

Draft Revised Mental Health Act 1983 Code of Practice Consultation

Response from SignHealth

SignHealth
5 Baring Road,
Beaconsfield,
Buckinghamshire,
HP9 2NB

info@signhealth.org.uk



Mental Health Act Code of Practice — Response to consultation from SignHealth

SignHealth welcomes the specific inclusion of Deaf people in the draft Code of Practice. We have confined our comments to those paragraphs which apply particularly to Deaf people.

Chapter 2

We are pleased that the chapter on communication is contained at the start of the Code. Elsewhere in the CoP reference is made to providing information both orally and in writing, e.g. paragraph 9.44. We agree that this is necessary, but wonder whether Chapter 2 could state that in these important circumstances, “oral and in writing” should also include sign language if that is the person’s chosen communication method.

These instances may already be covered in paragraph 18.24.

Chapter 4

This contains the most pertinent guidance on Deaf patients and so have included detailed amendments as follows:

Patients who are Deaf

4.36 An AMHP or clinician examining or assessing a Deaf person should, ~~wherever possible¹~~, have had Deaf awareness training, including basic training in issues relating to mental health and deafness². ~~They should know that some Deaf people can present as if they have a personality disorder, mental illness or learning disability despite this not being the case, that there are characteristic ways in which Deaf people with mental illness may communicate psychotic phenomena, and that in taking the ‘role’ of another person as part of sign language their emotions or beliefs may be misunderstood. Where required they should also³~~ An AMHP or clinician examining or assessing a Deaf person should seek assistance from specialists with appropriate expertise in mental health and deafness. This may be available from one of the specialist hospital units for deafness and mental health. ~~A telephone consultation would be sufficient as a minimum.~~ Contact with such units may, in particular, help to forestall Deaf people being wrongly assessed as having a learning disability, ~~personality disorder, or psychosis.~~

¹ “Wherever possible” implies that it might not have been possible to receive this training. There is no reason why any AMHP cannot attend a Communication Tactics or Deaf Awareness course.

² This sounds reassuring, but no such course exists.

³ Even in the most straightforward of presentations involving a Deaf patient, it is still expedient that a specialist be contacted. We have no desire for the specialist units to ‘police’ colleagues, but, at the very least, a specialist could check that certain considerations have been made and the local clinical team are pointed towards best practice. If the local service chooses, this link could prove very valuable and have a huge impact on the patient’s care.

- 4.37 Unless different arrangements have been agreed locally, the AMHP involved in the assessment should be responsible for booking and using registered qualified interpreters with expertise in mental health interpreting. **Interpreters must be Members of the Register of Sign Language Interpreters (MRS LI)⁴.** Relay interpreters may be necessary, for example, when the Deaf person has a visual impairment, does not use British Sign Language to sign, has minimal language skills or a learning disability⁵. **The interpretation of thought disordered language is often impossible and less experienced interpreters may approximate a word-for-sign translation. This may enable a degree of understanding of the form of thought, or confuse by mis-interpretation or translation. Additionally there are disorders of form of sign language specific to deaf people.**
- 4.38 ~~The use of~~ Unqualified interpreters such as family members or health professionals with only limited signing skills should **not be used, though occasionally someone who knows the patient's idiosyncratic use of language can assist communication through an interpreter or professional fluent in sign language be avoided wherever possible.**
- 4.39 ~~Preverbal~~ **Prelingual** deafness may cause delayed language acquisition which may in turn influence social behaviour. People carrying out assessments under the Act should have an awareness and knowledge of how mental health problems present in ~~pre-verbally~~ **such** deaf people. Cultural issues **also** need to be taken into account ~~for instance in people who are pre-verbally deaf as they~~ **as many Deaf people** have a visual perspective of the world and may consider themselves to be part of a **Deaf** cultural and linguistic minority. This means that they may behave in ways which are misperceived as mental illness. For example, animated signing may be misunderstood as aggression, while touching a hearing person to talk to them may be misunderstood as assault. Deaf people's spoken or written English may be poor, giving rise to a false assumption of **learning disability or thought disorder. It is just as important to follow the above Code in assessing whether a patient is ready for discharge as it is for detention – whether that be by clinicians or appeal bodies.**

Chapter 9

SignHealth support the monitoring provision in paragraph 9.38. However, we would like the monitoring to record the number of Deaf people subject to section 136. We assume a form will be developed for this purpose, in which case, perhaps, alongside ethnicity categories of disability could be included.

⁴ It is easy for interpreters to be qualified (perhaps to Level 3) and registered (perhaps as Junior Trainee Interpreters), but this is not sufficient. We are fortunate that a recognised standard exists, so it is worth being specific about it. Despite the national shortage of interpreters, it should always be possible to use an appropriate interpreter. This may involve using an expensive agency that specialises in short-term bookings, but that is a small price to pay where someone's liberty and wellbeing is concerned.

⁵ A relay interpreter is a deaf person fluent and flexible in the use of sign language and its various forms and derivatives.

Chapter 10

We know that conveying patients can often be an area fraught with problems for professionals. When considering the Deaf patient then ideally an interpreter would accompany the patient. The Deaf person may want to communicate (to have their fears allayed, understand where they are going, when they will arrive, etc.) and professionals may want to calm the Deaf person, offer reassurance or issue instructions. In either scenario an interpreter would be desirable.

Perhaps more crucially, when the Deaf person arrives at the hospital there will be a need to give them information and get information from them. At such an important transitional stage then the presence of an interpreter would be necessary.

Chapter 21

We welcome the acknowledgment that patients should have a right to privacy and a maintain links with their family and friends. Mobile phones are extremely important to most Deaf people. It would be appreciated if some note to this effect could be included in 21.4 or 21.5, so that Trusts consider this when devising local policies. Deaf people will feel more isolated than hearing people on a ward and so communication with friends and family via SMS will be even more important.

Chapter 28

SignHealth was very pleased to see that the “Case Example” used someone with hearing loss. We wondered whether the paragraph starting “how interpretations of behaviour” could include “his hearing loss” (as this would undoubtedly affect his behaviour). Also, the final paragraph says to use interpreters “where needed” for consultations. This raises the question of who decides the need. We frequently find that doctors feel they can manage without an interpreter, while the Deaf person – if asked – says they need one. In view of the respect principles, it might be helpful to clarify that interpreters should be provided for consultation if that is the patient’s choice.

Chapter 35

SignHealth appreciates that paragraph 35.38 makes it clear who is responsible for providing interpreters, and who is responsible for notifying the MHRT that they may be necessary.

If you have any enquiries or questions regarding this response, then please contact:

Paul Stemman
SignHealth, 5 Baring Road, Beaconsfield, Buckinghamshire, HP9 2NB

pstemman (at) signhealth.org.uk