1. **About NDCS** - NDCS is the national charity dedicated to creating a world without barriers for deaf children and young people.

1.2 We represent the interests and campaign for the rights of all deaf children and young people from birth until they reach independence.

1.3 In the absence of centrally collected data, we estimate that there are at least 3,000 deaf children in Scotland.

1.4 In this response, we use the term ‘deaf’ to refer to the whole range of childhood hearing loss, including temporary deafness such as glue ear.

1.5 NDCS aims to raise awareness of preventative mental health measures and also to encourage the development of effective services to meet the mental health needs of deaf children, when they arise.

1.6 The Society also aims to promote the positive mental health and wellbeing of deaf children. We have developed a *Healthy Minds* resource which promotes positive emotional health and wellbeing for young deaf people, encouraging them to use positive strategies for managing their deafness and eradicating barriers. Over 5,000 copies are due to be distributed to young deaf people over the age of 10, and we will train and recruit facilitators to work with young deaf people throughout the UK to deliver support around this resource.

1.7 NDCS welcomes the opportunity to submit evidence to the Scottish Parliament Health and Sport Committee on mental health services for young people. Members of the Committee will be aware that we have previously submitted written evidence in June 2008 to support the Committee’s consideration of the issue of access to specialist mental health services for deaf and deafblind people. We were supportive of Public Petition PE808 submitted to the Parliament by the Scottish Council on Deafness in 2007, and shared the concerns contained therein about the lack of access to specialist mental health services for deaf people, and in particular, deaf children and young people.

2. **Deaf Children and Mental Health** - NDCS recognises that deaf children experience a higher risk of psychological, behavioural, and emotional problems, and have conducted research in Northern Ireland which confirms this as being the case.\(^1\)

2.2 It has been estimated that over 40% of deaf children experience mental health problems, compared with 25% of hearing children\(^2\). Environmental factors associated with deafness contribute to the increased risk of mental health needs for deaf children and young people. 90% of deaf children are born to hearing parents who have little or no previous experience of deafness, and this lack of shared experience can often lead to a sense of isolation in adolescence. Deaf children frequently experience unfamiliar language and communication structures, reduced opportunities for fluent two-way interaction, limited access to incidental learning, a partial understanding of what is happening around them, and difficulties in forming and maintaining relationships with others. Research\(^3\) suggests that deaf children have an increased vulnerability to physical, emotional and sexual abuse, as evidenced by a recent high profile prosecution over the sustained sexual abuse of 12 Scottish deaf children\(^4\).

2.3 However, deafness in itself is not a risk factor for increased mental health needs; it is the consequence of being deaf in a hearing-orientated world where the ability to hear is considered a necessity to function in every day life. Many deaf and hard of hearing children and teenagers experience social and cultural isolation because people may not understand their hearing loss and they may find it hard to communicate their frustrations. They also experience difficulties in accessing everyday services such as health, education, work experience and training, arts and culture because of communication barriers. Because they experience barriers to social interaction and services, they are more likely to be isolated from the rest of society, which can have an impact on their mental health and wellbeing.

2.4 Deaf children are particularly vulnerable for a number of reasons - they may lack the communication skills or vocabulary to explain what is happening to them; carers and professionals may not have the communication skills to understand what is being disclosed; they are often exposed to a greater number of carers, in residential schools, transport, respite situations, etc.; and abusers may seek out deaf children because of their perceived and real vulnerability.

3. Specialist Mental Health Services for Deaf Children in Scotland: However, when it comes to deaf and hard of hearing people accessing mental health services for help and support, they continue to experience barriers. According to the BMJ, thousands of profoundly deaf people still struggle to communicate with healthcare professionals on a daily basis, and that as such the “…mental health needs of these people are often undermined.”\(^5\)

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\(^1\) Department of Health (2005) Mental Health and deafness: towards equity and access p.3
\(^4\) http://news.scotsman.com/scotland/Jailed-Sexual-predator-who-stalked.4615305.jsp
3.2 Whilst there has been some research into the unmet need of deaf adults who would benefit from accessing mental health services tailored to accommodate their needs\(^6\), there has been to date no consideration of the level of unmet need for deaf children in Scotland, nor analysis of the ability of deaf children and adolescents to access current provision.

3.3 NDCS Scotland has approached an adult mental health service in Scotland with staff skilled in working with deaf people to establish informally their experiences with Scottish deaf children and adolescents, given in the case studies below.

**CASE STUDY 1**: Client X felt frustrated/angry that her parent didn’t accept her deafness and would refuse to use sign language to communicate but forced her to try to lipread instead. Client X became a bit of rebel towards her parent therefore their relationship became tatters. Other relatives tried to patch up their relationship without any success because they both were stubborn. The client felt that her sibling was treated differently because she is not deaf.

**CASE STUDY 2**: Client Y’s parents had split up when Y was at primary school. Y moved to a different town and had to leave Deaf friends, a parent and grandparents behind. Y felt isolated and without Deaf role models. This contributed to challenging behaviour at secondary school. Staff were concerned that Y had psychological problems, however, diagnosis was difficult due to the lack of staff with BSL skills. Y met with a counsellor (using SSE) for several sessions and started to express feelings, frustrations and fears and recognise that there were other options. Y’s behaviour at school improved and the relationship was restored between Y and the estranged parent.

3.4 Clearly, deaf children in Scotland are experiencing mental health difficulties which have a potentially devastating impact on their adult lives, and placing additional pressure on adult mental health services to provide the specialist services they will need to manage their condition.

3.5 In terms of preventative measures, NDCS believes that increased access to CAMHS and improved strategies for ensuring emotional wellbeing for deaf children in education and social care settings can reduce the risk of exacerbated mental health problems in adulthood. Case Study 2 demonstrates how access to appropriately skilled professionals improves the emotional wellbeing and access to education of just one deaf adolescent.

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\(^6\) RNID Scotland commissioned SAMH to carry out a scoping exercise on *Mental Health Crisis and Deaf People* in 2006. They have subsequently commissioned Glasgow Caledonian University to carry out in-depth research into services for the deaf and hard of hearing, results expected in 2009.
3.6 In terms of unmet need, in relation to the examples given above, NDCS Scotland asked one mental health practitioner operating in this same NHS area about her caseload of deaf children:

**CASE STUDY 3:** “We have seen four under 18s for counselling in the past year…. All of these clients needed specialist communication (BSL, SSE or good deaf awareness) and would have struggled in mainstream counselling services. As our services are "adult" services, we have not promoted to children or adolescent service users so I would think that these four clients represent the very tip of the iceberg.”

3.7 Yet, in Scotland, there are presently no specialist mental health services for deaf adolescents for identification, support, or treatment.

4. Services for Deaf Children in England and Wales: England has a better history of providing specialist CAMHS for deaf children, and may be considered as an example of good practice for Scotland to consider. The first specialist mental health service for deaf children in the UK was established in London in 1991. In 2004, two further services (in the West Midlands and York) were funded to extend access. An innovative aspect of this network was the use of teleconferencing (known as the telelink) to facilitate case management and supervision between services, and to allow, where appropriate, children referred to the West Midlands and York services the opportunity to work with a clinical psychologist based in the London service who was fluent in British Sign Language (BSL).

4.2 NDCS Scotland would like to draw Committee members attention to the fact that to complement the UK Government’s recently completed review of child and adolescent mental health services in England and Wales, the Department for Health also commissioned an independent evaluation of specialist mental health services for deaf children and young people in England and Wales, conducted by the University of York. The resulting report was published in September 2008.

4.3 The report authors interviewed service users, parent and practitioners involved in these services in England, and concluded:

“The findings from this project support the conclusions of previous research that generic CAMHS cannot typically meet the mental health needs of deaf children. It also provides evidence that the current specialist services are effective in working with deaf children with mental health difficulties. The findings support the argument for the need to increase the number of specialist mental health services. The research also identified additional activities that such services...”

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should engage in, including preventive work and skilling up generic practitioners. The presence of deaf staff on the teams was highly valued by the children. The dearth of deaf mental health practitioners has been noted in government reviews of services. Actions to support training in mental health by deaf people are needed to ensure there are, in the future, sufficient numbers of deaf people within the workforce. An innovative aspect of the specialist services was the use of telehealth technology. Findings from the research would support continuing to develop its use within the service. The technology also played a central role in facilitating and enabling service development and staff support. This illustrates the potential of such technology to meet training, supervision and peer support needs in situations where services and/or expertise are rare and scattered.”

4.4 NDCS Scotland understands that this research has enabled the UK Government to commission a ‘hub and spoke’ approach to further developing CAMHS for deaf children in England and Wales, with a main centre in London providing support to others in York, Dudley and an as yet unidentified centre to serve the south west of England. We are aware that a business case is being made for a ‘hub and spoke’ model in Scotland but this is for adults only. While we welcome this development, we would also like to see the Scottish Government look at specialist mental health services for children in Scotland.

5. The way forward for Scotland: NDCS Scotland is working towards a significant diminution in the environmental effects of deafness in order to reduce the incidence of mental health needs amongst deaf children, and will continue in general to promote the emotional, behavioural and psychological well-being of the deaf child and their family.

5.2 However, if statutory services are not equipped to address mental health issues for deaf adolescents, the system will ultimately fail those deaf children who are facing difficulties in achieving emotional well-being, and leave them potentially requiring more acute mental health support in adulthood – of which there is a dearth for deaf adults, as organisations such as SAMH, SCOD, and RNID Scotland have outlined in other submissions to the Committee in June 2008.

5.3 NDCS would recommend further research into current provision and unmet need in relation to deaf children accessing specialist mental health services in Scotland, with a view to moving towards a hub and spoke model of provision, similar to the English example, utilising teelinking where possible, and a greater emphasis on preventative measures facilitated by increased deaf awareness amongst mainstream professionals working with deaf children in health, education and social care settings.

9 An evaluation of specialist mental health services for deaf children; Beresford, Greco, Clarke & Sutherland, University of York, September 2008
5.4 NDCS Scotland believes that basic mental health training should also be offered to those working with deaf children in mainstream health, education, and social care settings to address such issues as early as possible in a deaf child’s life in order to minimise the impact on their progression to adulthood, and enable timely referrals where an issue has developed. NDCS Scotland believes that this training should be developed jointly by CAMH services and those working in the field of childhood deafness.

5.5 This response has been endorsed by RNID Scotland.

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The National Deaf Children’s Society
19 January 2009