The Mental Health Needs and Experiences of the Deaf Community in Ireland – A Qualitative Exploration

Authors: Dr Michaela Hammond, Clinical Psychologist, HSE, Dr Mike Murphy, School of Applied Psychology, UCC & Dr Rosarie Crowley, Clinical Psychologist, HSE, CKCH Primary Care

Executive Summary

Research suggests that rate of mental health difficulties within the Deaf community is higher than that of the hearing population. However, despite the publication of policy guidelines to improve Deaf people's access to appropriate services and supports, it appears that a number of gaps remain in terms of implementing these recommendations. The overall aim of this study was to explore the current mental health needs and experiences of the Deaf community in Ireland. A qualitative research design consisting of two focus groups (n = 18) was conducted with members of the Deaf community in Ireland and data was analysed using reflexive thematic analysis. The data were classified into three main themes: (i) vulnerabilities for mental health difficulties, (ii) difficulties accessing and attending services and (iii) the hope to be heard. Findings from this study indicate that greater efforts should be made to raise awareness of the needs and unique culture of the Deaf community, to improve the accessibility and suitability of services for Deaf people, and to provide Deaf people with more opportunities to work within services.

Introduction

It is estimated that approximately 5% of the world's population (466 million people) live with disabling hearing loss, which is projected to increase to 8% by 2030 and 11% by 2050 (World Health Organisation, 2018). A number of terms are used within the literature when describing people with varying kinds or degrees of deafness, including Deaf with an uppercase 'D', and deaf with a lowercase 'd'. The uppercase Deaf is used when describing people who identify as culturally Deaf and engage within the Deaf Community. They are often born Deaf and use sign language as their primary mode of communication. A lowercase deaf is used when referencing those with hearing loss who often do not have a strong connection to Deaf culture and prefer to communicate orally (Roberts & Hindley, 1999). There is no universally accepted definition of what constitutes the Deaf Community in Ireland. For the purposes of this study, it is defined as people who are Deaf, identify as part of the Deaf community, and use Irish Sign Language (ISL) as their first language. It is estimated that there are approximately 5,000 people in Ireland using ISL as their first language (Leeson & Saeed, 2012).

There has been a lack of large-scale research conducted on the prevalence rates of mental health issues in the Deaf population; however, existing studies show ample evidence that rates of mental health problems within this population are higher than the general population (Fellinger et al., 2005; Kvam, Loeb, Tambs, 2007). Many factors contributing to this increased risk have been highlighted - for example, many Deaf people also have physical and/or learning disabilities; are more likely to have experienced emotional, physical or sexual abuse in childhood; often experience social exclusion; have reduced education and employment opportunities; and can find it difficult to gain access to, and information on, existing supports and services (Fellinger, Holzinger, & Pollard, 2012).

Internationally, it has been reported that people from the Deaf community have substantially poorer access at all elements of the healthcare system, including access to mental health services (Fellinger et al., 2012; Kuenburg, Fellinger, & Fellinger, 2016). Indeed, a number of barriers to accessing and attending mental health services have been discussed within the literature (Pertz, Plegue, Diehl, Zazove, & McKee, 2018). For example, a guidance document published by the Joint Commissioning Panel for Mental Health (2017) indicated that low levels of literacy in a written language means that written self-help, health-related information leaflets, and screening and psychometric measures, are often inaccessible and/or unreliable for members of the Deaf community. Furthermore, for the majority of Deaf people, spoken language is either inaccessible or not the preferred method of communication when engaging with services; including psychological therapy.

In terms of relevant policy in Ireland, *A Vision for Change* (Department of Health & Children, 2006) clearly states that mental health needs of minority groups, including the needs of the Deaf community, should be responded to appropriately. Given that this population may have additional needs upon accessing a mental health service, the policy states that services are required to have the necessary understanding and knowledge in order to meet these needs; as well as ensuring effective interpretation services are made available to the Deaf community to facilitate access and communication. In addition, the policy states that interpreters must be of a standard to be able to empathise with the client, interpret the idioms of their distress as well as the actual words they express, and that family members or children should not be used as an alternative to professional interpreters. Moreover, the *National Guidance of Accessible Health and Social Care Services* (Health Service Executive, National Advocacy Unit, & National Disability Authority, 2016) published guidelines as to how services should be provided to the Deaf community; which alludes to the importance of developing appropriate communication channels, providing interpretation services, not relying on family members to interpret, and providing accessible written and visual information. Thus, it is clear from these policies that services should aim to provide an accessible and culturally appropriate service to the Deaf community in Ireland.

However, in their assessment report on the implementation of the recommendations in *A Vision for Change*, Mental Health Reform (MHR) identified numerous gaps in mental health services and supports for people who are Deaf in Ireland (Mental Health Reform, 2015). Reporting on a pilot specialist mental health service for Deaf people established in 2005, the MHR stated that the number of referrals received was below the level expected given the size of the Deaf population in Ireland. The lead consultant for this pilot service also reported that mental health professionals often receive little training in working with people who are Deaf and have little exposure to this area of care in practice; that there is a lack of qualified sign language interpreters; and there is a lack of knowledge about this population among mental health care providers.

There is strong evidence that provision of mental health care within primary care settings is fundamentally important in reducing the impact of mental health issues on individuals, families and the wider community (World Health Organisation & World Organization of Family Doctors, 2008). Thus, it is important to ensure the Deaf community has access to primary care mental health services (Levine, 2014). However, existing research highlights numerous gaps in mental health services and supports at all levels for people who are Deaf in Ireland (MHR, 2015). This was also reflected in the feedback provided by members the Deaf community in Ireland who attended a Stress Control course led by a Clinical Psychologist working in primary care. Their feedback revealed a lack of information and services for members of the Deaf community with regards to mental health, though this was not the main focus of the feedback questionnaire (R. Crowley, personal communication, October 22, 2019).

As outlined by the Sign Language Interpreting Service (2016), the national ISL interpreting service, one means of facilitating equality within services is to improve the awareness service providers and decision makers have of the issues Deaf people experience. However, there is a significant lack of research that has been carried out in this area. Therefore, this project aimed to provide insight into the current mental health needs and experiences of the Deaf community by carrying out focus groups with members of an organisation for Deaf people in Ireland. Findings from this study will contribute to initial steps in identifying the needs of this group and understanding their current experiences with services, with a longer term view of developing appropriate psychological assessment and intervention tools.

Method

Participants

In total, there were 18 participants in this study. Of these, 11 (61%) were female and 7 (39%) were male. Only members of the Deaf community who were 18 years or older were invited to participate. Recruitment was conducted in an organisation for Deaf people in the Republic of Ireland, where information on the research study was provided to members via an Information Sheet and a PowerPoint presentation. An ISL interpreter was present during recruitment in order to translate information into ISL, facilitate communication, and allow all questions to be answered and clarifications to be made. Those interested in taking part in the study were invited to state their preferred method of participation (focus group or individual interview); all selected focus group participation.

Study design

A qualitative exploratory approach consisting of two focus groups was employed. A focus group design was chosen as the preferred approach as it is considered a suitable design to identify and provide an in-depth description of issues that are not well understood by the researchers and has been described as an effective way of ‘giving voice’ to cultural minorities and marginalised groups (Balch & Mertens, 1999; Morgan, 1996). In addition, focus groups facilitate the development of a rich data set as they allow for participants to respond to and comment on one another’s contributions, challenge, develop or extend on points made, and raise important issues which may not be foreseen by the researchers (Willing, 2013). Recognising that some potential participants might prefer individual interviews to focus groups, these were also offered.

Materials

The semi-structured interview protocol (Appendix A) was developed on the basis of the literature review and discussions within the research team. The interview guide consisted of a description of the study and questions relating to the following topics:

- Meaning of good/poor mental health
- Factors which influence mental health in the community
- Management of mental health issues
- Perceptions of how mental health needs are currently being met

- Experience of accessing supports and services
- Barriers/facilitators for accessing supports and services
- Recommendations for improving supports and services

Within each of these topics specific probes were utilized to encourage further discussion.

Procedure

This study was conducted in Ireland between October 2019 and April 2020. Data collection was conducted with participants at a time and location convenient to them. Participants chose whether they wanted to carry out a focus group or individual interview, with all participants choosing the focus group. Before the focus group, participants were provided with an Information Sheet to read. The researcher then went through the Information Sheet section by section with the assistance of a visual PowerPoint presentation and a ISL interpreter. Written and signed consent was obtained from participants. Reponses from participants were translated from ISL to English via an interpreter, whose translations were audio-recorded. Data collection took place across two focus groups to provide participants with sufficient time to discuss the topic of interest. Seventeen participants took part in the first focus group, and seven participants took part in the second focus group (six of whom had already participated in the first focus group and one new participant joined at this stage). The first focus group had one interpreter present, and the second group had two interpreters present to facilitate translations. The duration of the two focus groups group were 62 minutes and 85 minutes, respectively. All interviews were transcribed verbatim and de-identified by the researcher.

Data analysis

Data transcripts were subjected to reflexive thematic analysis. Reflexive thematic analysis is a system for analyzing qualitative data that consists of the researcher actively engaging with their data in order to identify, analyze and generate themes within the data. This method of analysis was chosen as it is a flexible approach and allows for an insightful analysis of the data that can answer research questions. A semantic inductive approach to reflexive thematic analysis was undertaken whereby coding and theme development were directed by, and reflective of, the explicit content of the data. Reflexive thematic analysis was conducted according to the stages outlined by Braun and Clarke (2006): 1) Preparing data: transcribing and data familiarisation; 2) Coding; 3) Generating initial themes; 4) Reviewing themes; 5) Defining and naming themes.

Ethical considerations

Prior to initiation of the study, ethical approval was sought from and granted by the Clinical Psychology Research Ethics Committee (CPREC) in University College Cork.

Results

The views and experiences of participants are presented in terms of three main themes: (i) vulnerabilities for mental health difficulties, (ii) difficulties accessing and attending services and (iii) the hope to be heard.

Vulnerabilities for mental health difficulties

Participants discussed a number of factors associated with being Deaf within a predominantly hearing society that impact upon their mental health. These experiences fell under the subthemes of social isolation; lack of access to self-care activities; poor job opportunities; and stigma.

Social isolation

Many participants spoke about feeling socially isolated and excluded within a number of contexts. For example, a number of participants described being left out of conversations with hearing people, particularly within their home environments. This was described by one participants who stated: "*in my family setting they were all hearing…at the dinner table everyone would be chatting and I would be left out…that can put you in very bad form…that is a serious problem for Deaf people".* Another participant alluded to the loneliness that this isolation can evoke: "*So I think its very hard… you can feel alone…you don't hear what's going on around you".* In addition, a number of participants described being *"the last to know"* information and feeling forgotten about by hearing people: *"in my family life… if there was any news about let's say a funeral, or something coming up or going on I would be the last person to hear and I don't understand why that is. So hearing people don't bother to tell Deaf people what's going on!".* Furthermore, some participants spoke about their concern for Deaf people who are living in rural Ireland or in nursing homes, describing them as being particularly vulnerable to experiencing isolation due to the lack of communication they have access to, with one participant stating: "*they can be very very isolated… very lost, in a way, with no one to communicate. No access to interpreters. No access to services".*

Lack of employment

Many participants discussed the lack of employment opportunities that are available for Deaf people and the negative impact this can have on their self-esteem and mental wellbeing. They felt that their poor job opportunities stemmed from their poor educational experiences, the introduction of disability allowance, and being perceived as 'unable' by society. This was discussed by one participant whom stated: "*A lot of Deaf people are very angry and frustrated because we have very poor job opportunities. At lot really to do with the very poor education experiences we have had and so that can lead to a lot of frustration and difficulties."* This was discussed further by another participant who explained that although disability allowance may be required for some people, this does not mean that Deaf people cannot work: "*And now you have the disability allowance but you have no work, and I think that is wrong! Deaf people can and are able to work. And your health depends on that."* A number of participants also spoke of the health and safety concerns they feel employers have with regards to employing members of the Deaf community.

Lack of access to self-care activities

Many participants discussed lack of access the Deaf community have to many activities within their community that the hearing population generally utilise for self-care purposes. As stated by one participant: "*Sometimes I'd like to be able to go to the cinema if I felt bad or frustrated, but there are no subtitles. So then I get angry about that! Even in terms of trying to relax, like yoga or… like for Deaf people to go into yoga classes can be very difficult, you don't know what the instructor is saying so its very hard to follow… or listening to music for example… music isn't an option for us".* Participants also stated that many local groups within communities, including sports groups and youth clubs, are only accessible for hearing people and thus they experience fewer opportunities to be a part of social groups.

Stigma

Many participants discussed the stigma they feel exists within society and the inaccurate assumptions that they are *"unable"* or *"stupid".* This was expressed by one participant who stated: *"If you compare the attitude, what happens is people are told 'You can't! You can't! You can't!' and so we are put to one side because people perceive us not to be able to do things, even though we have the skills!".* Another participant also spoke of the felt stigma she experienced during her time in school and the negative impact this had on her: *"Sometimes there is a stigma that Deaf people are stupid… As you an imagine the label that we would have had was 'deaf and dumb', 'deaf and mute',… growing up Deaf people had the image that they were stupid, that they couldn't do things. And we were told 'can't become a teacher, can't do this, can't do that' so that does have an impact on us."*

Difficulties accessing and attending health services

Many participants described the variety of difficulties they face when seeking to access and attending health services. These have been broken down into the following subthemes: challenge of contacting services; the fight to obtain an interpreter; and the lack of awareness of Deaf culture within services.

The challenge of contacting services

Lack of text/email services

Many participants spoke of the frustration they face when seeking to contact services, explaining that many services require a phone call to make an appointment and thus are inaccessible to the Deaf community: "*No they are not suitable. Like ringing for example, I CAN'T RING! you know I feel like screaming down the phone like… and you might be experiencing all these kind of emotions!".* In addition, another participant spoke of the fact many support services provide helpline numbers which are only contactable by phone calls: *"its always phone numbers… and at the end you get the sheet and its always phone numbers. And there might be one number… just the one maybe that gives a text number or email. But all the others, there is no access…they are showing you all these numbers but I cant contact any of them!".* Other participants spoke about the need for more text services, though also mentioned that text services can be too slow: *"the text service is very difficult or very slow… You're finding there is layer upon layer of barriers and that can really affect you!"*

Reliance on others

A number of participants spoke about their frustration at having to rely on family or friends in order to make contact with services, with some stating that relying on others made them feel like a burden. One participant explained that relying on her family to contact services reduced her motivation to attend, stating: "*I usually have to get my husband to make the call to book the GP because there isn't a text or an email system. So I end up having to wait for my husband to make that call or I end up relying on my daughter and that does annoy me and turns me off wanting to make an appointment."*

The fight to obtain an interpreter

The vast majority of participants in the study alluded to the importance of having an ISL interpreter provided in services in order to facilitate communication between the Deaf person and healthcare professionals. However, participants discussed the many barriers they have to overcome when trying to obtain an ISL interpreter.

Lack of funding

Many participants discussed the lack of provision of ISL interpreters within certain services due to a lack of funding. For example, one participant explained the lack of funding provided for interpreters within GP settings for patients whom do not have a medical card, stating: *"it is fine for those who have a medical card, interpreters are provided, and then a Deaf person who is in full time employment cannot access a GP with an interpreter because there is no funding there… it is very frustrating!".* In addition, participants outlined the negative impact that a lack of funding for ISL interpreters can have on the community, stating: "*I think the attitude in the health service is always about the funding – 'oh we have to pay for interpreters, oh who is going to pay' – it's the cost! That creates an extra anxiety."*

Reluctance from services

Furthermore, participants described a reluctance within some services to provide an interpreter. Participants explained that this reluctance can lead the service asking the Deaf person to bring a family member to translate instead, as illustrated by one participant whom stated: *"I did say that I was depressed and I wanted to know if I was able to access services with an interpreter and they suggested that I would bring a family member and I said 'no I did not want to bring a family member with me' and they did not want to provide an interpreter."* Likewise, another participant recounted the difficulty they had in trying to get access to an ISL interpreter during counselling due to the reluctance of the service provider: *"I went to a counsellor… and initially they said 'No no no, no interpreter!' and so we tried to write it down. And it took about two hours! And it was so frustrating… and I said to them please can we get an interpreter… eventually I gave up after a couple of times."*

Poor organisation within services

In addition, a number of participants spoke of attending appointments in services whereby the ISL interpreter that they had requested had not been organised due to poor organisation within services. Many participants described feeling frustrated, angry, let down and reluctant to engage as a result of these experiences, as illustrated in an excerpt from one participant: *"that happens a lot in the Deaf community. So everything is arranged and things are in order, we have the interpreter and we have the appointment, and then they say 'oh we forgot* *to book it'... then people are reluctant then to do that again and your motivation to engage is gone… and that's in a mental health setting!".*

Responsibility lying with the Deaf person

Lastly, when discussing the provision of ISL interpreters, many participants alluded to the active role they have to play to obtain an ISL interpreter, often having to take responsibility in terms of organising the interpreter. Participants explained how this could often be a challenge for Deaf people due to the added pressure, burden and high motivation required to take on this task. This is illustrated by one participant who stated: "*It ends up being the responsibility of the Deaf person to book the interpreter, to check the availability, to get in contact with the interpreting agency… I should be able to just turn up and know that an interpreter is going to be there! But the burden is on us, as Deaf people, to ensure the interpreter is available.".*

The lack of Deaf awareness within services

When describing current services, participants spoke about the lack of awareness of Deaf culture within services. This was discussed in terms of professionals making inaccurate assumptions about communication needs and providing an unsuitable service to the Deaf community.

Inaccurate assumptions about communication needs

Many participants spoke about health professionals making inaccurate assumptions that they could just lip-read or use paper and pen during consultations: "*Sometimes you hear* '*Oh you don't need an interpreter, you can lip read.' and I said 'No. I cant lip-read, and I want the interpreter!'*". Likewise, one participant spoke about the difficulty this can pose with communication during the consultations, stating: *"the doctor will be looking at his computer and is not looking at me when he is talking to me… So I am kind of of missing out on things… So he is expecting and assuming I can lip read him, but I can't even see his face… there is an issue with communication".*

Providing an unsuitable service

Participants spoke about how the lack of awareness and appreciation for Deaf culture can have a negative impact on the quality of the service Deaf people receive. Participants spoke about the unique history, experience, and difficulties that members of the community face, which must be understood in order to provide an effective service to them: *"Say if you're explaining something to a psychologist and then the psychologist has no Deaf awareness… they can give the wrong information, or the wrong recommendations because they don't know the background!".* One further participant spoke about her experience of becoming ill after being prescribed with unsuitable medication by a GP as a result of communication difficulties during the consultation.

The hope to be heard

Throughout the discussion, participants spoke of their hope for change and the development of inclusive services for Deaf people; including increasing the number of Deaf people working within services and being provided an option of obtaining counselling abroad.

Deaf people working within services

Many participants made reference to the fact that there are currently very few Deaf counsellors available in Ireland and explained the necessity of having Deaf people trained to work directly with service users in order to facilitate communication. This was illustrated in an excerpt from one participant who stated: *"We need Deaf people, who have qualifications working in the HSE… who know how these things work rather than hearing people who know a lot about mental health and have done research, and that's fantastic… but they won't have a good understanding of the Deaf community… understand Deaf culture, the background, the history as well… in order to understand each other".* The need for Deaf people working within services was also described by a number of participants as being important to provide members of the community with *"role models".*

Option of going abroad for counselling

For some participants, they outlined the importance of Deaf people having an option of availing of services from outside Ireland via use of technology in order to maintain their privacy and confidentiality. This was outlined by one participant in particular who noted: *"They have deaf counsellors in England, they have a big system there. And I think that would be more helpful to be able to go outside. I think it would be better because they wouldn't know me, and I wouldn't know them and we would be able to have… a better counselling relationship, it would be easier."* Participants spoke about the importance of receiving support and funding for interpreters in order to access this remote counselling.

Discussion

This research provided insight into the views and experiences of members of the Deaf community in Ireland with regards to mental health needs and the accessibility of services. Participants discussed factors that increased their vulnerability for mental health issues, the difficulties they experience in accessing and attending health services, and the hope to be heard and improvements to be made within services.

In terms of vulnerability factors, participants spoke about their experience of social isolation within the home environment, as well as within specific contexts, such as nursing homes and living in rural settings, and the negative impact this has on their mental wellbeing. Indeed, the literature suggests that approximately 90% of Deaf children are born to hearing parents, and thus due to the resulting communication barrier, many Deaf people are regularly excluded from conversations within their home environments (Hauser, O'Hearn, McKee, Steider, & Thew, 2010). As highlighted by participants, social isolation can further extend into the school and workplace environments, making it challenging for Deaf people to develop friendships and good working relationships (Batten, Oakes, & Alexander, 2014; Steinberg, Sullivan, & Montoya, 1999). In addition, participants spoke about the negative impact poor employment opportunities can have in terms of their self-esteem and mental wellbeing. This is consistent with a report carried out in the UK which demonstrated that those with hearing loss felt limited in terms of their employment opportunities, often felt isolated at work, felt unable to fulfil their potential, and two-fifths had retired early due to communication difficulties at work (Arrowsmith, 2014). Furthermore, participants in this study discussed the stigma they experience within society and the negative impact this has on their mental wellbeing. Deaf stigma can be understood as the discrimination the Deaf community face as a result of living in a society which views deafness as a disability and thus operates in ways to devalue or exclude Deaf people (Mousley & Chaudoir, 2018). Research with a number of marginalized communities, such as those from sexual minorities, has demonstrated that stigma can have a negative impact on one's psychological and physical health (Hatzenbuehler, 2011; Quinn & Chaudoir, 2009). A recent study conducted by Mousley and Chaudoir (2018) with 171 Deaf emerging adults found that enacted stigma, though not anticipated or internalised stigma, was found to be related to worse depression, anxiety and quality of life, thus highlighting the negative impact stigma can have on the mental health of

Deaf people. Given that the Deaf community are more at risk of experiencing mental health difficulties, this highlights the importance of ensuring there are available services for them to avail of.

A Vision for Change and the *HSE's National Guidance of Accessible Health and Social Care Services*, outlined a number of recommendations to ensure services are made accessible for members of the Deaf community. However, as discussed by participants within this study, many of these recommendations have not been successfully implemented within clinical practice and current services continue to present many significant access barriers. Many participants spoke of their frustration at having no email or text service option for contacting numerous services, including crisis supports, thus rendering them inaccessible. The common practice of accessing services and supports via telephone contact is clearly inaccessible to Deaf people and thus this needs to be taken into consideration when designing services. Participants spoke about their frustration at having to rely on family or friends to contact services on their behalf which reduces their independence and can create feelings of burdening others. Of concern, a number of participants also reported that they were consequently less likely to contact and engage in services due to accessibility issues.

Furthermore, many participants discussed the challenges they face in terms of accessing an ISL interpreter for healthcare appointments. Effective communication is a central and pivotal component of providing high quality mental health services and thus interpreters play an important role in facilitating the communication between health professionals and clients (Miletic et al., 2006). The alternative options often relied upon, as discussed by participants, include relying on friends or family members to interpret, using written communication or relying on lip-reading, which are all problematic (Earis & Reynolds, 2009). Issues with relying on family or friends to interpret include the fact that their signing skills may not be at the required level to enable them to translate and explain more complex terms or ideas, they are impartial and thus may not relay all information, they may interject their own opinions or conclusions, and the confidentiality of the client is compromised (Reeves et al., 2003; Wright 1993). In terms of lip-reading, Reeves and colleagues (2003) highlighted that this can be a difficult mode of communication due to the fact many words in English can be difficult to distinguish from one another based on mouth movements alone, and this can be made even more difficult based on one's accent or speed of speaking. Furthermore, relying on written communication can be frustrating and time-consuming as highlighted by participants within this study, whilst also potentially posing additional challenges given that sign language users often have lower levels of literacy than the hearing population (Dye, Kyle, Denmark, Dury, & Ladd, 2000). Therefore, ISL interpreters can play a key role in terms of ensuring members of the Deaf community can communicate effectively with non-signing healthcare professionals and thus efforts should be made to improve Deaf people's access to interpretation services.

Many of the barriers the Deaf community face in terms of societal and occupational participation and access to services are reflective of a broader lack of awareness and understanding of the cultural and communication needs of the community (Luft, 2000). Participants in this study outlined how a lack of Deaf awareness often led to health professionals making inaccurate assumptions regarding their communication needs, and increased the risk of them receiving an unsuitable service. As discussed by Corbett (2003), it is imperative that mental health professionals have an adequate understanding of the culture of a client so as to provide them with a good quality service. Thus, it is important for mental health professionals to ensure that they have sufficient knowledge of the unique cultural and linguistic issues that are relevant to the Deaf community so as to meet their needs. To allow for this, relevant training, education and supervision should be provided to increase Deaf awareness amongst health professionals (Boness, 2016).

In addition, many participants spoke of their hope for changes to occur to allow for more inclusive services for the Deaf community. In particular, many participants spoke of the importance of having Deaf people trained and working directly within services. According to guidelines published by the Joint Commissioning Panel for Mental Health (2017) in the UK, Deaf people should have the option of receiving primary mental health care services directly from a sign language practitioner, if preferred. Research suggests that Deaf people not only prefer direct access to sign language- fluent mental health care providers, but achieve better outcomes when provided with this opportunity (Landsberger et al., 2013; Pollard et al., 2014). Furthermore, participants proposed that having an option of remotely availing of counselling services based in the UK would be helpful in terms of protecting their privacy.

To our knowledge, this is the first study undertaking a qualitative exploration of the views and experiences of the Deaf community in Ireland on mental health and accessing relevant services. This study has therefore provided a valuable insight into the views and experiences of this community and highlighted areas in which services and supports must improve in order to be inclusive and accessible for Deaf people. In terms of limitations of this study, participants were all members of an organisation for Deaf people within a community setting and thus findings should not be interpreted as representative of the national Deaf community. In addition, it is important to note that running focus groups within the Deaf community, an often close knit community, may have reduced participants' levels of comfort with disclosing personal experiences in terms of their mental health experiences. In an attempt to mitigate against this, participants were provided with the option of an individual interview, though all opted to participate in the focus group. Furthermore, due to the large number of participants in the first focus group, it is possible that not every participant was provided with enough time to share their views. On this basis, a decision was made to have a second focus group and add a second interpreter to facilitate the moderation and interpretation process. The Deaf organisation, interpreters and participants were provided multiple opportunities to provide recommendations and feedback to ensure the research project was accessible, met the needs of participants, and improvements could be made to facilitate communication and understanding between the research group and participants.

Conclusion

Overall, the findings from this study suggest that the Deaf community are vulnerable to experiencing mental health difficulties due to a range of societal factors, including isolation, exclusion and stigma. However, it is of concern that Deaf people experience many barriers when accessing and attending services which therefore limits their opportunity to receive appropriate support. There is a need for services to implement changes and improve accessibility, ensure services are contactable via email or text messaging, that health professionals have an awareness of Deaf culture, that ISL interpreters are organised and provided by services, and that there is a effort to train and employ more Deaf people within services.

References

Arrowsmith, L. (2014). *Hidden Disadvantage: Why people with hearing loss are still losing out at work.* Retrieved from https://www.actiononhearingloss.org.uk/~/media/Documents/Policy%20research%20and%20influencing/Research/Hidden%20Disadvantage/Hidden_Disadvantage_full_report.ashx

Balch, G., & Mertens, D. (1999). Focus Group Design and Group Dynamics: Lessons from Deaf and Hard of Hearing Participants. *The American Journal of Evaluation*, *20*, 265–277. https://doi.org/10.1016/S1098-2140(99)00019-3

Batten, G., Oakes, P. M., & Alexander, T. (2014). Factors associated with social interactions between deaf children and their hearing peers: A systematic literature review. *Journal of Deaf Studies and Deaf Education*, *19*(3), 285–302. https://doi.org/10.1093/deafed/ent052

Boness, C. L. (2016). Treatment of Deaf Clients: Ethical Considerations for Professionals in Psychology. *Ethics & Behavior*, *26*(7), 562–585. https://doi.org/10.1080/10508422.2015.1084929

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Corbett, C. A. (2003). Special Issues in Psychotherapy with Minority Deaf Women. *Women & Therapy*, *26*(3–4), 311–329. https://doi.org/10.1300/J015v26n03_09

Department of Health & Children (2006). *A Vision for Change: Report of the Expert Group on Mental Health Policy*. Retrieved from https://www.hse.ie/eng/services/publications/mentalhealth/mental-health---a-vision-for-change.pdf

Dye, M., Kyle, J. G., Denmark, C., Dury, A., & Ladd, P. (2000). *Deaf people in the Community: Health and Disability.* Bristol: Deaf Studies Trust.

Earis, H., & Reynolds, S. (2009). *Deaf and hard-of-hearing people's access to primary health care services in North East Essex.* Retrieved from http://www.sally-reynolds.com/wp-content/uploads/2012/12/Report-on-access-for-NE-Essex-PCT.pdf

Fellinger, J., Holzinger, D., Dobner, U., Gerich, J., Lehner, R., Lenz, G., & Goldberg, D. (2005). Mental distress and quality of life in a deaf population. *Social Psychiatry and Psychiatric Epidemiology*, *40*(9), 737–742. https://doi.org/10.1007/s00127-005-0936-8

Fellinger, J., Holzinger, D., & Pollard, R. (2012). Mental health of deaf people. *Lancet (London, England)*, *379*(9820), 1037–1044. https://doi.org/10.1016/S0140-6736(11)61143-4

Hatzenbuehler, M. L. (2011). The Social Environment and Suicide Attempts in Lesbian, Gay, and Bisexual Youth. *Pediatrics*, *127*(5), 896–903. https://doi.org/10.1542/peds.2010-3020

Hauser, P. C., O'Hearn, A., McKee, M., Steider, A., & Thew, D. (2010). Deaf epistemology: Deafhood and Deafness. *American Annals of the Deaf*, *154*(5), 486–492; discussion 493-496. https://doi.org/10.1353/aad.0.0120

Health Service Executive, National Advocacy Unit, & National Disability Authority. (2016). *National Guidelines on accessible health and social care services - a guidance document for staff on the provision of accessible services for all.* Retrieved from https://www.peamount.ie/assets/natguideaccessibleservices.pdf

Joint Commissioning Panel for Mental Health. (2017). *Guidance for commissioners of primary care mental health services for deaf people.* Retrieved from https://www.jcpmh.info/resource/guidance-commissioners-primary-care-mental-health-services-deaf-people/

Kuenburg, A., Fellinger, P., & Fellinger, J. (2016). Health Care Access Among Deaf People. *Journal of Deaf Studies and Deaf Education*, *21*(1), 1–10. https://doi.org/10.1093/deafed/env042

Kvam, M. H., Loeb, M., & Tambs, K. (2007). Mental health in deaf adults: Symptoms of anxiety and depression among hearing and deaf individuals. *Journal of Deaf Studies and Deaf Education*, *12*(1), 1–7. https://doi.org/10.1093/deafed/enl015

Landsberger, S. A., Sajid, A., Schmelkin, L., Diaz, D. R., & Weiler, C. (2013). Assessment and treatment of deaf adults with psychiatric disorders: A review of the literature for practitioners. *Journal of Psychiatric Practice*, *19*(2), 87–97. https://doi.org/10.1097/01.pra.0000428555.48588.f9

Leeson, L., & Saeed, J. L. (2012). *Irish Sign Language: A Cognitive Linguistic Approach*. Edinburgh, UK: Edinburgh University Press.

Levine, J. (2014). Primary care for deaf people with mental health problems. *British Journal of Nursing (Mark Allen Publishing)*, *23*(9), 459–463. https://doi.org/10.12968/bjon.2014.23.9.459

Luft, P. (2000). Communication barriers for deaf employees: Needs assessment and problem-solving strategies. *Work (Reading, Mass.)*, *14*(1), 51–59.

Mental Health Reform. (2015). *A Vision for Change Nine Years On: A coalition analysis of progress*. Retrieved from https://www.mentalhealthreform.ie/wp-content/uploads/2015/06/A-Vision-for-Change-web.pdf

Miletic, T., Piu, M., Minas, H., Stankovska, M., Stolk, Y., & Klimidis, S. (2006). *Guidelines for Working Effectively with Interpreters in Mental Health Settings*. Retrieved from http://www.vtpu.org.au/docs/interpreter/VTPU_GuidelinesBooklet.pdf

Morgan, D. L. (1996). Focus Groups. *Annual Review of Sociology*, *22*, 129-152. http://dx.doi.org/10.1146/annurev.soc.22.1.129

Mousley, V. L., & Chaudoir, S. R. (2018). Deaf Stigma: Links Between Stigma and Well-Being Among Deaf Emerging Adults. *Journal of Deaf Studies and Deaf Education*, *23*(4), 341–350. https://doi.org/10.1093/deafed/eny018

Pertz, L., Plegue, M., Diehl, K., Zazove, P., & McKee, M. (2018). Addressing Mental Health Needs for Deaf Patients Through an Integrated Health Care Model. *Journal of Deaf Studies and Deaf Education*, *23*(3), 240–248. https://doi.org/10.1093/deafed/eny002

Pollard, R. Q., Betts, W. R., Carroll, J. K., Waxmonsky, J. A., Barnett, S., deGruy, F. V., Pickler, L. L., & Kellar-Guenther, Y. (2014). Integrating primary care and behavioral health with four special populations: Children with special needs, people with serious mental illness, refugees, and deaf people. *The American Psychologist*, *69*(4), 377–387. https://doi.org/10.1037/a0036220

Quinn, D. M., & Chaudoir, S. R. (2009). Living with a concealable stigmatized identity: The impact of anticipated stigma, centrality, salience, and cultural stigma on psychological distress and health. *Journal of Personality and Social Psychology*, *97*(4), 634–651. https://doi.org/10.1037/a0015815

Reeves, D., Kokoruwe, B., Dobbins, J., & Newton, V. (2003). *Access to Primary Care and Accident & Emergency Services for Deaf People in the North West: Final Report*. Manchester: University of Manchester.

Roberts, C., & Hindley, P. (1999). The assessment and treatment of deaf children with psychiatric disorders. *Journal of Child Psychology and Psychiatry, and Allied Disciplines*, *40*(2), 151–167.

Sign Language Interpreting Service. (2016). *Evaluation of the Irish Remote Interpreting Service (IRIS)*. Retrieved from https://slis.ie/wp-assets-slis/uploads/2018/04/Irish-Remote-Interpreting-Service-IRIS-Evaluation-Report-2016.pdf

Steinberg, A. G., Sullivan, V. J., & Montoya, L. A. (1999). Loneliness and Social Isolation in the Work Place for Deaf Individuals During the Transition Years: A Preliminary Investigation. *Journal of Applied Rehabilitation Counseling*, *30*(1), 22–30. https://doi.org/10.1891/0047-2220.30.1.22

Willig, C. (2013). *Introducing Qualitative Research in Psychology*. Maidenhead, Berkeshire, England: Open University Press/McGraw-Hill Education.

World Health Organisation. (2018). *Hearing loss: rising prevalence and impact.* Retrieved from https://www.who.int/bulletin/volumes/97/10/19-224683/en/

World Health Organization, & World Organisation of Family Doctors. (2008). *Integrating mental health into primary care: A global perspective*. Retrieved from https://www.who.int/mental_health/resources/mentalhealth_PHC_2008.pdf

Wright, D. (1993). Deaf people's perception of communication with nurses. *British Journal of Nursing*, *2*, 567-571.

Appendix A

Focus Group Interview Schedule

1. Tell me what good mental health means to you?

2. (a) Tell me what mental health difficulties mean to you?

2. (b) How do people know if they are running into difficulty with their mental health?

3. (a) What things can we do to take care of our mental health?

3. (b) What do you think has a negative impact on our mental health?

4. (a) How do you think mental health is in the Deaf Community in Ireland?

4. (b) How are the mental health needs of the Deaf community currently being met in Ireland?

5. (a) Is there anything in particular the Deaf community need to do to take care of their mental health?

5. (b) Is there anything that has a negative impact on mental health in the Deaf community in particular?

6. Who would you like to talk to about mental health difficulties (e.g., feeling stressed, anxious or depressed)?

7. What are some of the things that might prevent someone from the Deaf community getting help for mental health difficulties?

8. What are some of the things that might help someone from the Deaf community getting help for mental health difficulties?

9. How can the current mental health and wellbeing services provided be improved for the Deaf community?