

Lilian Greenwood MP, Chair of the APPG on Deafness

Rosie Cooper MP

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Dr Bola Owolabi, Director, Health Inequalities, NHS England

Dr Neil Churchill, Director for Experience, Participation and Equalities

Dr Michael Brady, Deputy Director, Patient Equalities, NHS England

Dr Mike Hunter, Chair of Clinical Reference Group for Specialised Mental Health

Marlon Brown, National Lead Commissioner, Specialised Mental Health CRG

To: James Watson O'Neil
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NHS England
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30 November 2022

Dear James,

Thank you for your letter of 12th July about NHS England's regard for the mental health of Deaf people.

We recognise the need to improve access to mental health treatment and support for Deaf people in this country and are delighted to be working with SignHealth on the provision of the first BSL specific IAPT talking therapies service. The opening of this service demonstrates that we can do better for Deaf people and that partnership working with organisations like yours is critical to this ambition.

I understand that over recent months you have met with colleagues in the mental health and specialised commissioning teams in NHS England. The outcome of those meetings has been an agreement that the Deaf MH working group will work to summarise scope of current gaps between demand and provision within mental health services for the Deaf community and a series of options for how we can work together, alongside government, to close that gap over coming years. This work will be all ages and will need to focus on BSL provision in the community required to reduce reliance on inpatient care.

As part of this work we are particularly keen to ensure BSL access to our 24/7 urgent MH helplines. To date we have included a requirement for all lines to make adjustments to support access for Deaf people within the crisis lines quality checklist. In parallel we are working with NHS England colleagues on scoping an enhanced BSL service that will support all onward referrals from NHS 111, including those to urgent 24/7 mental health helplines.

Your letter also raised queries about next steps in terms of implementing the recommendations from the rapid review of BSL interpreting services across the NHS, more widely than just within mental health. The Patient Equalities Team, who are responsible for the review and follow up, have provided the update below:

> NHS England continues to work on implementing the recommendations of the rapid review into BSL interpreting services. In terms of both provision of BSL interpreting services and the work we are doing to review and update the Accessible Information Standard (AIS), we recognise from the 'Sick of It' report, the recent HealthWatch report, work by others and our own consultation and engagement for the review of the AIS that there remain significant challenges in ensuring robust and equitable provision of BSL interpreting services.

The BSL rapid review recommended that an enhanced 111 BSL service be developed, and NHS England continues to work to explore the feasibility of this recommendation. In line with the recommendations in the rapid review related to NHS 111, we convened a workshop of national representatives which included national charities, 111 BSL leads and BSL service users to review the existing 111 BSL support service and worked on developing the specification for an enhanced 111 BSL offer. We also held a number of further meetings to model the potential volumes of additional activity to identify future demand on the enhanced service, to cost the enhanced service and to consider how this might be commissioned.

NHS England has established and is supporting a national network of BSL regional leads to share the outcomes from the BSL rapid review and to support the implementation of the review's recommendations. This group will also support the work of sharing and implementing the updated Accessible Information Standard (AIS) once that is published. We are working to strengthen this network of regional leads in coordinating implementation across Integrated Care Boards (ICBs) and are undertaking a local area mapping exercise of the commissioning and delivery of BSL services to better support local areas to produce their system level plans in line with the recommendations of the BSL rapid review.

Both the work to implement the recommendations of the rapid review of BSL interpreting services and the review of the AIS are being led by NHS England's Patient Equality Team and, if you would like to discuss the implementation of the recommendations of the BSL rapid review, the team would be very happy to meet with you to do this and can be contacted on: england.eandhi@nhs.net

We remain committed to ensuring that NHS England discharges its functions and duties in relation to meeting the needs of Deaf people who are BSL users.

In summary, the decision to reclassify the deaf MH CRG does not mean that we will cease work on improving Deaf MH services. Indeed, as set out above, we are committed to working in partnership with your organisation, and the wider Deaf MH working group on a work plan for improving access and quality.

Yours sincerely,

Claire Murdoch CBE
National Director for Mental Health
NHS England

References

[1] Glickman, N. (2019). Cultural Identity, Deafness, and Mental Health. JADARA, 20(2). Retrieved from https://repository.wcsu.edu/jadara/vol20/iss2/4

[2] Du Feu, M. (2017). Deaf people: What every clinician needs to know. *BJPsych Advances, 23*(2), 89-94. doi:10.1192/apt.bp.116.016154, NHS England – Making health and social care information accessible - https://www.england.nhs.uk/wp-content/uploads/2014/03/access-info-sign-wrkshp-evn-110214.docx

[3] https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/ (Center for Health Care Strategies, n.d.)

[4] https://www.england.nhs.uk/blog/providing-effective-mental-health-services-for-deaf-and-hard-of-hearing-patients/

[5] Kuhl, P., 2011. Early Language Learning and Literacy: Neuroscience Implications for Education. Mind, Brain, and Education, 5(3), pp.128-142.

[6] Hall, W, Levin. L, Anderson. M, 2017, Language deprivation syndrome: a possible neurodevelopmental disorder with sociocultural origins, Social Psychiatry and Psychiatric Epidemiology, volume 52, pg 761–776.

[7] English, T., John, O. P., & Gross, J. J, 2013. Emotion regulation in close relationships. In J. A. Simpson & L. Campbell (Eds.), Oxford library of psychology. The Oxford handbook of close relationships (p. 500–513). Oxford University Press.

[8] Puente. C, Garvi. D, Gómez. L, Álvarez. A., 2019. Emotional Functioning, Positive Relationships, and Language Use in Deaf Adults. Journal of deaf studies and deaf education. 25. 10.1093/deafed/enz034.

[9] Mitchell RE, Karchmer M. Chasing the mythical ten percent: Parental hearing status of deaf and hard of hearing students in the United States. Sign Language Stud. 2004;4(2):138–63.

[10] Wing, J. K. (1988) "Community Care: Agenda for Action. A report to the Secretary of State for Social Services. By Sir Roy Griffiths. London: HMSO. 1988. Pp 28.

[11] Report of the independent inquiry team into the care and treatment of Daniel Joseph - https://www.scie-socialcareonline.org.uk/report-of-the-independent-inquiry-team-into-the-care-and-treatment-of-daniel-joseph/r/a11G00000017vJQIAY

[12] Northern, J.L. and Downs, M.P., 2002. Hearing in children. Lippincott Williams & Wilkins.
Andrews, J.F., 2003. Benefits of an Ed. D. program in deaf education: A survey. American Annals of the Deaf, 148(3), pp.259-266.
Schick, B., Williams, K. and Kupermintz, H., 2006. Look who's being left behind: Educational interpreters and access to education for deaf and hard-of-hearing students. Journal of deaf studies and deaf education, 11(1), pp.3-20
Leigh, I., 2009. A lens on deaf identities. Perspectives on Deafness.

[13] https://www.gov.uk/government/consultations/transforming-children-and-young-peoples-mental-health-provision-a-green-paper

[14] Gentili, N., & Holwell, A. (2011). Mental health in children with severe hearing impairment. Advances in Psychiatric Treatment, 17, 54–62. doi:10.1192/apt.bp.109.006718

[15] https://signhealth.org.uk/wp-content/uploads/2022/02/Review-of-the-NHS-Accessible-Information-Standard-FINAL.pdf

[16] Anderson ML, Wolf Craig KS, Hall WC, Ziedonis DM. A Pilot Study of Deaf Trauma Survivors' Experiences: Early Traumas Unique to Being Deaf in a Hearing World. *J Child Adolesc Trauma*. 2016;9(4):353-358. doi:10.1007/s40653-016-0111-2

[17] Access to Work is a government scheme which can support costs to enable someone to work such as BSL interpreters, lip speakers or notetakers. https://www.gov.uk/access-to-work