

Written evidence from National Deaf CAMHS (COV0219)

Written submission submitted by National Deaf Child and Adolescent Mental Health Services (North)

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Introduction

NDCAMHS (North) is part of a National Deaf CAMH Services providing community and in-patient mental health services for deaf children, hearing children born to deaf parents and their families who are unable to access local mental health services. It is funded by NHS England as a highly specialised service and was created in response to recognition that deaf children are more likely to experience mental health problems (a rate of 40% compared with 25% in the hearing population) and less likely to receive a satisfactory service as non-specialised services can struggle to understand the cultural and linguistic needs well enough. Additionally, there are factors which influence and impact on a deaf child's developmental trajectory that are not always acknowledged or understood outside of specialist deaf services.

Evidence

As a service we have seen a disproportionate affect of the Covid-19 Act on deaf children and their families:

1. 90% of deaf children live with hearing families, many do not use sign language; therefore communication between the deaf child, parents and siblings is limited and there is little meaningful in-depth communication.

When families have been in lock down and they do not have shared communication, it can negatively impact upon family relationships and the mental health of the deaf child.

Services should move sign language lessons online, and these lessons should be available to all families with deaf children.

2. Access to services and information has been very limited e.g.:

GPs moved to telephone consultations that are not accessible for deaf British Sign Language (BSL) users.

Sign health (national charity) funded online video BSL interpreting for the deaf community so that, during the pandemic, they are able to access health appointments. It is hoped that NHS England will take on the responsibility for funding and providing this access.

Social care reduced services and in some cases support ceased, leaving families providing around the clock care with no respite. This includes, deafblind communicator guide services being withdrawn, social workers for the deaf being re-deployed to other departments and the service becoming very limited, personal assistants funded by direct payments ceasing or reducing support.

We know that deaf children are more likely to suffer abuse and that domestic violence rates increased during the pandemic, therefore services should ensure that they have 'sight' of vulnerable groups so that their wellbeing is being checked and documented.

3. According to the Human Rights Act, all children have a right to accessible education (article 2, protocol 1).

Deaf children have an Educational Health Care Plan (EHCP) that outlines the educational provision they should receive. During lock-down many of these plans have not been followed and deaf children have not had access to education. For example, when schools were open a deaf child would have a support worker with them in the classroom signing what the teacher and children were saying. This has not been provided for online lessons and therefore the deaf child has not received an optimal education experience compared to their hearing peers.

Many deaf children have not had access to their Teacher of the Deaf, BSL lessons for parents or speech and language therapy; these services just stopped and did not move online – these services are vital to the deaf child and their families.

There is evidence that many deaf children were already at risk of falling behind their hearing peers both academically and social and emotionally; this gap is likely to widen now.

4. Sixteen of the 154 families that we currently support are experiencing digital exclusion (due to poverty), they have no, or extremely limited, access to the internet. This means that deaf children in these families have not only been unable to access education, support from other services but this is compounded by their inability to connect with others, especially deaf peers with whom they could communicate using BSL.

A robust EHCP process should enable schools to provide these children with a digital device so that they can access education, wider information, social interactions and the world around them.

5. Healthcare has been rationed and face-to-face contact has been limited (Cf, Article 2 ECHR right to life; Article 3 ECHR).

Audiology clinics have closed, therefore, hearing aids and cochlear implants cannot be maintained and operations for these have been cancelled. This contravenes NICE guidance.

6. Access to information about Covid-19:

In the UK, England has been the only government not to provide an interpreter for briefings (the BBC provided BSL interpretation for the main briefings, though this has now ceased). It is important that deaf people have access to the same information in a timely manner about Covid-19 as hearing people do.

This is also relevant to people who use other community languages, there has been a dearth of information available in other languages, in particular on the government and NHS England webpages regarding Covid-19.

7. 'Wear protective clothing' has been directed and includes facemasks. One in seven people in the UK have a hearing loss and rely on lip-reading and/or facial expressions. Currently there are no suitable facemasks with a clear mouthpiece, which therefore severely limits communication. The government did not prioritise these masks, not only for deaf people but also for other groups such as those with dementia, older people, people with learning disability, people with psychosis and children.

Other CAMH services are going back to work and resuming face to face contact. Deaf CAMHS cannot do this due to the 'facemask' making communication inaccessible.

The overall impact upon deaf children and their families has yet to be fully understood; though undoubtedly they will be experiencing the consequences of limited access to language, communication, education, and services. Deaf people are already a higher risk of experiencing difficulties with their mental health and it will be further compounded during the management of the pandemic.

Recommendations

1. EHCPs should have an exceptional review, when unexpected unprecedented circumstances arise, to ensure that deaf children's needs are met and that they continue to receive an education e.g. provide digital devices and provide access to online lessons.
2. NHS England should review the current interpreting provision and fund the continuation of 'interpreter now' for deaf BSL users to access all healthcare settings.
3. The government should provide BSL interpreting/translation for all public briefings. Information provided by the government and other

statutory services e.g. NHS should provide information in accessible formats e.g. with BSL interpretation/translation.

4. When services are responding to changing situations, they should remain mindful of accessibility issues and put necessary adjustments in place, this includes procuring sufficient PPE that enables lip-reading.
5. The Government should be active in developing or sourcing transparent face masks as a matter of priority.

Should the committee wish to discuss our evidence any further, service representatives would be happy to provide consultation.

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