

DEAF PSYCHIATRY: A REVIEW OF THE DIFFICULTIES AND THE EFFECT OF AN INQUIRY ON CURRENT PRACTICE

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SUMMARY

Communication is a huge difficulty in researching Deafness in psychiatry and in practically assessing and treating deaf patients. This paper aims to review the difficulties surrounding the assessment and treatment of deaf patients, using a review of the current literature on audio-visual hallucinations as an example. It will also include a summary of the published inquiry into the care and treatment of Daniel Joseph (a profoundly Deaf man), and a review of the Department of Health consultation document and NHS England responses to that inquiry as evidence of why these difficulties have relevance in everyday practice. In structuring the paper in this manner, the author hopes to review the current state of healthcare provided for Deaf individuals within psychiatry, and what still needs to be done.

Key words: Deaf – communication - hallucinations

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INTRODUCTION

The terminology surrounding deafness is widely accepted to fall into two categories: the uppercase “Deaf” and lowercase “deaf”. The lowercase version (“deaf”) refers to individuals who have hearing loss and use oral methods of communication, whereas the uppercase version (“Deaf”) refers to a cultural community that does not view their Deafness as a disability and uses sign language as their primary method of communication. This paper is focused on the mental health of the latter group.

The biggest problem facing the assessment of the mental health of Deaf patients arises because of the communication barriers in place. Not only is there a different language being used by the patient, but there may also be the issue of language dysfluency – a lack of proficiency in any particular language, primarily due to early language deprivation (Angelmyer 2018). There is also a lack of appropriate assessment tools tailored specifically to deaf patients (Ram 2015). This extends to the treatment for deaf patients due to the lack of evidence based psychotherapy available. One aspect of communication barriers includes the difficulty of assessing acute psychosis, which will be explored in the form of a literature review of audio-visual hallucinations as a specific example in Deaf patients. The ramifications of these difficulties in practice will be addressed through an overview of the Daniel Joseph inquiry (Merton Sutton and Wandsworth Health Authority and Lambeth Southwark & Lewisham Health Authority, 2000), and the Department of Health’s consultation document (Britain 2002) and NHS England response (Department of Health 2005) to that inquiry.

EXAMPLES FROM THE LITERATURE

When searching for literature concerning the assessment of hallucinations in Deaf individuals, there was little distinction found between the uppercase “Deaf” and the lowercase “deaf”; instead there seemed to be a split between congenitally deaf patients and those whose deafness arose later in life. In congenitally deaf patients with psychosis, auditory hallucinations presented as common phenomena (du Feu 1999) that seem to lack the auditory properties that hearing patients may be able to describe e.g. loudness, pitch and intonation. However, gender and identity were able to be distinguished (Bellugi 1975, cited in Perrone-Bertolotti 2014). In some cases, the voice hallucination may actually present as signed or lip read communication, or through somatic perceptions such as vibrations felt in certain positions within the body (Atkinson 2006). The range of modalities in which these hallucinations may be felt highlights the difficulties in thoroughly assessing the presence of ‘voices’ in their full range of presentations. It has been suggested that there are methodological shortcomings in the linguistically appropriate assessment of hallucinations in deaf patients for reasons such as the use of interview tools developed for hearing people and that there is a lack of control for degree of hearing loss, preferred communication mode and language fluency levels (Landsberger 2011, Atkinson 2006).

The reason why these difficulties are relevant in clinical practice is succinctly summarised by Glickman in his review of problems in the assessment of mental status in Deaf persons (Glickman 2007). He describes how in the mental state examination, clinicians look for evidence of abnormalities of language that may indicate

thought disorder, but that this is made more problematic because making sense of language patterns in prelingually deaf patients who do not receive adequate exposure to sign language is challenging. It is very difficult to determine whether language problems are due to mental illness, language deprivation, both, or other factors. In a case study, Glickman outlines how even with a proficient interpreter, understanding such patients can be extremely difficult.

Glickman also weighs in on the nature of auditory hallucinations in deaf patients. Although many deaf individuals may not be able to understand speech, they may hear that speech is occurring (Glickman 2007). This is even more true of individuals who use devices such as cochlear implants. This residual hearing may allow some deaf people to form representations of the auditory consequences of articulation, which may then be misattributed to voice-hallucinations (Atkinson 2006) with uncertainty about mode of perception (Atkinson 2007). The idea of subvocal articulation/inner speech being the root of deaf hallucinations has since been further developed by Perrone-Bertolotti et al., who also raised the issue that within research, questionnaires studying hallucinations in deaf people need to be designed to avoid audiocentric biases (Perrone-Bertolotti 2014). Throughout the literature, there is the recurring motif that identification and characterisation of auditory hallucinations in deaf individuals is extremely challenging, especially in a healthcare system that is tailored to the hearing population. It is therefore unsurprising that Daniel Joseph's case arose, greatly impacting the perception of Deaf services in the UK.

THE INQUIRY AND ITS INFLUENCES

It is usual in the UK health system that, when serious incidents occur, an inquiry is held, so that its findings become the evidence base for development of mental health policy in order that the risks identified can be minimised in future. One such published inquiry concerns the serious incident in which Daniel Joseph was involved.

Daniel Joseph is a profoundly Deaf man with severe mental illness who was found guilty of manslaughter of his landlady on the grounds of diminished responsibility in 1998. His case led to an inquiry into the care provided for Deaf individuals in the UK, which found there was a range of incidents leading to the index offence that demonstrated the lack of coordination between services (Merton Sutton and Wandsworth Health Authority and Lambeth Southwark & Lewisham Health Authority 2000). The inquiry panel recognised many points of improvement that largely hinged on a need for greater coordination between Deaf services and a clear, regularly updated list of specialist services available to all clinicians. This was due to one of the factors hindering Daniel's treatment being confusion over what services the National Deaf Service offered,

with many other teams expecting them to deliver the equivalent of a community child and adolescent mental health service for Deaf patients. They additionally identified the need for a better educational network for Deaf children, better multidisciplinary working, and the need to develop emergency assessments of mental health in the community, with a greater capacity within forensic placements for suitable individuals. In the case of serious incidents, the inquiry panel highlighted the importance for all staff involved to undergo a review but also have external support available and be encouraged to use reflective practice in a 'no blame' environment. This need for reflection has continued to be relevant in healthcare and triggered the development of subsequent government reviews.

'A Sign of the Times' (Britain 2002) is a Department of Health consultation document produced in part as a response to the Daniel Joseph case. In this consultation document the difficulty of Deaf patients presenting to a mental health service that is primary organised on the basis of hearing patients was highlighted. The seven mental health standards set out by National Service Framework for Mental Health were reviewed and the challenges faced in delivering those standards for Deaf individuals were identified. It was suggested that one of the existing challenges in current Deaf services is the resource intensity needed for multiple agencies across the UK to liaise with each other. The difficulty in developing an organised network of new services was also emphasised. This was due to units arising largely due to the passion and dedication of individuals in geographically scattered areas rather than a national approach. This increased the personal inconvenience and travel costs for Deaf individuals. One of the largest areas of deficit in Deaf services was (and is) psychiatric intensive care, which current services are not commissioned to provide. Another issue raised is the difficulty Deaf patients have in accessing a number of mainstream services e.g. recognition of mental health problems in primary care, counselling post diagnosis of cancer and legal information leaflets. There is even less access for assessment and treatment of Deaf individuals in prisons. 'A Sign of the Times' additionally emphasised the need for more BSL interpreters if mental health promotion initiatives are to be delivered, and it was suggested that there was need for greater employment of Deaf people in health and social care, and increased training of specialist staff.

The NHS England document titled 'Mental Health and Deafness' (Department of Health 2005) provides best practice guidance for the treatment of Deaf patients with mental health needs which is built on 'A Sign of the Times' and the Daniel Joseph inquiry. Its recommendations echoed much of those presented by 'A Sign of the Times' with an additional breakdown of the specific services that could benefit from enhancement. For example, it recommended the increased integration of communication technology into primary and secondary

care, e.g. email and minicoms, and the current SIGN (a charity) development of a program that translates questions and advice into BSL. It also suggested the possibility of Gateway Workers for directing Deaf individuals to the relevant mental health services and piloting of Health Living Centres that act as a “one-stop shop” for healthcare for Deaf patients. A greater use of specialist community practice nurses could enhance local services. Specialist advice should also be sought when performing prison inreach for Deaf patients.

DISCUSSION

The inquiry and subsequent responses have identified the most important problems within the Deaf services currently available and suggested some potential interventions. However, the scattered nature of the services and their limited availability not only increases the personal inconvenience and the travel costs of the Deaf patients, as suggested by ‘A Sign of the Times’ (Britain 2002), but it also does the same for professionals carrying out assessments of Deaf patients, thereby increasing the time it takes for patients to be assessed and treated. The issue of succession planning is also mentioned by ‘A Sign of the Times’ (Britain 2002) and is still very relevant, in that, particularly for specialist consultant psychiatrists, there is very limited recruitment of new trainees who may be able to sustain a service. This not only contributes to the paucity of resources but also to a stagnation in the quality of Deaf services available since ‘something is better than nothing’.

While the recommendations may address the current deficits in mental health services, they do little to suggest how the scattered range of specialist services might be unified into a coherent national network that is self-sustainable. In the current economic climate, the NHS is under strain and so a delayed development of services is understandable, but further investigation of whether these suggestions have been implemented needs to be carried out. There needs to be a push towards greater Deaf awareness and training for healthcare staff, and a greater number of interpreters because communication is so important in all aspects of mental health.

CONCLUSION

So what now?

Communication underpins all aspects of healthcare, ranging from public health awareness of Deafness, to the practicalities of assessment, treatment and management options available for Deaf patients. ‘A Sign of the Times’ (Britain 2002) quotes the following statistics:

“The Royal National Institute for Deaf People estimate that there are over eight million people in the UK with hearing loss, most often associated with

ageing and that the first and preferred language of over approximately 75,000 Deaf people in Britain is British Sign Language (BSL).”

If Deaf people are not considered as a percentage of the British population but as individuals who can benefit from the presence of a robust mental health system that can deliver the expected standard of care, then the evidence bases and the healthcare protocols need to be expanded to adequately meet those needs. The current literature provides evidence for the difficulties in assessing Deaf patients in a common presentation of psychosis, and the Daniel Joseph inquiry provides evidence for the need to overcome those difficulties. These challenges exist in Deaf psychiatry but also outside of that specialty, with many of the same themes echoed in treating patients in an ever more multi-cultural environment. While it may be unrealistic to meet many of the recommendations made by the referenced documents immediately, there at least needs to be a “tried and tested” protocol for accessing the appropriate Deaf services when necessary in order to ensure the best possible healthcare for those patients.

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