

See it through deaf eyes:

# Healthy Deaf Minds

Final Report on Deaf Children Australia's  
National Tour on the emotional and social  
wellbeing of deaf Australians.

**4 October - 9 November 2010**



Deaf Children  
Australia



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## **EXECUTIVE SUMMARY**

Following the successful hosting of the 4<sup>th</sup> World Congress on Mental Health and Deafness in Brisbane in October 2009, Deaf Children Australia was able to negotiate the availability of three leading experts in the field of mental health and deafness to undertake a national tour of Australia from October 4 to November 9, 2010.

Dr Margaret Du Feu, a profoundly deaf person and leading psychiatrist from Ireland and keynote speaker from the 4<sup>th</sup> World Congress, together with her colleague, Joyce Pennington, a clinical nurse specialist in mental health and deafness from the North East of England, conducted professional workshops and community forums across the country. Their objective was to continue to raise awareness within the mental health profession and Deaf community of the issues confronting deaf people with mental health and wellbeing concerns. Joyce Pennington left the Tour in Perth and Dr Margaret Du Feu was then joined by Stephen Browne, a highly qualified clinical nurse in mental health and deafness in the United Kingdom.

These three international guests generously donated their time to Deaf Children Australia's Healthy Deaf Minds Tour at no charge. In return for this generous gesture, we provided a tour of Australia, which included weekends in Kakadu National Park, Sydney and the Margaret River region of Western Australia, as well as a day at Melbourne's world famous Spring Racing Carnival.

Major sponsorship by the Queensland Department of Health, Mental Health Division and the encouragement of Dr Aaron Groves, Director of the Division and his senior executive team, were pivotal in securing commitment for the undertaking. The support of the Northern Territory and South Australian Directors of Mental Health and the WA Mental Health Commission, and co-sponsorships by three universities and six deaf sector organisations, as well as three mental health organisations, made it possible to tour most states of Australia.

A total of 25 events were held throughout Australia and four in New Zealand. These included two Parliamentary receptions, four meetings with Directors of Mental Health and Ministerial staff, 13 professional development workshops and nine community forums.

Events were held in six capital cities and five regional centres. In excess of 650 people participated in the Tour events.

The key finding of the Tour underlined the enormous challenges confronting Australia, which has a geographically dispersed deaf population comparable to similar population cohorts in the United Kingdom, which demand specialist services. Apart from the program sponsored by Queensland Health and generally known as the Princess Alexandra Hospital's Deafness and Mental Health Services, such specialist services are non-existent in Australia. No identifiable data concerning deaf people's access to mental health services are currently collected in Australia.

The establishment of a National Strategy for Research and Information on Mental Health and Deafness would provide leadership, resources and expertise to more effectively address the community awareness, knowledge and service gaps identified in the course of the Healthy Deaf Minds Tour.

## **BACKGROUND TO THE TOUR**

The hosting of the 4<sup>th</sup> World Congress on Mental Health and Deafness in October 2009 was the first such event in Australia. Deaf Children Australia and its co-host Deaf Services Queensland envisioned the Congress as an opportunity to raise awareness within the mental health sector of the prevalence and needs of deaf people, and to commence the process of open discussions within the deaf sector of the topic of mental health and wellbeing for deaf Australians.

In the 18 months leading to the event, a series of pre-conference workshops were conducted around Australia with members of the Deaf community to raise awareness of mental health and wellbeing among deaf people. These events attracted some 300 members of the community who attended a total of 13 events.

A National Reference Group was established to provide advice in the build-up to the Congress. Further, a national Consensus Statement (see Appendix 1) was developed, which called for the establishment of a National Strategy for Research and Information on Mental Health and Deafness - a centre of excellence. This Consensus Statement was endorsed by professionals and services across the spectrum of deaf services in Australia.

The Congress itself attracted some 320 participants predominantly from the deaf sector, as well as a good representation of health and education professionals. It was clearly evident that there was a low level of awareness of mental health issues for deaf people in the Australian mental health sector.

A significant contribution was made by one of the Congress keynote speakers, Dr Margaret Du Feu, a profoundly deaf psychiatrist who had herself been directly involved with establishing three specialist mental health services for deaf people in the United Kingdom. Dr Du Feu's experience of an acquired deafness leading to profound deafness during her medical training, her professional practice over some thirty years, her keen advocacy on behalf of deaf people and knowledge of the sector, as well as her pending 'retirement', led to an invitation to return to Australia to continue the work of raising awareness of the mental health needs of deaf people.

With the acceptance of this invitation, a tour extending over a period of some six weeks was negotiated to commence in October of 2010. The aims of the tour were to provide expert consultancy with regard to best practice in mental health service delivery for deaf people within the Australian context; to raise the profile of this issue with the Directors of Mental Health and mental health providers in Australia; and to visit the regional areas of Australia and as many States as possible in order to gain a comprehensive understanding of the challenges and opportunities.

Currently, the Princess Alexandra Deafness and Mental Health Service program in Queensland is the only dedicated mental health service in Australia for deaf people. In the lead up to the Congress efforts were made to inform the Directors of Mental Health around Australia and across the sector in general of the issues faced by deaf people in accessing mental health services.

In the United Kingdom, several specialist mental health services for deaf people have been established in response to the needs of the community. Typically, these services are located within mainstream mental health service providers and are funded to provide a range of services including health maintenance and support, community outreach clinical services and in-patient care.

Deaf Children Australia is a national leader in the area of welfare and advocacy on behalf of deaf children, young people and their families. Deaf children have a much higher propensity or likelihood of encountering mental health and wellbeing issues throughout their lives. As an organisation we are committed to achieving the best possible early intervention and most effective approaches to positive wellbeing. Equally, we are committed to developing a community that is more accessible and supportive of those young people as they mature into adult life.

### **THE HEALTHY DEAF MINDS TOUR**

In March 2010, Deaf Children Australia recruited a part-time project coordinator to commence the process of establishing a national program to engage partners within the deaf and mental health sectors. As a result of the enthusiasm for the proposed venture, a total of 25 events were developed and held across Australia in all States and Territories with the exception of the ACT and Tasmania. The events took the form of community forums, organisational visits and professional development workshops.

The Tour would not have been possible without the generous support of the international visitors who donated their time at no cost. The major sponsorship by Queensland Health, Mental Health Division, as well as the support of the Deaf Societies and other organisations in each State (who assisted with costs and also provision of access for deaf people) contributed to the overall success of the Tour.

The difficulty of co-ordinating such a large series of events unfortunately led to delays in marketing, which no doubt influenced the attendance levels of mental health sector professionals in several States. A major aim of the Tour was to increase the interest and knowledge of mainstream mental health sector professionals. While specific data were not collected, the majority of those who attended the professional workshops were deaf sector professionals rather than those from mainstream mental health services.

### **Structure of Forums and Workshops**

The community forums were structured to provide introductory materials by way of case studies and the sharing of experiences of the challenges of establishing mental health services for deaf people. This was followed by open discussion with members of the community with a view to providing opportunities for people to share their own experiences of mental health and wellbeing within the Deaf community in the Australian context. The professional development workshops, in addition to case studies and the sharing of professional experience, provided more information concerning the vulnerability to mental health issues among the deaf population.

Background knowledge that helped to inform the development of both the professional development workshops and the community forums included the following:

- At least one in seven of the Australian population has some hearing loss, the proportion rises with age.
- About one in 1,000 people are profoundly deaf from early life.
- Approximately 90 per cent of deaf people are born into hearing families.
- The causes of early profound deafness are 50 per cent genetic, mainly recessive, and 50 per cent non genetic with the main causes being rubella, meningitis, birth problems etc.
- There is an increased prevalence of mental health problems among the deaf population with the risks factors including neurological risk, childhood risk factors, social exclusion and delayed access to services.
- Lack of early diagnosis of deafness increases the risk of delays in language development in deaf children.
- Failure to provide parents with clear information to enable them to make informed choices and access appropriate services may delay intervention and impact on children's language development.
- Persistent confusion and controversy concerning oral methods and sign language has led to children's failure to develop a first language competence and resulted in preventable psychological and emotional problems.
- Known childhood risk factors including low self esteem, inconsistent discipline, rejecting relationships, low academic achievement, developmental delay and abuse (emotional, physical and sexual) can impact more heavily on deaf children.
- Deaf people and their families may not present to services. Mainstream services can find it difficult to access deaf people and generally are not equipped to treat deaf people with mental health problems.
- Many mental health problems stem from childhood experiences; positive mental health promotion for deaf young people is a priority.
- In the United Kingdom, specialist mental health services for deaf people have taken from five to fifteen years to develop and establish.
- In the United Kingdom, a tragic murder which drew attention to a lack of community based support and transition triggered the development of services with an interface between mainstream and specialist deaf mental health services.
- It takes considerable time to build a client base once a specialist mental health service is established because of the reluctance or lack of awareness within the community and the dispersed deaf population.

### International Comparison - how different is Australia?

Based on the discussions held across Australia, the international experts concluded that there appeared to be a great deal in common with the United Kingdom's experience of profoundly deaf people and their mental health and wellbeing.

However, they noted two key differences: the enormous challenge of geographical distance in the Australian context; as well as the high incidence of hearing loss within the Australian Indigenous population, especially in remote parts of the nation.

To appreciate the challenge posed by Australia's dispersed population across significant geographic distances, Dr Margaret Du Feu drew comparison with the Midlands Mental

Health Service for Deaf People based in Birmingham in the United Kingdom, which serves a population of approximately 18.5 million people, but with an area covering approximately one-third of England. This service had developed a program for deaf people, which included 12 beds and outreach services, with a total staff in the order of 40. A large number of the staff in this team were deaf people, many of whom were initially untrained but subsequently qualified as mental health professionals.

Given the differing population distribution, such a concentrated centre within Australia would be inappropriate. Thus, the challenge seems to be the development of a specialist centre of knowledge that could provide expertise, training and support to mental health professionals within existing mainstream service providers.

As the Tour included discussions in the Northern Territory, it was noted with much concern that the incidence of hearing loss in Indigenous children can be as high as 80-90 per cent of sampled populations. Underlined was the need to better address the social-emotional wellbeing of these children.

## **PARTICIPANT FEEDBACK**

The evaluation of the participants' surveys confirms that the Healthy Deaf Minds Tour was very well received throughout Australia. The attached Report (Appendix 5) concludes:

*The Healthy Deaf Minds Tour was enthusiastically received throughout Australia. The responses were overwhelmingly positive. Margaret and Joyce were viewed as informative, interesting and engaging presenters. While there were many suggestions for improvement, the Tour has likely set a precedent in Australia. Raising awareness has perhaps been the most obvious achievement of the Tour. It is clear that mental health for people who are deaf is an important topic across a range of Australian deafness-related professionals. Many expressed a desire to act on the ideas represented to them, to take action towards improving the mental health of people who are deaf. Sixty participants also provided their contact details. This suggests a desire to continue contact into the future and maybe develop further initiatives in Australia. Moreover, the issue of mental health in people who are deaf appears to be equally applicable across the countries of Northern Ireland, the Republic of Ireland, and England as they are across the diverse states of Australia.*

While the 128 survey responses represent less than 20 per cent of those involved, they do give a good indication of the overall impact of the Tour. Conducting the professional development workshops presented the challenge of allowing sufficient time to present detailed information to a wide audience, some of whom had little or no experience, while also providing for others who sought a more interactive discussion regarding practice and wished to share their own experiences.

The community forums were deeply engaging on occasions when deaf people chose to delve into their own personal experiences of treatment as deaf people. Consistent themes included:

- schooling experiences, and in particular being “forced” to undergo learning through “oral” methods where no signing was permitted.
- personal experiences or those of family/friends who had experienced, first hand, mental health services which were not deaf-friendly.
- family isolation.
- poor levels of service experienced by deaf people, particularly in regional areas.
- an overwhelming gratitude to the presenters and organisers for including regional Australia in the Tour.



## **FINANCES**

The total cost of the Healthy Deaf Minds Tour was **\$38,632.83**

		\$
<b>Income</b>		
	Queensland Health, Mental Health	8,181.82
	Deaf Services Queensland	909.09
	Queensland University of Technology	909.09
	Department of Health & Families	1,818.18
	Continuing Professional Education	909.09
	Deaf Can Do	909.09
	WA DEAF SOCIETY Inc.	909.09
	VICDEAF	909.09
	Mental Health Commission	1,818.18
	Deaf Aotearoa	2,272.73
	Other Contributions	7,686.33
		<b>27,231.78</b>
<b>Expenditure</b>		
	Airfares and Accommodation expenses	22,691.89
	Meals and incidental expenses	273.50
	Interpreting costs	3,541.60
	Venue Hire	1,738.18
	Posters/Fliers	280.00
	Taxi Fares	323.91
	Project Salaries	9,783.75
		<b>38,632.83</b>
<b>Net DCA Investment</b>		<b>(\$11,401.05)</b>

## **ACKNOWLEDGEMENTS AND APPRECIATION**

Deaf Children Australia wishes to thank the major sponsor, the Queensland Government through Queensland Health, Mental Health Division. In addition we would like to recognise the following co-sponsors and partners:

- Deaf Services Queensland
- Queensland University of Technology
- the Northern Territory Government
- the Royal Institute for Deaf and Blind Children and Renwick College (NSW)
- VicDeaf
- Mental Health Foundation of Australia (Victoria)
- Deaf Can Do (South Australia)
- WA Mental Health Commission
- WA Deaf Society
- Deaf Aotearoa New Zealand
- University of Otago

The event would not have been possible without the generous gift of time from our international experts, Dr Margaret Du Feu, Joyce Pennington and Steven Browne. We are truly indebted to each of them.

At Deaf Children Australia, we wish to acknowledge the tremendous work of the project co-ordinator, Karyn Barrasso, and that of the members of the Marketing and Communications team and our communications consultancy, *10 Feet Tall*.

In addition, the excellent administrative support provided by those behind the scenes, including Karen Grey, Executive Assistant to the CEO, valuably contributed to the success of the Tour.

Finally, we wish to express our appreciation to all who attended the events around Australia, thereby lending support to the Tour's ultimate goal of achieving better mental health and wellbeing for deaf Australians.

## **RECOMMENDATIONS**

A review of the Tour concluded that the prevalence of mental health issues within the Deaf community of Australia was clearly comparable to that of the United Kingdom's experience.

In consideration of the challenge of the spread of the deaf population in Australia, the core recommendation was the establishment of a National Strategy for Research and Information on Mental Health and Deafness, an action recommended in the national Consensus Statement (see Appendix 1).

From the core recommendation flow further recommendations, many of which could be achieved through or in conjunction with the establishment of a National Strategy for Research and Information on Mental Health and Deafness.

The recommendations are as follows:

## **RECOMMENDATION ONE: National Strategy**

### **1.1 National Strategy for Research and Information on Mental Health and Deafness**

It is recommended that the deaf sector in Australia continue to lobby for the establishment of a National Strategy for Research and Information on Mental Health and Deafness.

This National Strategy to address, oversee and support the following areas, as appropriate:

#### **1.2 Responsibility for mental health services to deaf people**

Mental health services for deaf people should be integrated with mainstream mental health services. Governments and Directors of mental health services should be responsible for ensuring deaf people's access to both services and preventative programs.

#### **1.3 Health professional training and development**

Maintaining and expanding the professional development and training of health professionals is a priority. In addition to mental health workers, it is also essential that other community health care providers such as GPs receive deafness awareness training. In particular, GPs are front line primary health care providers and as such most likely to undertake the initial medical consultations with deaf people presenting with mental health concerns. It is therefore important that GPs are equipped to properly assess deaf people to ensure that their mental health issues are not obscured by their deafness.

#### **1.4 Professional networks**

Stemming from the World Congress of 2009, the Australian Psychological Society (APS) has established a Deafness Interest Group consisting of some 40 or more members. The Australian deaf sector needs to support this interest group to encourage the development and sharing of knowledge and skills across the mental health and counselling professions.

#### **1.5 Deaf participation in service delivery and development**

Participation of appropriately qualified deaf people in service delivery would strengthen deafness awareness and facilitate informed policy and planning with regard to mental

health service provision for deaf people. In addition, consultation with deaf consumers would assist with identifying barriers to access.

## **1.6 Wellbeing of Indigenous children with hearing loss**

It is recommended that Deaf Children Australia establishes a multidisciplinary professional group to investigate ways of better addressing the social-emotional wellbeing of Indigenous children with hearing loss.

## **RECOMMENDATION TWO: Prevention and early intervention**

### **2.1 Specialist counselling service**

From a public health perspective, the most socially beneficial and cost effective way to promote mental health fitness is through prevention and early intervention. Fostering protective factors in childhood and adolescence, such as positive family relationships and self esteem, resilience and self-reliance promoting experiences and interpersonal communication skills can help support social-emotional health and wellbeing across the lifespan. The challenges of deafness can increase the vulnerability of deaf children and young people to social-emotional issues which, without timely intervention, may contribute to the development of mental health disorders. The provision of specialised counselling services which support deaf children, young people and their families to better manage and resolve social-emotional and relationship difficulties as they arise would potentially reduce the prevalence of mental health issues in the Deaf community.

**It is recommended that Deaf Children Australia undertakes a feasibility study concerning the establishment of a nationally co-ordinated counselling and information service for deaf children, young people and their families.**

### **2.2 Safe program**

Deaf Children Australia has obtained the licence to adapt the UK Safe Program (personal safety skills for deaf children) to the Australian context. This resource features an interactive DVD-ROM and equips deaf primary and secondary children with the knowledge and skills to safely and positively participate in the wider community, thereby reducing risks such as social isolation and abuse, which can contribute to the onset of mental health problems.

**It is recommended that Deaf Children Australia urgently seeks sponsors to ensure that this innovative, preventative personal safety program is made available as soon as possible to schools and health professionals across the country.**

### **2.3 Healthy Deaf Minds**

Through the Healthy Deaf Minds Tour, Deaf Children Australia provided the Deaf community with significant opportunities for preventative mental health education. Deaf Children Australia is well situated to undertake further initiatives to promote mental health awareness and social-emotional wellbeing among deaf people.

**It is recommended that Deaf Children Australia, in collaboration with Directors of Mental Health and the deaf sector, builds on the recognition achieved as a result of the Tour and thus considers annual campaigns under the banner of Healthy Deaf Minds.**

### **RECOMMENDATION THREE**

#### **3.1 Audit and service mapping**

The deaf sector must continue to map deaf and deaf-friendly services, resources and professionals throughout Australia and disseminate this information amongst the Deaf community in order to promote better access and utilisation of services. To complete this mapping, an audit incorporating a review of deaf accessibility in terms of technical equipment, deafness awareness training and the collection of Deaf community utilisation data is needed. This exercise would have the additional benefit of raising the deafness mental health agenda among mainstream service providers.

**It is recommended that the Australian Federation of Deaf Societies and the APS Deafness Interest Group be invited to undertake the lead role in this systematic audit and mapping of mental health services across Australia, and to seek funding accordingly for this endeavour.**

### **RECOMMENDATION FOUR**

#### **4.1 Auslan interpreting services to mental health sector**

Further work is needed to ascertain the training needs of Auslan interpreters to Mental Health Services both to improve access to interpreters and to ensure that they are appropriately trained for the mental health setting.

**It is recommended that the Australian Federation of Deaf Societies, the Australian Sign Language Interpreters Association and the APS Deafness Interest Group be invited to establish a joint working group to investigate and address the issues of provision and access to training for interpreters.**

## APPENDIX 1

### Consensus Statement on Mental Health and Deafness

**800,000 deaf and hard of hearing Australians also experience mental health problems at some time.**

- Fact:** 1 in 6 Australians currently suffer from hearing loss, a rate that is predicted to increase to 1 in every 4 Australians by 2050 (*Access Economics Report- Listen Hear! The economic impact and cost of hearing loss in Australia, 2006 p. 5*)
- Fact:** 1 in 5 Australians will experience a mental illness at some time in their life, a quarter of whom will receive treatment. (*Mental Health Foundation of Australia (Victoria), Depression Fact Sheet*)
- Fact:** Hearing loss is the second most prevalent national health issue, yet it remains the 8<sup>th</sup> national funding priority. (*Access Economics Report- Listen Hear! The economic impact and cost of hearing loss in Australia 2006 p.38, p.48*)
- Fact:** There is only 1 dedicated mental health service in Australia which responds specifically to the needs of deaf and hard of hearing people. That service is located in Brisbane and is staffed by 2.1 FTE workers. (*Briffa, D Clinical Specialist, State-wide Service for People who are Deaf or Hearing Impaired, A Centre of Excellence, Princess Alexandra Hospital Deafness and Mental Health Service Brisbane, 2007*)

### Situation analysis

Deaf and hard of hearing people experience increased risks of mental health problems because:

- they experience increased social isolation and emotional vulnerability, leading to higher risk of abuse;
- they face linguistic and cultural barriers to access and participate in existing mental health services and programs;
- there is a lack of knowledge within the mental health sector of deaf specific considerations; and  
a lack of knowledge and acceptance of mental health issues within the deaf sector, communities and individuals.

### What can be done?

1. Improve the quality of life for deaf and hard of hearing individuals with mental health problems, promoting protective factors and a focus on early support systems.
2. Increase awareness of mental health issues of deaf and hard of hearing Australians within the broader community and within the mental health and deafness sectors.
3. Build accessible and responsive service systems, which draw on the strengths of the specialist deafness sector and the wider mental health sector.

## **Action Required**

We need a commitment from Government to:

1. Actively support the 4<sup>th</sup> World Congress on Mental Health and Deafness, '*A Life to be Lived*', Brisbane 27-30 October 2009, where we will promote awareness of the mental health issues faced by deaf and hard of hearing people in Australia and lead a collaborative movement that brings together both the deafness and mental health sectors internationally.
2. Support the establishment of a National Strategy for Research and Information on Mental Health and Deafness

## APPENDIX 2

### HEALTHY DEAF MINDS TOUR – 2010 Calendar of Events

<u>LOCATION</u>	<u>DATE</u>	<u>EVENT</u>
<b>BRISBANE</b>	4.10.10	Meeting with PA staff
	4.10.10	Civic function
	5.10.10	Deafness Symposium
	5.10.10	Community Forum
	6.10.10	QUT PD Workshop
<b>TOWNSVILLE</b>	6.10.10	Community forum
<b>CAIRNS</b>	7.10.10	Community Forum
	8.10.10	Deaf Mental Health Symposium
<b>DARWIN</b>	11.10.10	PD Workshop
	11.10.10	Civic Reception/Parliamentary welcome
	11.10.10	Consumer and Carer Forum
<b>ALICE SPRINGS</b>	12.10.10	Healthy Deaf Minds Forum
<b>SYDNEY</b>	14.10.10	RIDBC PD Session
<b>ADELAIDE</b>	21.10.10	Meeting with Dr Honeyman
	21.10.10	PD Workshop
	21.10.10	Healthy Deaf Minds Symposium & Community forum
<b>PERTH</b>	22.10.10	WADS AGM/Civic Reception
	25.10.10	PD Seminar
	26.10.10	Meeting with Minister for Mental Health
	26.10.10	Community Forum
<b>MELBOURNE</b>	18.10.10	Interpreters Forum
	19.10.10	DCA Staff forum
	19.10.10	PD Workshop (Mental Health)
	8.11.10	Community Forum (VicDeaf
	9.11.10	DCA AGM
<b>CHRISTCHURCH</b>	15.11.10	PD Workshop
		Community Forum
<b>WELLINGTON</b>	16.11.10	PD Workshop
		Community Forum
<b>AUCKLAND</b>	17.11.10	PD Workshop
		Community Forum



See it through deaf eyes:

# Healthy Deaf Minds

A National Tour and Community Forums about the emotional and social wellbeing of the deaf,  
**4 October - 9 November 2010.**

**Brought to you by Deaf Children Australia**

More must be done on emotional and social wellbeing of the deaf in Australia. Let's keep talking!

**An open forum to speak your mind and share with international experts:**

**Dr Margaret du Feu, a leading Deaf Psychiatrist from Ireland (a keynote speaker at the 4th World Congress on Mental Health and Deafness, Brisbane 2009) returns for this important agenda.**

**Also featuring: Joyce Pennington, Clinical Nurse Specialist, Mental Health and Deafness North-East England.**

The most comprehensive opportunity of the year to better understand emotional and social wellbeing issues of Deaf and hard of hearing Australians.

**Mental Health & keeping your mind healthy**

**Date: Wednesday 6 October 2010**

**Time: 6.30pm to 8.30pm**

**Venue: Cootharinga North Queensland**

**Address: 20 Keane Street, Currajong**

**Reserve your place now** at a Healthy Deaf Minds workshop today:

RSVP: Liza Clews, email: [liza.clews@deafsq.org.au](mailto:liza.clews@deafsq.org.au)  
or mobile: 0433 441385

[www.deafchildrenaustralia.org.au/healthydeafminds](http://www.deafchildrenaustralia.org.au/healthydeafminds)

\*Auslan Interpreters and refreshments provided

Co-hosted by:





## APPENDIX 4 – LIST OF PARTNERS



*Te Whare Wānanga o Ōtāgo*

## **EVALUATION OF SURVEYS:**

### **Healthy Deaf Minds Tour**

Presenters:

**Dr. Margaret Du Feu**

Consultant Psychiatrist

National Deaf Mental Health Services (Birmingham),

Queen Elizabeth Psychiatric Hospital

**Joyce Pennington**

Community Clinical Nurse Specialist

North East England Mental Health and Deafness Service

Facilitator:

**Karyn Barrasso**

Project Coordinator

Deaf Children Australia

Report prepared by:

**Dr. Paul Jacobs**

Research and Policy Officer

Deaf Children Australia

Dr. Margaret Du Feu and Joyce Pennington presented the Healthy Deaf Minds Tour at 16 venues across Australia in October and November 2010. The Tour included Community Forums and Professional Development Workshops, which were facilitated by Karen Barrasso of Deaf Children Australia and associated stakeholders. Karen Barrasso also authored, disseminated and collected the surveys. Feedback was received from 12 (75%) of the Healthy Deaf Minds Tour events. Dr. Paul Jacobs analysed the surveys and wrote this report.

An overall total of 128 surveys were received from the Community Forums (n = 66) and the Professional Development Workshops (n = 62). The breakdown of participants per location for the Community Forums was: Brisbane (18); Townsville (11); Cairns (1); Darwin (9); Alice Springs (6); Deaf Can Do – South Australia (2); Western Australian Deaf Society (WADS) - Western Australia (10); VicDeaf - Victoria (6); and New Zealand (3). The participant breakdown for the Professional Development Workshops was: Mental Health Foundation of Australia - Victoria (3); Deaf Children Australia - Victoria (7); Deaf Can Do – South Australia (29); and Mental Health Commission - Western Australia (22).

This report analyses the strengths and weaknesses of the Tour using a blend of both statistical and qualitative analyses. Two different types of surveys were scrutinised. The surveys for the Community Forums contained six measures of the participant's appraisal and the survey for the Professional Development Workshops had 21 measures. Each measure was evaluated using a five point Likert scale (i.e., "Great" to "Disappointed<sup>1</sup>"). In addition, over three-quarters of the Community Forums' participants (n = 48 or 77%) and nearly half of the Professional Development Workshops' participants (n = 30 or 48%) provided written feedback. Some of these responses will be included to illustrate trends and will be quoted verbatim.

### **Community Forums**

Of the six measures of the participant's appraisal for the Community Forums, four measures were related to the performance of the presenters - "Presenter", "Content", "Material" and "Expectations." The other two measures "Venue" and "Access" were

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<sup>1</sup> The surveys featured rankings of "Very Satisfied to Not Satisfied" with number rankings between 1 and 5. For the purposes of this report, these labels were changed to Great (1), Good (2), Unsure (3), Not Happy (4), and Disappointed (5).

unrelated to the presenters and were specific to environmental factors. Figure 1 provides a summary of the participants' responses to the Community Forums they attended.

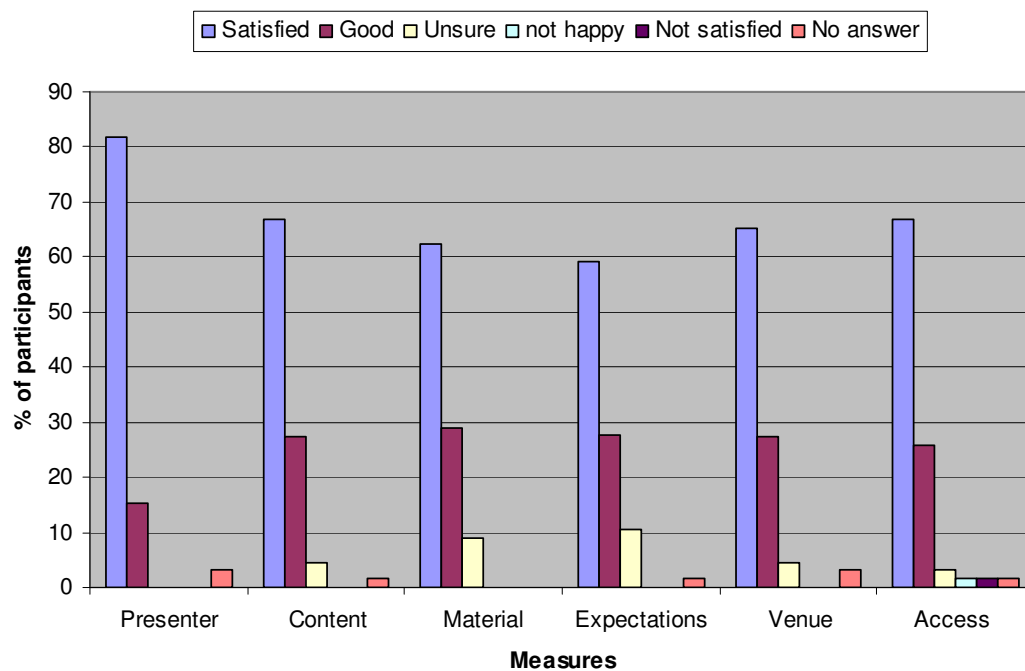


Figure 1  
*Community Forums evaluation summary*

It is clear that the participants from Community Forums who provided feedback gave high approval ratings for all of the six measures. Closer inspection of Figure 1, however, shows slightly lower approval ratings for the measures of “Material” and “Expectations” when compared with approval ratings for the “Presenter” and the “Content” of their speeches. This suggests the audiences had a strong liking for the presenters but some had queries about the material of the speeches. Some individuals also felt their expectations were not met. The environmental factors of “Venue” and “Access” also had high approval ratings, which suggest the organisers provided good locations and access for the Community Forums. The venue that featured a single ranking each of “unsure” and “disappointed” for the measure of “Access” was at Queensland’s Moorooka venue.

## Professional Development Workshops

The high approval rankings for the presenters also appeared in the surveys from the Professional Development Workshops. This was particularly true for measures of the “Speakers’ knowledge”, and use of “Appropriate Language” and also “Appropriate examples” (see Figure 2). At least 79 per cent of the participants were satisfied with each of these attributes of the speakers. However, a greater spread of responses was recorded for the measures of “Ran on time”, “Delivery style” and “Responses to questions.” Interestingly, the location for most of the lower approval ratings for each of these three measures was at Deaf Children Australia in Victoria.

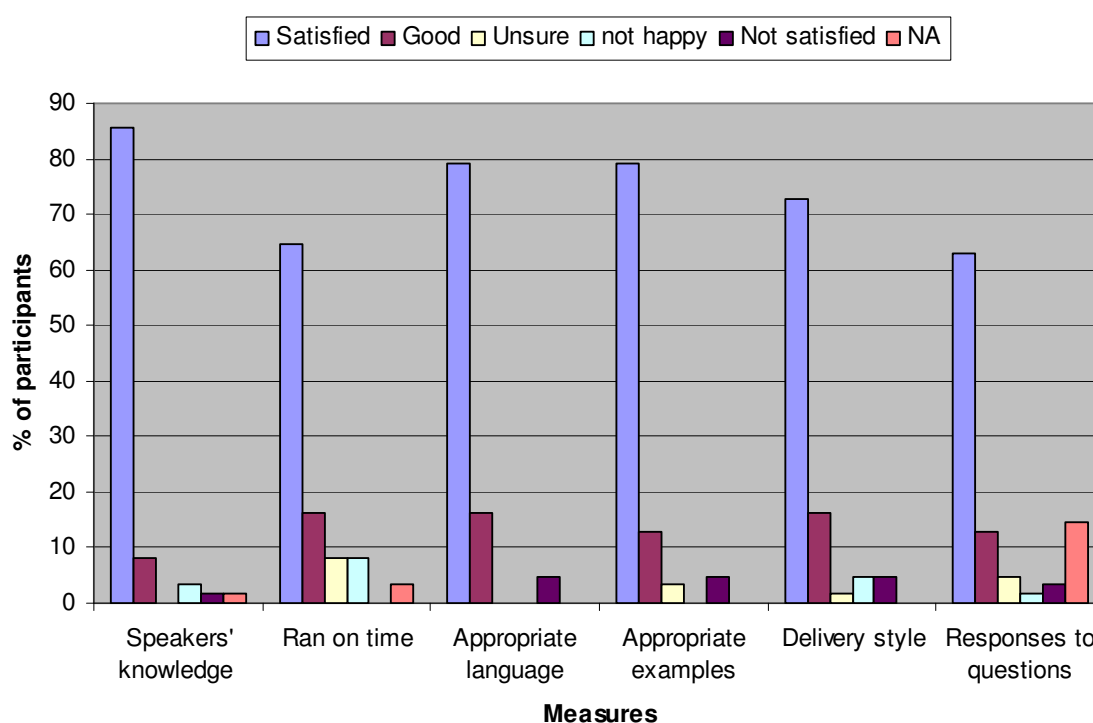


Figure 2

*Presenter evaluation - Professional Development Workshops*

## Written feedback

High approval ratings for both the Community Forums and the Professional Development Workshops were reflected in the participants’ open ended responses. The generally positive responses are summarised in three themes outlined below in accordance with the type of session delivered.

## **Interesting and informative**

### *Community Forums*

The most common responses were that the Community Forums were interesting and informative, which included expressions of gratitude and superlatives (e.g., “excellent!”). Twenty-seven (56%) respondents gave these types of responses. Praise was also given to the different points of view provided, as well as the importance, helpfulness and concise nature of the content. A typical response was, “It was inspiring and has given me a lot to think about. I am now more vigilant about picking up on subtle questions given to me by clients.”

### *Professional Development Workshops*

Seventeen respondents (57%) from the Professional Development Workshops also found the sessions interesting and informative. Three noteworthy responses were: “Very interesting perspective in UK (United Kingdom), what's happening in SA (South Australia)?”; “Very important Information - a topic which is often ignored. Good Work!”; and, “the case studies provided an excellent prompt to the rest of the session.” One participant, however, mentioned that tailoring the presentations “to the Australian context would have been more engaging.”

## **Innovative ideas**

### *Community Forums*

Five respondents further considered that innovative ideas were presented. One person acknowledged that the awareness of mental health in deaf individuals “is still quite low in the community”, and another stated that the session was a “great eye-opener for me - a challenge to continue my involvement.” Two respondents further thanked the presenters for giving them the opportunity to plan for better mental health services in Victoria. Another person wrote, “Really hit home how much of an issue this is”, and another said, “I like Joyce's quote, ‘You don't know what you don't know, until you know it’.”

## **The ‘Deaf story’**

### *Community Forums*

Two respondents were pleased to hear Margaret in the roles of an advocate and as a practitioner. But, one participant thought the presenters required more “deaf stories as different deaf different ways (sic)”, suggesting that the needs of the non-culturally Deaf were under-represented in the sessions. This point was further supported by an

individual who wrote, “Could the presenters ... please be aware of the issue that some audience may be hard of hearing”.

## **Discussion and time management**

### *Community Forums*

There were 10 comments about discussion and time management. There were two types of negative responses relating to discussion. First, “Perhaps have small group discussions about problems in their lives and how they felt about it; things like that instead of listening and talking for two hours.” Second, three individuals complained of lacking the opportunity to question presenters due to another attendee asking most of the questions. However, four other respondents were pleased with the discussions. In addition, four more participants indicated that the sessions could have been longer or that the future sessions would be welcome. According to one respondent, “This could easily have been a user pays two day workshop.”

### *Professional Development Workshops*

Seven participants gave three types of responses to the issue of discussion and time management: the desire for more discussion time (n =3); having more interactive activities to identify some key priorities and guidelines to set up a network of professionals in Australia (n = 2); and the timeslot (2.30pm to 4.30pm) was not favourable for teachers to attend (n =2).

## **Venue and access**

### *Community Forums and Professional Development Workshops*

Again, there were many high approval ratings for “Venue” and “Access” (see Figure 3). An interesting response was that the Northern Territory “is an isolated place, (and) to have such a specific forum provided in Darwin was outstanding.”

The irregularities in Figure 3, however, appear to be with the measures of “Easy to find” and the “Hearing loop”. These responses featured the highest percentages of ‘non-applicable’ or ‘no answer’ responses for the eight measures in Figure 3. Plausible reasons are the sessions were held at or near the respondents’ workplace and the likely low number of respondents not requiring a hearing loop. In addition, Figure 3 shows two other measures with the most impartial or negative responses. These were mostly given by participants from the Deaf Can Do South Australian session. Eight out of 29 (28%)



participants were not satisfied with “Seating comfort” and seven (24%) from the same session believed the Tuesday 2.30-4.30pm timeslot was not a “Good session time”.



Figure 3  
*Venue and access – Professional Development Workshops*

Despite positive statistical trends regarding venue and access, there were some noteworthy written responses. One participant in Darwin and another in Perth complained of not knowing about the workshops (i.e., “Getting info on the three public forums from WADS was impossible! ... We rang a number of times but no help was available”). Another participant had trouble finding the venue and another finding parking in Moorooka, Queensland.

There were four further comments concerning the lack of communication access. One respondent from Deaf Can Do in South Australia suggested “Would have been good to have a second video to focus on signers.” In addition, a person from Brisbane wrote, “I used loop system. When comments and questions were raised from the floor in Sign they were not repeated verbally. Verbal interpreting - spoke too quickly.” Another participant from WADS desired having access to a loop system for optimal listening.

## **Suggestions for improvement: Miscellaneous practical applications**

### *Community Forums and Professional Development Workshops*

While the previous insights offer suggestions for improvement, there were nine other suggestions with the number of respondents supplied in brackets:

- Providing handouts of the presentations (n = 4)
- Target more teachers of the deaf as well as parents of children who are deaf (n = 2)
- Ensure that more Australian mainstream general practitioners and mental health professionals know about the issues (n = 1)
- Having clients talk about their own experiences (n = 1)
- Providing contact information on Powerpoint (n = 1)
- Incorporate role play into the sessions for hearing people to understand the unique mental health issues of deaf people (n = 1)
- Present in more regional locations (n = 1)
- Capture presentations on DVD for podcasts (n = 1)
- Provide specific support young people, Aboriginal people and remote communities (n = 1)
- Sponsor an online forum for healthy deaf minds - open to professionals and community with contacts of professionals who are experienced in deaf/hearing impaired mental health care, plus community support groups (n = 1)

## **Suggestions for improvement: Content and delivery**

The surveys offered areas for improvement for content and delivery of the sessions. Figure 2, on page 3, showed high approval ratings for six measures related to “presenter evaluation” from the Professional Development Workshops. However, six further measures related to content and delivery showed slightly lower ratings of general approval (see Figure 4). These measures were related to material relevance; the usefulness of the information, presentation materials and methods; the importance of the subject matter; and whether the participants’ expectations were met.

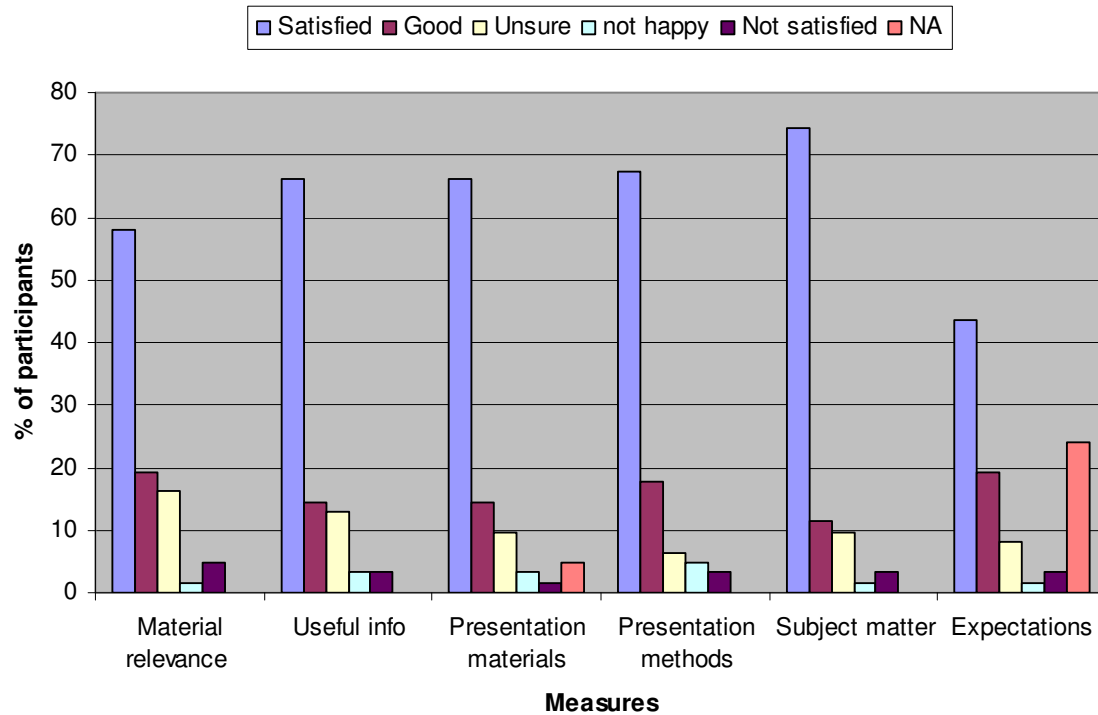


Figure 4  
*Content and delivery – Professional Development Workshops*

While the approval ratings for each of the six measures in Figure 4 are high (i.e., above 62%), they had a greater distribution of answers that were non-satisfactory when compared to the other measures in Figure 2. The presenters thus had higher approval rankings for presenter evaluation (Figure 2) than for their content and delivery (Figure 4). The following summary of the written responses may provide reasons for these trends.

### **The need for evidence-based research and clinical skills**

#### *Community Forums*

The presenters' anecdotal references were appreciated by many participants, but four participants suggested a need for more clinical or evidence-based research for referrals and training, and specific clinical skills for professional practices. For example, one participant wrote, "Because of the title of this session, I was expecting on how to live well mentally. Most of it was about people and cases Margaret and Joyce had worked with." Despite this, another participant wrote "My thoughts were about getting Joyce and Margaret to provide direct training".

#### *Professional Development Workshops*

Six more respondents gave feedback on this topic. These were:

- “Would have liked practical ideas and steps they adopted to implement these 'mental centres' that we could use.”
- “More on how to prevent mental illness in children. How to develop healthy minds. How to identify issues.”
- “I'd be interested in actual prescriptive means in the area of cognitive and social development.”
- “Include more academic info ie. Models of dev (sic), social cognition and how deafness impact on this dev (sic).”
- “Training and awareness for teachers/lecturers needs to be made available.”
- “Need to look at collaboration across government.”

### **The need to focus on children and young adults**

#### *Professional Development Workshops*

Two respondents wanted to hear more about “transition points” in life and of cognitive development from childhood to adulthood for people who are deaf. For example, one suggested, “Focus on a transition from school to tertiary pathways ... Transition points need to be identified and addressed”, and the other said, “Very adult focused presentation. Would have valued hearing about teenagers and children/self esteem and cognitive dev (sic).”

### **Why some expectations may not have been met**

Given this, the feedback from the participants of the Professional Development Workshops appears to show more detailed suggested areas for improvement than that of the Community Forums. These content related issues in the qualitative data may be explained by the comparison that appears in Table 1. The approval rating was conducted by combining the scores of rankings for “Satisfied” and “Good” then comparing them between the two types of sessions using percentages.

Table 1:

*Approval rating for Material and Expectations - comparison*

		Performance Measure	
		Material	Expectations
Session	<b>CF</b>	91%	87%
type	<b>PDW</b>	77%	63%

**Note:** CF = Community Forums; PDF = Professional Development Workshops.

Table 1 shows relatively higher approval ratings for “Material” and “Expectations” in the Community Forums when compared with the Professional Development Workshops. Participants from the Community Forums (n = 5) remarked that the sessions were innovative or were impressed by new ideas. No such feedback came from the Professional Development Workshops, which suggests greater awareness of mental health and deafness in professionals. In addition, two participants observed that the ideas in the session were not innovative (e.g., “The information I heard was not new”). Neither participant, however, gave an explanation.

### **Suggestions for improvement: A research perspective**

Anecdotal evidence suggests that the Healthy Deaf Minds Tour had a high attendance rate. The numbers of attendances were not recorded, so the return rate of the surveys cannot be estimated. It appears, however, that the varying number of responses per venue could be attributed to the method of distributing and retrieving the surveys. Participants were more likely to complete the survey on the day of the presentation. For example, the researcher followed up five event organisers for the surveys of participants who attended six events. This yielded just five more surveys. Therefore, email requests appear to be a less effective means of retrieving surveys.

It is possible that participants had difficulty completing the surveys. Indeed, two participants requested larger font. In addition, some of the measures were difficult to distinguish from each other. Examples include distinguishing between the measures of “Content” and “Material” in the survey for the Community Forums; and distinguishing between “Material relevance” and “Useful information” and “Subject matter”, plus between “presentation materials” and “Presentation methods” in the survey for the Professional Development Workshops. These ambiguities made it difficult to offer an accurate evaluation and may explain why the written answers perhaps proved more insightful than the statistics.

### **Conclusion**

The Healthy Deaf Minds Tour was enthusiastically received throughout Australia. The responses were overwhelmingly positive. Margaret and Joyce were viewed as informative, interesting, and engaging presenters. While there were many suggestions for improvement, the Tour has likely set a precedent in Australia. Raising awareness has perhaps been the most obvious achievement of the Tour. It was clear that mental health

for people who are deaf is an important topic across a range of Australian deafness-related professionals. Many expressed a desire to act on the ideas presented to them, to take action towards improving the mental health of people who are deaf. Sixty participants also provided their contact details. This suggests a desire to continue contact into the future and maybe develop further initiatives in Australia. Moreover, the issue of mental health in people who are deaf appears to be equally applicable across the countries of Northern Ireland, the Republic of Ireland, and England as they are across the diverse states of Australia.