LETTER TO THE EDITOR

Breaking Barriers to Professional Achievement

Herbert Klein
Communication Facilitator National Deaf Services South West London & St Georges Mental Health NHS Trust

My working career started after I attained a diploma in Theatre Design, when I went to work for both The National Theatre and the British Theatre of Deaf. Following this I studied for a diploma in carpentry, and took a variety of jobs. I found myself answering an advertisement in the British Deaf News offering a job in mental health. To date I have worked within the National Deaf Service for 24 years, and have been ideally placed to see the transformations within this workplace. The following is a personal account of how Deaf professionals came more and more to the fore in what is still a largely hearing-led field of work.

One of the main reasons that Deaf staff did not exist within the field of mental health was the lack of access to professional training. Although many Deaf people were capable and skilled, running Deaf events and Deaf clubs for example, there was a prevalent feeling that we ‘cannot do’ a professional career. To compliment this unfortunate mindset was the hearing professionals’ lack of understanding as to why Deaf people were not working alongside them. They thought that we were unable to achieve, rather than not having the opportunity. This attitude had been present for hundreds of years, the result being that Deaf people were labelled, for lack of a better word ‘dumb’. A practical barrier to overcome was the need for a recognised professional qualification – the hearing staff demanded we had one before we could start working alongside them, and the Deaf population had few opportunities to attain one.

The hearing professionals believed they had all the
skills necessary to treat Deaf patients, but in many cases the reality was quite different; research on mental health had only been conducted on a hearing population, and diagnostic tools were often based on a knowledge and use of the English language. Many Deaf people had BSL as their first language, and in some cases it was their only means of communication. Realising the void between the hearing and Deaf worlds there came a point were it was understood that there could be some merit in employing Deaf staff to work along the hearing professionals. There were questions raised over whether the Deaf staff would be able to maintain boundaries and keep information confidential. Despite these concerns three Deaf people were employed, including me.

Upon starting my work as a Deaf therapist, I noticed that a power struggle quickly began. The hearing professionals had the training and understanding of mental health, and so felt skilled in being able to diagnose psychological illness, whereas the Deaf staff had the language and empathy of being a member of the same culture and community. The Deaf staff were often more able to distinguish between a person behaving strangely or within the norms of our community. These conflicting views regularly became heated debates. It was a teaching process, explaining to our hearing colleagues that Deaf people had a unique culture, perspective and set of life experiences, and that there were even regional differences within these. It was a period of people from all backgrounds feeling deskilled.

Over time however there was a cross-pollination of skills and experiences; the Deaf staff were given more access to the medical models of psychiatry and psychology, and the hearing staff came to understand more about Deafness in mental health. I noticed that attitudes changed as this went on, as we all realised that we had to work together as a team for the benefit of our patients. Research projects, journals and many other aspects or work became less precious and guarded, as hearing professionals would seek collaboration from the Deaf staff. Psychiatric language remained a sticking point for a few years though, as I would understand a patient’s current difficulties, but would not have the medical language to explain it. In a similar way there were few recognised BSL signs to describe specific mental health difficulties, and so had to be created through a Deaf professional’s mental health working group.

It was understood that training for the Deaf staff was paramount, but we would inevitably fall foul of the training boards, which did not see the value in giving us the opportunity to learn. The varying boards would deny entry on grounds such as health and safety, or that a Deaf student would not be able to operate on placement in a predominantly hearing ward. As a testimony to our hearing colleagues’ change in attitude it was they who championed our needs and got us the training we needed. They would challenge the board’s concerns, in some instances explaining how an interpreter would negate many of their worries. This ultimately resulted in a shared perspective, and diagnostic tools and therapy were changed to match the language of our patients.

This all resulted in a better service for our patients. Through the biased systems of diagnosis and treatment there were many of the Deaf patients labeled as
schizophrenic, and given the related medicines and therapies. However after the service’s period of change and growth it was noticed that many of these patients were actually experiencing depression, anxiety, mood disorders and a whole host of other problems.

In the same way that we were able to change the attitudes of the predominantly hearing working population, things were stirring in the Deaf world as well. The ‘cannot do’ belief was shifting, as Deaf people came to understand that there were work and training opportunities to be had in the field of mental health. The change happened slowly, and over the past ten years prejudices and barriers have needed to be broken through.

The Royal College of Psychiatrists have strived to gain an understanding in certain minority issues, such as BME, but recently have looked to Deafness, and in 2002 invited a Deaf speaker, Julia Lord, to co-present at one of their conferences. Prior to this my colleagues and I had established a counselling course at the Westminster Pastoral Foundation, which encouraged Deaf people to attend and gain qualifications.

The English Nurses Board for one had always refused to allow Deaf people to study under them. This came to an end when Susan Eagling became the first Deaf registered mental nurse in 2003, graduating from Salfords University. The course has since swelled in numbers and has produced many more qualified professionals.

Following this success we’ve also seen the first Deaf clinical psychologist, Sara Rhys-Jones in 2003, the first Deaf Chartered Counselling Psychologist, thought to be Julia Lord in 2008, and the first Deaf psychoanalytic psychotherapist, Jane Douglas in 2009.

Barbara Brown who become qualification Occupational Therapist in 1989, all of whom act as invaluable role-models for aspiring Deaf professionals. The numbers of deaf professionals are still growing, for example the number of Occupational therapist, art therapist, person centred counselling, registered mental nurses and clinical psychologists.

My recommendations would be to look at creating opportunities and this can be done through various means:

1) To establish an apprenticeship style of training, where deaf people are given both academic and on-the-job training.

2) Hearing professionals who work with Deaf people are encouraged to adopt a behaviour which promotes good relations with the Deaf community, and take steps toward trying to understand the Deaf community’s specific needs; e.g. that listening and consultation with Deaf people. This type of partnership can ensure developments and changes to services have a more targeted approach, and developing solutions to actual problems experienced by Deaf people in the community. And when introducing these changes ensure positions are created for Deaf staff who can make sure it is widely used by those who need it in the community.

3) Encourage Universities & College to make their courses accessible for Deaf students, look at possible opportunities to have ‘work placements’.
4) Making the most of new talent, new skills from the Deaf work force (student graduating from Universities or other mental health training courses).

5) When hearing professionals meet with commissioners & government departments about the provisions of services for Deaf people, ensure that Deaf professional are also present and seen by these funders. This form of visible representation can change misconceptions about Deaf people, and hopefully change attitudes and stereotypes about Deaf people in a more positive way.

Special thanks to Iain Case, Fleur Shaddick, Julia Lord, Kevin Buckle and Donna Lewin